Memorandum

June 23, 1988

To: Blue Ribbon Commission members

From: Graham Atkinson

Regarding: Draft report of the Blue Ribbon Commission.

Attached is my first attempt at a draft report. It follows the outline I described at the end of second retreat, and the instructions you gave me at that retreat. It embodies the results of the discussions that the Commission has had over the past six months, and my understanding of the decisions that were made, even where these decisions were not the subject of a vote. In some instances the views expressed were not the unanimous view of the Commission members, and in some, where I have inadvertently used too much discretion, they may not even represent the majority view of the Commission. Non-Commission members should keep this point in mind when reading this first draft report.

Where a list of options has been presented I have attempted to give a recommendation as to which option is preferable.

Annika is preparing an introduction and background section to be included in the report.

Once decisions have been made on the various open issues I would plan to provide more background in the report to explain these decisions. I would also plan to include an executive summary listing the major recommendations, and the areas which the Commission considers require further study.

DRAFT REPORT

of the

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

DRAFT 1
June 23, 1988

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Draft report of the Blue Ribbon Commission on Health Care Expenditures

Introduction and background

This section is being written by staff.

Regulation of hospital rates or revenues

Inpatient rates or revenues

Three options are still open:

1) No rate regulation of hospitals of under 55 beds (This option has not received much discussion yet) .

2) Total revenue system for hospitals with relatively self contained catchment areas[1].

3) Rate per case (DRG) payment system[2].

These options are not mutually exclusive. In fact a decision could be made to recommend all three for different situations.

Recommendation: Provide both options 2) and 3).

We should also have some further discussions of the implications of no rate regulation for small hospitals, and make a decision on that issue.

The question then arises as to how hospitals will choose or be assigned to an option. Hospitals which have no close competitors could be allowed to choose freely. Hospitals which have close competitors should be required to be in the per case payment system.

Outpatient rates or revenues

The current system of regulating the rates of hospital outpatient services is unsatisfactory because the unit of measure for volume, equivalent inpatient admissions, is inadequate. Some

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[1] This system is described briefly in Appendix B.

[2] The DRG revenue system is described in outline in Appendix C.

change in the method of regulation is therefore needed. Outpatient services are the fastest growing component of hospital care, but the growth is mainly due to increase in volume and not increase in rates. Separate recommendations will be provided for hospitals on the total patient revenue system and for hospitals on the rate per case system.

Hospitals on the Total patient revenue system:

The total patient revenue payment system would include the revenues from both inpatient and outpatient services. This is essential since there is a shift occurring from inpatient to outpatient settings, and it would be unreasonable to have a system which guaranteed a constant inpatient revenue while inpatient volume was declining, and an increasing outpatient revenue because outpatient volume was increasing. Also, to attempt to separate the inpatient and outpatient costs and revenues would unnecessarily complicate the system. Hospitals on this payment system will be in areas with relatively steady or declining populations. The rate setting body will set a total revenue for the hospital each year. This revenue will include both inpatient and outpatient revenues. More detail on the working of this system is provided in Appendix B.

Hospitals on the rate per case payment system for inpatients:

Choices: 1) No regulation of outpatient rates, or

2) Set the rate per unit of service by department[3].

Recommendation: No regulation of outpatient rates.

Rationale: Setting the rate per unit of service is a cumbersome regulatory mechanism. It only controls the increase in the rate per unit of service, and does nothing to control utilization, which is the major driving force behind outpatient cost increases. Hospitals will be collecting different units of volume, so the rates set for a department in different hospitals will not be comparable. The system would generate many complaints from hospitals due to the problems associated with tracking the rate being charged and staying close to the approved rate.

Regulatory Agency

Some agency must be assigned to administer the rate regulation system that is established. The principal options are:

1) The Maine Health Care Finance Commission, or

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[3] A description of this system is provided in Appendix A.

2) Some new Commission.

Recommendation: Option 1, since the MHCFC has an established staff with knowledge of the Maine hospital system, and a data base which will be essential for any new system.

In the subsequent discussion the regulatory agency is referred to as the Rate Setting Body (RSB).

Components of the rate setting system.

Specialty hospitals

There are two specialty hospitals in Maine which will require separate consideration. These are a psychiatric hospital and a rehabilitation hospital. The Diagnosis Related Groups are not satisfactory for setting the rates for these hospitals, or for reviewing their efficiency level.

The recommended system to control the rates of the specialty hospitals would be a total revenue system with adjustments for change in volume of service. An alternative, which in practice is very similar, would be a per diem system.

If the specialty hospitals are likely to experience a change in their case mix, then they may want to suggest a method of measuring that change, and a set of output measures which would accurately reflect changes in their volume of service.

Cost base

The two major choices for the cost base for deriving the rates or revenues under the new system are:

1) The current MHCFC cost base, or

2) the actual costs incurred in some recent year, as reported in the Medicare Cost Report, and augmented by the additional cost categories used by the MHCFC.

One of the complaints that is often heard from hospitals against the current system is that hospitals which had the misfortune to be low cost in the base year used by the MHCFC have been kept low cost, and hospitals which had relatively high costs in their base year have continued to be paid relatively generously. This is a problem with any system which picks one year and then pays the hospitals on the basis of their own costs in that year with adjustments for inflation, volume, and such factors. Thus moving to a more recent base year would not correct the problem, just change the winners and losers somewhat. Building in a standard component to the rates, as discussed below, does deal with this

problem, but at the cost of considerable extra complexity in the system.

Recommendation: Change the cost base to a more recent year. To deal with the problems of hospitals which were low cost in the base year include a standard component in the rate. If the decision of the Commission is that budget neutrality should be preserved relative to the current system then this could be accomplished by making a pro-rata reduction to all the rates to reduce the overall cost base to the level of the MHCFC cost base.

Standard component or screens

As mentioned above, when the payment rates for several years are based upon the actual costs of the hospital in a single year then hospitals which are low cost in that year will be required to stay low cost and hospitals which were inefficient in that year will be permitted to stay inefficient, or will be overly rewarded as their efficiency improves. To adjust for this problem it is possible to base the rates of the hospitals partly on hospital specific costs and partly upon a standard. An alternative, which deals with the problem of the inefficient hospitals but not the low cost hospitals, is to set upper limits on the charges. The appeal mechanism would be left to deal with problems experienced by hospitals which were low cost in their base year.

Question: Should the rate for each hospital be based:

1) Entirely on its historical cost, or

2) Partly on the historical cost of the hospital and partly on a standard cost.

Recommendation: Option 2.

The standard rate could be based on a state (or peer group) average rate, or could be calculated from the Medicare rate, with some adjustments for the inequities of the Medicare payment system. The advantage of basing it on the Medicare rate is that this is already known, while developing a state standard would turn into a complicated exercise as it became necessary to adjust for all the various factors which would be raised and which account for justifiable differences in the cost levels of the hospitals, e.g. direct and indirect medical education costs,

Question: Should the standard rate be developed from:

1) Maine hospital data, or

2) Medicare payment rates, adjusted for known inequities, and the difference between the resource use of Medicare versus non-Medicare patients.

Recommendation: Option 2.

Question: How much of the rate should be the standard and how much should be hospital specific?

Recommendation: The standard component should start at 10%, and increase over time, but not go over 50%.

Capital costs

The MHCFC defines capital costs in a different way from the Medicare program. The major question is whether hospitals should be paid depreciation for buildings and fixed equipment, or the principal payments that they are required to make. Depreciation payments are higher at the start of a facility's life cycle, while principal payments are higher towards the end of the life cycle. Many economic arguments can be provided against the use of depreciation for payment purposes, and changing now to using depreciation in place of principal would increase the payments to the Maine hospitals, so would result in an increase in charges.

Question:

The two major options for capital payments are:

1) the formula used by the MHCFC, or

2) the Medicare definition of capital costs.

Recommendation: Option 2, for the reasons and with the caveats described below.

This issue causes a great deal of controversy because use of a basis of payment other than depreciation results in paper losses in the financial statements of hospitals. Given this controversy it is probably better to just use the Medicare definition of capital costs. However, hospitals should be required to fund depreciation, and to either use their accumulated depreciation to pay for new projects, or alternatively, to offset interest income against income expense.

Adjustments for new projects

When new Certificate of Need projects are implemented some adjustments may be necessary to the rates of the hospital implementing the project. The use of the word "may" in this context is quite deliberate. Under either of the payment systems, if a project can be expected to result in savings in operating costs then these savings may offset the cost of the project and so no rate adjustment is in order. If the payment system involves a per case payment rate, and the project results

in additional volume of cases, or additional outpatient volume, then all or part of the project cost will be recovered through the increased volume. In the per case payment system, and in the total revenue system a component should be built into the adjustment factor from one year to the next to account for change in technology, new projects, etc. Additional revenues should only be provided for projects which have a large impact on cost which is not accounted for through volume, cost savings, or the allowance provided.

Question:

The addition of new project costs can be accomplished by either:

1) requiring all adjustments to be subject to a review, or

2) by providing a fixed allowance to cover most small projects, and changes in medical practice which apply to most hospitals, and only making adjustments for major projects.

Under a per case payment system based on the hospital's own historical cost, with or without a standard element, some adjustments will be required for major new projects. The net increased cost not covered by volume adjustments would have to be calculated and used to adjust the approved payment rate. However, many projects could be covered within an allowance for new technology and changes in medical practice. The cost per discharge could be allowed to increase at 1% over the market basket factor, and this 1% allowance would be intended to cover changes in technology, new projects, and changes in medical practice. Only major projects which could not be covered within this allowance would result in a rate change. The advantage of this approach is that the majority of CoN and other projects would not require explicit rate adjustments, and the problem of quantifying cost offsets and net incremental costs for these projects is sidestepped. This simplifies the system, and provides an incentive to the hospitals to plan their projects cost effectively.

Recommendation: Option 2.

Differentials and discounts

The current system allows for some approved discounts. Blue Cross currently receives such a discount, and the rates of other payors are increased to adjust for the discount provided to Blue Cross. The discount to Blue Cross was quantified through a study which demonstrated the magnitude of the discount that was economically justified. Such discounts could continue.

The major question which must be addressed is whether the

hospitals and payors should be permitted to negotiate discounts which are not economically justified, and not reviewed by the RSB. Certainly hospitals should not be provided solvency guarantees if they provide unapproved discounts, and they should not be permitted to increase their charges to other payors to recoup the shortfalls resulting from voluntarily negotiated discounts which are not economically justified or approved.

Question: Should hospitals be allowed to negotiate discounts and alternative payment methods with payors?

Recommendation: Total patient revenue system hospitals should only be permitted to give discounts which are approved by the RSB. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods, provided that the discounts do not increase the charges to other payors.

Inflation and other adjustments

Various agencies produce estimates of the impact of inflation on the prices of goods and services purchased by hospitals. Medicare does this for the PPS (although the PPS rate increases end up being driven by budget considerations rather than the market basket inflation), the American Hospital Association publishes a market basket, and the various state rate setting agencies have similar indices. These indices are generally quite similar in their construction and magnitude. The rate of inflation in the prices that hospitals pay for goods and services is generally a little higher than the inflation experienced in the Consumer Price Index. This year it is likely to be considerably higher because of the higher wage and salary increases being provided to nurses and other health professionals. Any of the standard indices is satisfactory for the purpose of adjusting for the reasonable impact of inflation on hospital supply costs. The major question which must be addressed is what index to use to adjust for increases in wage and salary costs. If the index for wages is based on the increase in wages in Maine hospitals then it becomes a self-fulfilling prophecy.

Question: What index should be used to adjust for inflation in hospital wage and salary costs?

Options: 1) Hospital workers in the North-east.

2) Health care workers in the North-east.

3) Hospital workers nationally.

4) Health care workers nationally.

5) Service workers.

Recommendation: Option 1).

Medical technology, changes in medical practice and case mix increases have consistently resulted in hospital inpatient cost per discharge increasing at a substantially higher rate than the market basket inflation factors discussed above. Historically the rate of increase in hospital cost per discharge has increased at 3 to 4% per year faster than the market basket[4].

Question: How much of an allowance should be provided within a per case payment system to account for changes in medical technology, new projects, change in medical practice, new drugs, etc.?

The Prospective Payment Advisory Commission has recommended that the increased costs due to these factors should be offset by improvements in productivity. Maryland provides an allowance of 1% per year for these factors, but requires hospitals to absorb the costs of most new projects within this allowance. New York State has provided some enhancements to the cost bases of the hospitals, which probably amount to about 1% for 1988, but thereafter is apparently intending to permit no specific allowance for these factors. New York State will adjust the rates for the "incremental non-volume related operating costs" of CoN projects.

Case mix change will be automatically accounted for in the per case DRG payment system being discussed, so it is necessary to estimate the amount of the increase in revenue per case that can be expected as a result of increase in case mix intensity. While no good national data is available on the total population, there is good case mix data for the Medicare population. The case mix intensity increases from 1984 to 1985, and from 1985 to 1986 for all hospitals in the U.S. and for New England are provided in the table below[5]:

	Percent change	
	1984-85	1985-86
U.S.	3.1%	2.0%
New England	1.9%	2.9%

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[4] For specific figures for recent years see the projections paper recently distributed.

[5] The source of this data is "Medicare Prospective Payment and the American Health Care System: Report to Congress", June 1988, Prospective Payment Assessment Commission.

Options:

1. Provide an allowance of 1%.

2. Provide a higher allowance.

3. Provide no allowance and deal with this issue on an exception basis through appeals.

Recommendation: Option 1. But track the case mix increase in Maine, and any allowances provided for appeals, and review this figure after 2 or 3 years.

Volume adjustments

Within the total revenue system there would be no automatic volume adjustments. There could be some volume adjustments, say using a 50% variable cost factor, for volume changes exceeding some corridor, say of 5%.

Within the per case DRG payment system there are a multitude of options. The major options are:

1 Make no volume adjustments to the operating cost rate

This simplifies the system, and reduces the magnitude of adjustments, but provides an incentive to increase volume and a penalty for decreasing volume.

2 Volume adjustments at some variable cost factor

This ensures that the rates will be decreased as volume increases, and that the rates of hospitals with declining volumes will be increased to compensate for the volume decline. For any substantial changes in volume a variable cost factor of 70 to 85% would be appropriate. To reduce the complexities of the system a corridor can be established, and no volume adjustments made while the volume stays within that corridor. A corridor of 2% would be suitable for this purpose.

If the volume changes during a year, should the approved rate for that year be changed retroactively, or should the changes only be made prospectively? Should the prospective changes be for the past difference between budgeted and actual volume, or only for the new budgeted volume?

Recommendation: Within the per case payment system have no retroactive volume adjustments for the year in which the volume change takes place. This simplifies the system, and reduces revenue fluctuations from year to year. When setting rates use new volumes based on the most recent year available, and adjust

for changes in volume from the base year using an 80% variable cost factor.

Appeal mechanism

The systems being discussed are largely formula driven, but no formula driven system can anticipate every eventuality. Some mechanism must be built into the system so that a hospital can appeal for changes which are unexpected and not automatically adjusted for. At the same time, the appeals must be limited or they will defeat the purpose of the regulatory system to control costs and charges.

The appeal mechanism should be limited to major items, say items having an impact on costs or revenues of at least 2% of the total costs of the hospital, and which are not taken account of in the formula used to develop the rates. The RSB should have the option of recommending that charges be cut if a hospital has filed an appeal and the RSB determines that the hospital's charges are too high.

Governmental shortfalls

The Medicare program is paying most hospitals much less than their charges and some less than their costs. Similarly the Medicaid program is underpaying hospitals. The current system ensures that the charges to the other payors can be increased to fully cover any shortfalls between the payments from Medicare and Medicaid and the financial requirements that the MHCFC allocates to Medicare and Medicaid. Two decisions have to be made in regard to the governmental shortfalls in the new system: 1) How much of the shortfalls should the hospitals be paid for, either by payments from pools or through increased charges to other payors, and 2) how is that payment to be made.

For the hospitals which opt for the Total revenue system, and which are needed for access to care, the costs and charges of the hospital will be subject to scrutiny by the RSB, which will be determining that the costs are reasonable. The governmental shortfalls relative to these reasonable costs should be paid in full. For hospitals on the per case payment system the answer is less clear.

This decision goes beyond just technical considerations. If the decision is made that the governmental shortfalls should be paid from a pool funded in part from general taxes, as recommended elsewhere in this report, then that places the decision of the amount of additional funding to provide for governmental shortfalls in an appropriate forum, namely the legislature. If the decision is that the shortfalls are all to be paid through hospital revenues, as at present, then some other mechanism must be developed for specifying the amount of the shortfall to be

included in the hospital charges. This could be done by the legislature on an annual basis, or it could be done by the RSB with some guidelines established in statute.

Options available include:

1 Include the entire amount of the shortfall

2 Freeze the shortfall at the 1987 level

3 Decide each year how much of the shortfall to fund

4 Include the shortfall in the 1987-88 rates in the rates approved for the hospitals, and have the legislature determine how much additional shortfall to fund from general revenues or special taxes.

Recommendation: Option 4.

Cross-subsidization

Emergency rooms and clinics are generally priced at substantially below cost. The charges for other services are increased to make up for the shortfall. There is some question as to whether the profits made on other outpatient services are sufficient to cover the shortfall on emergency rooms and clinics, or whether there is also some subsidy from inpatient care.

One option would be to provide direct subsidies from a pool to cover shortfalls in emergency room and clinic revenues, but this could remove any incentive to maximize collections for these services unless it was carefully designed.

The hospitals in the Total revenue system should continue to have cross subsidization permitted, as at present. For those in the per case payment system a policy decision must be made.

Question: Should hospital outpatient departments be cross-subsidized if they are not subject to rate regulation?

If the rates charged for outpatient services are deregulated, then it is difficult to justify charging the inpatients for services provided in an unregulated setting. It would be possible to include some set level of subsidy as long as the services were continued at the existing level.

Options for the level of cross-subsidy of emergency rooms and clinics:

1 Eliminate all explicit subsidies from inpatient services

2 Specify a set level of subsidy to be provided

3 Have the level of subsidy set each year

Recommendation: Option 1, with the proviso that some allowance for bad debts of clinics and emergency rooms would be provided from the pool.

Profit margins

Currently the MHCFC does not include any specific component for a profit margin. This is consistent with the rate setting mechanisms used in the other rate setting states in the north east. Hospitals do however require some profit margin in order to borrow at reasonable rates, for growth and for new equipment. The rationale that has been used for not including a profit margin is that the cost bases on which the rates have been set include some inefficiency, and so the hospitals should be able to generate profits by improving their efficiency.

A point which should be made clear is that this discussion of profit margins is not intended to limit the profits which could be generated by a hospital as a result of improvements in the efficiency of its operation, or response to incentives in the payment system. The question is whether an explicit element for profit should be built into the cost base. Such an additional element would result in increased payments by the payors since it is not included in the current cost base.

A mechanism whereby a profit margin could be included without increasing the charges to the payors would be to include a profit margin, but to limit the maximum charge per case so that the most expensive hospitals had to reduce their charges, with the profit margin and charge per case limit being set so that the net effect on revenues was zero. The profit margin could be increased and corresponding maximum charge decreased over time.

Questions: 1) Should some explicit profit margin be included in the rates of the hospitals?

2) Should any profit margin included be offset by reductions in the rates of high cost hospitals?

Demonstrations

Several different types of demonstrations should be encouraged. Demonstrations of pre-admission review of nursing home patients are discussed below so will not be discussed here. Two other

forms of demonstrations should be encouraged:

1) hospital payment demonstrations; and,

2) demonstrations on change of a hospital to a lower level of care.

Hospital payment demonstrations:

The current statute allows great flexibility for hospital payment demonstrations. The language in the current statute permitting demonstrations should be included in any new hospital rate or revenue regulation statute and hospitals should be encouraged to propose demonstrations.

Lower level facilities:

There are several hospitals in the state that are unlikely to be able to remain viable as acute general hospitals because of low patient volume. When the closure of such a hospital would cause access problems due to no acute general hospital being available within a reasonable travel distance it may be appropriate to have the hospital continue as a health care facility, but at a lower level than a general acute hospital. The State of Montana has a proposal to the Health Care Financing Administration for such lower level facilities, which would provide some basic inpatient care as well as outpatient care, and have lower licensing requirements so that costs could be reduced. Federal waivers would be needed to enable the facilities to be paid by Medicare for basic forms of inpatient care. This model, with some modifications, may be appropriate for Maine.

Legislation should provide for such demonstrations. The precise nature of the lower level facilities, the scope of care they should be permitted to provide, and the licensing requirements to which they should be subject, should be the topic for a task force including hospital, physician and payor representatives.

Pools for bad debts, charity care and governmental shortfalls

Bad debt and charity care pools are desirable where there are major differences in the bad debt and charity care loads of hospitals, and the resulting differential mark-ups from costs to charges place the hospitals with high bad debt and charity care loads at a disadvantage, for example, in contracting with HMOs or PPOs. At present there are hospitals which are relatively low cost, but which have relatively high charges because their rates include a large component for bad debts, charity care, and governmental shortfalls. In Maine the differences in bad debt and charity care loads among hospitals are not sufficient to justify the establishment of a pool just for the purpose of

spreading this more evenly across hospitals. Indeed, this spreading would have the effect of transferring money from less affluent rural areas to more affluent urban areas, which does not seem a very socially desirable result. Including the governmental shortfalls in the pool results in a reallocation which makes more sense from a social policy viewpoint.

Recommendation: A pool should be established to level the impact of bad debts, charity care, and governmental shortfalls across the hospitals, and to provide alternative sources for funding these requirements. This pool should be administered by the same agency that sets the rates of the hospitals.

Funding sources:

Possible funding sources for the pools are:

1. Contributions from hospitals.

2. General tax revenues.

3. Special taxes.

The states which have established bad debt and charity care pools have done so by a tax on the hospitals. The effect of the pools is thus to redistribute these costs uniformly across the hospitals, and so the private payors. However, it is still the case that the insured and the paying sick are being taxed to pay for the costs associated with treatment of the non-paying sick. It would be fairer to obtain a broader base of payment for these costs. The reason states have chosen the hospital tax option is that this is the option which has been most politically palatable, since it does not result in any new taxes, and is merely a redistribution of payments already being made which is difficult to argue against on social policy grounds.

A general tax, either an addition to the income tax or to the sales tax would spread the load more evenly. A payroll tax might be considered, or a tax on tobacco, alcohol or motor vehicles.

The payors for hospital services are now paying the bad debts, charity care and governmental shortfalls at the levels which are being incurred by the hospitals. It would be reasonable to expect the payors to continue to pick up the current level of these requirements. The governmental shortfalls are expected to continue to increase. It is proposed that the increase in the governmental shortfalls, together with any increase in reasonable bad debts and charity care, should be funded from a broadly based tax, e.g., a payroll tax. This would freeze the contribution from the payors at the current level, and require the legislature each year to determine how much of any increase in the governmental shortfall it was willing to fund, and what the

revenue source for that funding should be.

Question: Should the general funds pay for the increase in bad debts, charity care, and governmental shortfalls, or just for the increase in he governmental shortfalls?

Recommendation: A pool should be established to include bad debts, charity care, and governmental shortfalls. There should be two sources of revenue for this pool - 1) hospital contributions equal to the current level of these requirements, and 2) a general revenue contribution to pay for any increases.

The way in which the pool would be administered is outlined in Appendix D.

Certificate of Need review

The following represents my understanding of the majority opinion following the Commission's discussion of Certificate of Need. This was not a unanimous opinion, and there was agreement that the opinion should be reconsidered after decisions have been made on other aspects of hospital regulation and input has been received from other sources. In particular, a final decision on CON will not be made until after the Commission has received a presentation on LD2500.

Recommendation:

The CON process for high technology equipment should be applied uniformly, independent of the setting in which the equipment is to be installed. Thus, physicians or free standing diagnostic or other settings wishing to acquire high technology equipment exceeding the threshold would be subject to CON review in the same manner as hospitals.

The threshold for review of equipment purchases should be increased so that only very major equipment, such as MRI equipment or lithotripters, would be subject to review. It is recommended that equipment costing in excess of $1,000,000 be subject to CON review.

CON review should continue to apply to changes in capacity or services, as at present.

Nursing homes

No change is recommended to the regulation of nursing home rates for non-Medicaid patients. The hospitals in Maine have problems in placing high care Medicaid patients in nursing homes. These problems result in the patients experiencing extended hospital stays when they are not in need of that level of care. This

problem may be alleviated in three ways:

1) expansion of the supply of nursing home beds;

2) providing financial incentives to the nursing homes to take the heavier care Medicaid patients; and,

3) eliminating some marginal admissions to nursing homes by pre-admission review and thereby making more beds available for the patients in most need of them.

4) Allowing more "swing beds" in hospitals.

1. Expansion of the nursing home bed supply.

The state is already taking action to increase the supply of nursing home beds.

2. Providing financial incentives.

The Medicaid program is planning to develop and implement a severity based payment system for nursing home patients. The development and implementation of that system should be expedited.

3. Eliminating marginal admissions.

The Medicaid program should establish some demonstration programs in the use of pre-admission review for all patients, not just patients who are Medicaid eligible on admission to the nursing home. Such demonstrations have taken place in other states and some of these other demonstrations could be used as models for the program to be developed in Maine.

4. Swing beds for hospitals, subject to overall limits on nursing home beds

A swing bed program is available for small hospitals. This allows the eligible hospitals to use their unoccupied beds as nursing home beds, and be paid on that basis.

Hospice

Maine, like all other states, has a growing problem with AIDS in some of the major urban areas - particularly the Portland area. The existing providers are not ideally suited for the treatment of AIDS patients. It is, therefore, recommended that a hospice be established in Portland to provide care to AIDS patients. Given the high cost of care for those patients, and the bad debt problems they are likely to generate, some subsidy of this program will be necessary. This could be provided from the pool

established for bad debts, charity care and governmental shortfalls.

Physician Shortages

The responses to the survey distributed by the Commission indicated that there are shortages of a number of physician specialties in various regions of Maine. These shortages are being exacerbated by the rapid increases in malpractice premiums for certain specialties, particularly obstetrics. Two activities are needed to help to resolve these problems:

1) Some mechanism to reduce the malpractice premium increases, particularly for obstetricians; and,

2) a mechanism to attract physicians, particularly primary care physicians to practice in the medically underserved areas of Maine.

The mechanisms might include forgiveness of student loans tied to practicing in a medically underserved area, or explicit subsidy of the physician's income while the practice is being developed. More study may be appropriate on the particular problem experienced by physicians practicing in rural areas, and on methods to alleviate these problems.

Particular programs which might be beneficial include:

1) Increase Medicaid payments for primary care physicians

2) Start up grants for physicians setting up practices in underserved areas.

3) Loan forgiveness for physicians who practice a certain number of years in underserved areas.

The Medicare payment system for physicians should be carefully watched, and the state should be prepared to respond to the fairly radical changes which can be expected, either to adopt good ideas, or correct perverse incentives.

This is an area which should be the subject of further study by a group with strong physician representation.

Shortages of other health professionals

Nurses and other health professionals are apparently in short supply in Maine, as in the remainder of the country. Enrollment in nursing education programs is dropping and so greater shortages can be anticipated in the future. In the short term

hospitals will have to deal with these problems by using the professionals who are available as effectively as possible. In the longer term it is necessary to encourage more people to enter this field. This should start with programs in the high schools to educate the students on the opportunities available and encourage them to train as health professionals.

Appendix A

Outpatient rate per unit of service system

For each outpatient revenue center each hospital would specify to the RSB what unit of service it collected. For the base year the hospital would supply for each revenue center with outpatient activity: 1) The number of units of service provided, N, and 2) the cost of the center, C. The hospital would also provide an estimate of its budgeted volume of service, B, in each center for the rate year.

The RSB would establish a variable cost factor, V, to use for volume adjustments, a market basket factor, M, to account for inflation, and would calculate a mark-up, U, from costs to charges. All of these could be determined on a hospital wide basis rather than having to be calculated for each revenue center.

The rate for the rate year for the department would be:

$$\{ M \times U \times C \{ 1 + V \times [(B - N)/N] \}\} / B$$

If a hospital wished to convert from one measure of volume to another, it would be required to collect both volume measures for a year, and the ratio of the two measures would be used to calculate a conversion factor for the rate.

If the RSB wished to compare the relative efficiencies of hospitals in producing units of service then it could require that all hospitals collect consistent units of measure, and then use these standard units for setting the rates. This could not be done immediately.

Appendix B.

Total Patient Revenue System

Under a total revenue system the RSB would set the total revenue the hospital was allowed to charge for inpatient and outpatient services. This would be set based upon the actual costs of the hospital in some recent base year or the MHCFC cost base. The total revenue would be allowed to increase each year by a market basket factor plus, say, 2% for intensity and population change, with an adjustment for change in bad debts, charity care, and governmental shortfalls. The approved governmental shortfalls would be paid in full. Volume adjustments would be made for major changes in the overall volume of service.

This system is intended for hospitals with well defined catchment areas, and with a stable population.

Appendix C.

Revenue per Case (DRG) Payment System

Under this system the RSB would set the average charge the hospital was permitted to make for a case with a DRG weight of 1. The hospital would continue to charge for the services provided, as at present, but with the knowledge that the average revenue per case was limited. After the end of the year the RSB would compare the amount the hospital had actually charged for inpatient services with the amount that was approved. If an overcharge had been made then the amount of the overcharge would be reduced from the rates for the subsequent year.

Within this option there are a multitude of different decisions that must be made. Many of these decisions have been discussed in the body of this report.

If the charge per case with a DRG weight of 1 was $C, at the end of the year the hospital would report the number of inpatient discharges, N, the total inpatient gross revenue for these cases, G, and the average case mix index of the discharges in the year, I. The total approved revenue would be:

$$A = \$C \times N \times I.$$

This would be compared with the actual gross inpatient revenue G and any difference would be added to or subtracted from the rate for the subsequent year.

Appendix D.

Administration of the Pool

The RSB will determine the current level of bad debts, charity care and governmental shortfalls. A state-wide mark-up to generate this amount will be calculated. This factor will be included in the rates of each hospital in lieu of its current hospital specific mark-up for bad debts, charity care and governmental shortfalls. The legislature will determine on an annual basis the amount it will provide to pay for increases in these requirements, having received from the RSB an estimate of the expected amount of such increases. Any funds provided for this purpose will be added to the pool.

The RSB shall determine in advance of the year how much each hospital should receive from the pool, and may keep some portion in reserve for unexpected occurrences. Any hospital which receives more through the mark-up than its allowance as determined by the RSB shall contribute the difference to the pool, and any hospital which receives less than its allowance shall be provided with a contribution from the pool.

In the event that the legislature provides less revenue than the budgeted shortfall, the RSB shall determine how the available moneys in the pool should be distributed in order to provide as equitable a distribution as possible. Hospitals in the total revenue system would be provided the full amount of their shortfalls in this instance.

5737m

DRAFT INTRODUCTION AND BACKGROUND SECTION TO THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES REPORT JULY 5, 1987

Prepared by Annika Lane
Legislative Staff.

6-25-88 5690m

DRAFT REPORT

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

INTRODUCTION

The Blue Ribbon Commission on Health Care Expenditures was established in 1987 during the first regular session of the 113th Legislature in response to growing criticism of Maine's health care regulatory system.

During the first regular session the Joint Standing Committee on Human Resources heard testimony on a bill that sought to alter the composition of the Maine Health Care Finance Commission (MHCFC) to include a health care practitioner, someone already employed in the health care field. The original bill was replaced entirely by a committee amendment. The new version (LD 290), sunseted the Maine Health Care Finance Commission, effective October 1, 1989 and created the Blue Ribbon Commission on Health Care Expenditures to report on Maine's health care system 9 months prior to the termination of the MHCFC.

STUDY DESCRIPTION:

The Commission's purpose was to study the regulation of health care expenditures. The study specifies that the goals of the health care system must include the provision of quality care, the accessibility to care and the affordability of care. The Commssion was requested to:

A) Evaluate the current and anticipated market for health care services

B) Study the current methods and impending trends in the financing and delivery of health care

C) Study the current and anticipated environment for health care delivery systems

D) Study the various methods of regulating health care and health care expenditures, including, but not limited to, the present regulatory system under the Maine Health Care Finance Commission.

MEMBERSHIP:

The Commission consists of 17 members, representing large, medium and small hospitals, the business, labor and consumer communities, commercial health insurers, Blue Cross-Blue Shield, the Indigent, the Department of Human Services, the Legislature, and the Maine Health Care Finance Commission.

BACKGROUND

A BRIEF HISTORY OF HEALTH CARE REGULATION:

NOTE: Health Care regulation since 1930 has been summarized into a Timeline, attached as appendix A

In the 1930's, public health insurance was virtually non existent and private health insurance was still rare. Hospitals, in conjunction with the American Hospital Association developed Blue Cross group insurance plans in response to drastic decreases in hospital revenues during the Great Depression.

During World War II, employers began to turn to non-wage benefits such as health insurance to attract a scarce labor force. By 1950, approximately half of hospital revenues were derived from health insurance. Now, in the 1980's, more than 90% of all hospital revenue comes from health insurance.

During the post World War II era, governmental involvement in health care began. In 1947, Congress enacted the Hill-Burton Act which provided grants to states for constructing hospitals, and increased federal investment in health care research and education.

Medicare and Medicaid programs were established in 1966, which gave the elderly and the poor access to and financial support for a broad range of health care services. These programs increased the demand for health care services. The method of payment used was retrospective cost-based reimbursement. Payments to providers were based on actual costs incurred, i.e. the charges the providers made for the services. If a provider became more efficient, the payments from Medicare and Medicaid were reduced. If the costs increased, payments increased. This method resulted in tremendous incentives to increase the costs of medical care.

By the late 1970's it became apparant that health care costs were continuing to rise. Retrospective cost-based reimbursement was contributing to this increase.

In 1978, Maine enacted its Certificate of Need program, which required hospitals and other designated health care facilites to obtain approval for projects which are subject to Certificate of Need review. Projects include certain major medical equipment, capital expenditures, development of new services and facilities and other circumstances specified in the law. (22 MRSA § 302 sub-§ 1).

In 1983, Medicare payment for hospital inpatient services was changed to a prospective payment system. In the same year, Maine established a prospective payment system for hospitals and created the Health Care Finance Commission to implement this system (22 MRSA § 381 sub-§ 1).

The prospective payment system requires the determination of the financial requirements of each health care provider and the aggregate amount the provider must charge to meet those requirements. This is determined in advance by the Health Care Finance Commission. If the provider actually spends less to provide those services, it may keep the extra. The next year's financial requirements are based on the previous year's financial requirements, with adjustments, and not on the actual costs. The hospital is not penalized for saving by a reduction in financial requirements. Under the cost based system, the hospital would have received its actual costs, which, if less, would have resulted in less revenues for the hospital.

At the same time it enacted the Health Care Finance Commission Act, the Legislature required that all Certificate of Need projects that were approved be automatically added to a hospital's financial requirements (which are based on the costs of existing equipment and programs, adjusted each year to account for inflation and other items). The costs of these services were automatically passed on to the payors under the payment system established by the Health Care Finance Commission Act. Hospital regulation through the Commission would control the costs of existing services. Certificate of Need approval would be the cost containment tool for control of new services, construction and equipment. It would help control health care costs by requiring a state agency to review each new service, construction project, or purchase of new equipment and grant approval to only those projects which were actually necessary. Existing programs were held to a budget and any new programs added to that budget had to be found necessary or the system would not allow increases to a hospital's charges to pay for that service or equipment. (1)

TODAY'S HEALTH CARE ENVIRONMENT

Over the past 10 years, many changes have occurred in the nature and delivery of health services. Many of these have adversely affected universal access to affordable, quality health care. These changes include:

1. Significant advances in medical technology
2. Dramatic and rapid increases in health care costs
3. Declining Federal payments
4. An increasing number of uninsured and underinsured individuals

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1. Much of this background has been summarized from information provided in the 1986 Certificate of Need study of the Human Resources Committee of the 112th Legislature.

5. Maldistribution and shortage of health care personnel

6. Development of alternative delivery systems such as PPOs, HMOs, ambulatory service centers etc.

7. Increase in Medicare-Medicaid cost shifting, bad debts and charity care.

The Blue Ribbon Commission on Health Care Expenditures feels that Maine's current regulatory system was designed in a very different environment. A regulatory system designed several years ago may not be appropriate in the current environment, just as a regulatory system designed today may not be appropriate five years from now. The Commission does not necessarily believe that the present regulatory system designed in 1982-1983 was designed in error, but simply that Maine's health care environment has changed. It is quite likely that Maine will have to go through a similar process of evaluation five years from now.

COMMISSION PROCEDURE

The Commission held its first meeting in September 1987, and devoted the first few months of its existence exploring the current regulatory environment in Maine and in other states. James Graham Atkinson, D. Phil, was hired in February 1988, as a consultant to the Commission to assist in the process of assessing and developing change to the current system.

The Commission also received technical assistance from the National Conference of State Legislatures (NCSL), and held two meetings with David Landes of NCSL, who has substantial knowledge about other states' regulatory systems.

A questionnaire was sent out to interested parties to solicit written testimony on health care issues so that the Commission members could assess the current health care environment.

The Commission also held two retreats in order to devote concentrated time and effort on the issues and develop a set of recommendations that would comply with the goals of the health care system - to provide quality care, access to care and affordable care.

SUMMARY OF RECOMMENDATIONS

EVALUATING THE PERFORMANCE OF THE MHCFC (2)

Factors which can be evaluated at this point are:

1. Cost containment effects:

Since the start of MHCFC regulation the cost per adjusted admission in Maine hospitals has increased slightly less than the national average. In the prior six years the increase was slightly higher than the national average. Total expenses were increasing at just under the national average, and are now under the national average increase by a slightly larger amount. On average, over a three year period the rate of cost increase has been about 1% below the national average.

The MHCFC appears to have had a slight moderating effect on the rate of hospital cost inflation

2. Revenue containment effects:

Gross revenues increased much less in the period 1984 through 1986 than in the U.S. as a whole. This effect appears to have reversed in the past two years, and the increase in the mark-up from costs to charges appears to be greater in Maine than in the U.S.

The MHCFC had a dramatic effecton the cost to charge ratio in the first few years of operation. The requirement that all of the Medicare and Medicaid shortfalls be included in the rates of the other payors has resulted in large increases in charges in the past two years, balancinf this effect.

Net revenues increased at less than the national average.

Conlusions:

While the data is for far too short a time period, and the margins are too small to draw any very definite conclusions, regulation by the MHCFC does appear to have had a slight moderating effect on the rate of cost increases in hospitals in Maine, and a dramatic, if temporary, effect on the cost to charge ratio of the hospitals.

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2. This evaluation was prepared by Graham Atkinson. Most of the data used in the evaluation is contained in Atkinson's paper entitled "Costs, Revenue and Utilization Data, Maine and the U.S."

7/14/88

Prepared by Annika Lane,
Legislative Staff

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES
JULY 13 MEETING
DRAFT REPORT DISCUSSION
SUMMARY OF CONSENSUS POINTS AND STRAW VOTES

STRAW VOTES IN REPONSE TO INITIAL QUESTIONS POSED BY CHAIR:

1. Those opposed under any conditions to deregulation of hospitals
   OPPOSED = 2

2. Those opposed to allowing deregulation of hospitals in close competition with other hospitals in the area
   OPPOSED = 7
   NOT OPPOSED = 4

3. Those opposed to deregulating hospitals that participate in a pooling system.
   OPPOSED = 7
   NOT OPPOSED = 4

4. Those opposed to deregulating small hospitals if the Commission crafts a mechanism which prohibits cost shifting among private payors.
   OPPOSED = 8
   NOT OPPOSED = 3

CONCLUSIONS DRAWN FROM STRAW VOTES

1. Most commission members support deregulating some hospitals, depending on the circumstances.

2. Most commission members would not support deregulating hospitals that are in close competition with other hospitals in the area

3. Most commission members would not support deregulating hospitals that participate in a pooling system

4. Most commission members would not support deregulating small hospitals even if the Commission succeeds in developing a mechanism to prohibit cost shifting among private payors.

REGULATION OF HOSPITAL RATES OR REVENUES

1. INPATIENT RATES OR REVENUES

Options suggested in draft report:

1. No rate regulation of hospitals of under 55 beds
2. Total revenue system for hospitals with relatively self contained catchment areas.
3. Rate per case (DRG) payment system.

CONSULTANT recommendation: Provide both options 2) and 3)

Motions:

1. Change option 1 to allow for no rate regulation of hospitals that fall into certain categories. Categories to determine those hospitals are as yet undefined, but may include such factors as bed size and market area.

Vote: Yes 8 No 5

2. Add a fourth option which would allow an as yet undefined body to allow certain hospitals (as yet undefined) to opt for a budget review process.

Vote: Yes 6 No 7

2. OUTPATIENT RATES OR REVENUES

Options suggested in draft report:

1. No regulation of outpatient rates, or
2. Set the rate per unit of service by department

CONSULTANT recommendation: No regulation of outpatient rates

Motions:

Hospitals which opt for the rate per case system (DRG), to be regulated on both outpatient and inpatient services.

VOTE: YES= 6 NO= 6

CONSENSUS SUMMARY ON REGULATION OF HOSPITAL RATES OR REVENUES

Three Regulatory Options:

- Deregulation of certain hospitals (criteria to be determined)
- Total revenue system (inpatient and outpatient services)
- Rate per case system - inpatient services (Commission evenly divided on whether to regulate outpatient services under this option.)

REGULATORY AGENCY

Options:

1. The Maine Health Care Finance Commission
2. Some new Commission

CONSULTANT recommendation: Keep MHCFC

Motion:

1. To keep MHCFC, with periodic approval from Governor and Legislature.
2. To table motion 1 and delay discussion of regulatory agency until a later date.

VOTE: Table = 9 Not to table= 5

COMPONENTS OF THE RATE SETTING SYSTEM

1. SPECIALTY HOSPITALS

CONSULTANT recommendation:
Total revenue system with adjustments for change in volume of service. An alternative would be a per diem system.

Motion:

Commission recommends that the rate setting body (RSB) is given the authority to provide special requirements for specialty hospitals.

VOTE: YES = 11 NO = 1

2. COST BASE

Options:

1. The current MHCFC cost base

2. The actual cost incurred in some recent year, as reported in the Medicare Cost Report, and augmented by the additional cost categories used by the MHCFC.

CONSENSUS: It is necessary to know more about costs associated with rebasing before making a decision on this issue. To be revisited when that information is available (next meeting).

3. STANDARD COMPONENT OR SCREENS

Options for basing rates of hospitals:

1. Entirely on historical cost

2. Partly on historical cost and partly on standard

CONSULTANT recommendation: Option 2

Options for developing standard rate:

1. Maine Hospital data

2. Medicare payment rates, adjusted for known inequities, and the difference between the resource use of Medicare versus non-Medicare patients.

CONSULTANT recommendation: Option 2

Options for setting the rate: i.e. how much of the rate should be the standard and how much should be hospital specific?

CONSULTANT recommendation:
The standard component should start at 10%, and increase over time, but not go over 50%.

UNANIMOUS VOTE ON ADOPTING STANDARD COMPONENT. GENERAL CONSENSUS ON ALL THREE RECOMMENDATIONS.

4. CAPITAL COSTS.

Options for capital payments for buildings and fixed equipment:

1. The formula used by MHCFC

2. The Medicare definition of capital costs

CONSULTANT recommendation:
Option 2, but hospitals should be required to fund depreciation, and to either use accumulated depreciation to pay for new projects, or alternatively, to offset interest income against income expense.

Motion:

1. To adopt recommendation as follows:

   Use the Medicare definition of capital costs. However, hospitals should be required to fund depreciation, and to use their accumulated depreciation to pay for new projects.

2. Table above motion until more information is available regarding the impact of changing the capital payment system (Consultant to expand on this issue).

   VOTE to table motion 1 YES = 8 NO = 4

5. ADJUSTMENTS FOR NEW PROJECTS

Options:

1. Requiring all adjustments to be subject to a review

2. Providing a fixed allowance to cover most small projects, and changes in medical practice which apply to most hospitals, and only making adjustments for major projects. (N.B. entirely separate process from CON)

CONSULTANT recommendation: Option 2.

CONSENSUS: More information needed regarding this. Consultant to provide examples before this issue is discussed further.

SUMMARY OF COMMISSION RECOMMENDATIONS BASED ON STRAW VOTES AND GENERAL CONSENSUS

1. Commission proposes three regulatory options for Maine Hospitals:

   a) Deregulation of certain hospitals (Criteria to be determined, but may depend on bed size and market area).

   b) Total revenue system - which includes regulation of both inpatient and outpatiet services.

   c) Rate per case system - inpatient services only. (Commission is evenly divided on whether to regulate outpatient services.)

2. The rate setting body will be given the authority to provide special requirements for specialty hospitals.

3. Rates for hospitals should be based partly on historical cost and partly on a standard. The standard rate will be developed using Medicare payment rates, adjusted for known inequities, and the difference between the resource use of Medicare versus non-Medicare patients. The standard component should start at 10%, and increase over time, but not go over 50%.

SUMMARY OF ISSUES TO BE REVISITED

1. Regulatory Agency

2. Cost Base - more information needed about costs associated with rebasing.

3. Capital Payments - more information needed about impact of changing the capital payment system

4. Adjustments For New Projects
   - More information/examples needed.

5822m

8/2/88

Prepared by Annika Lane
Legislative Staff

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES
AUGUST 1 MEETING
DRAFT REPORT DISCUSSION
SUMMARY OF MOTIONS

CONSENSUS: That the draft report contain recommendations reflecting general consensus on concepts. Specific details to be filled in after public input and further discussion. In other words, this initial report will act as a framework for a later, more detailed product.

This draft report should outline areas of consensus, disagreement and issues to be revisited by this Commission. Topics for further study should also be listed.

The draft needs to indicate that several other legislatively established committees are studying health care issues. These are:

- The Commission to Study Access to Health Care is reviewing mechanisms to enhance health care access and curb inappropriate health resource utilization

- The Maine Health Policy Advisory Council is reviewing on an ongoing basis technological advances and development of innovative and alternative health care modalities

- The Commission to Study the Necessity & Feasibility of Establishing a Health Information Record is reviewing current health care data available to Maine consumers and businesses. It is considering possible expansions to the data collection system.

- Commission to Study the Status of the Nursing & Health Care Professions in Maine is conducting a wide-ranging six month analysis of Maine's health care personnel shortage.

MOTION 1

That one of the recommended regulatory options use adjusted cost per case methodology plus a factor (x) which reflects:

a) Changes in technology not covered by CoN
b) Changes in medical practice
c) Aging population

i.e. The process/methodology of this is to be revisited. X factor quantified at a later date.

VOTE: In Favor = 13 Against = 1

MOTION 2

That a total revenue system exist as an option for hospitals within limited catchment areas - not in direct competition with other hospitals. The total revenue system includes both inpatient and outpatient services.

VOTE: In Favor = 13 Against = 2

(Note: general consensus also reached on this at July 13 meeting)

MOTION 3

A different regulatory system should exist for specialty hospitals. These specialty hospitals are to be identified by certain (as yet undefined) criteria.

For later discussion
- Define scheme
- Define criteria

VOTE: Unanimous in favor of motion

MOTION 4

De-regulation for certain hospitals based on criteria yet to be defined. Hospitals can apply to the RSB for deregulation on the basis of a demonstration project.

VOTE: In Favor = 5 Against = 8

MOTION 5

That the RSB encourages demonstration projects which focus on reaching goals of accessible, affordable, quality health care. Provided the projects meet certain criteria to the satisfaction of the RSB, all and any regulatory requirements can be waived.

Criteria should include a list of goals/objectives that can be determined at a later date.

VOTE: In Favor = 11 Against = 2

MOTION 6

That the regulatory system establishes a standard component to increase over five year period, but not to exceed 50%.
How that standard is to be calculated is to be revisited.

VOTE: Unanimous in favor of motion

MOTION 7

To include regulation of outpatient services in rate per case system.

VOTE Motion tabled 7:6

Option remains under consideration until after public comment.

MOTION 8

Report to include description of problems associated with cross-subsidization. Refer to data problems and defer cross-subsidization issues until further discussion of deregulation.

VOTE: In Favor = 12 Against = 2

MOTION 9

That an amount be sought from the General Fund to cover the projected increase in total shortfalls over the next year.
The amount would be distributed amongst hospitals most affected by shortfalls. A specific formula would be calculated using this projected increase. Methodology to be determined at a later date.

VOTE: In Favor = 8 Against = 5

NOTE: Report should welcome proposals from public for dealing with shortfalls.

MOTION 10 - NURSING HOMES

To adopt recommendations as outlined in report.

UNANIMOUS agreement on general recommendations. More information requested on marginal admissions.

(NOTE: A Study of Preamission Screening for Long Term Care Services issued by the DHS Bureau of Medical Services in March 1987, indicates that approximately 8.0% of all nursing home admissions under Medicaid in December 1986 were Level 1, or "lighter care" patients. These patients may be able to function equally as well at home with community-based services as in an institution. No updated information is available, but the general sense at DHS is that this figure has not gone up)

MOTION 11 - DATA COLLECTION ISSUES - NON-HOSPITAL SERVICES

Report to indicate that the Commission has discussed the problems associated with limited information on non-hospital services such as ambulatory service centers etc. It concludes that an improved data collection system is needed to facilitate public policy decisions regarding the regulation of these services.

Report also to indicate some of the causes of the increases in medical costs and in insurance premiums as outlined in Jack Dexter's letter dated July 8, 1988.

These are:

1. Cost shifting
2. Mandated benefits
3. Malpractice insurance and defensive medicine
4. Technology and service distribution
5. Technology growth
6. Inappropriate or over utilization
7. Insufficient peer review mechanisms
8. Nursing shortages
9. The growing and changing population

10. The aging population

11. AIDS

VOTE: In Favor = 12 Against = 1

MOTION 12 - HOSPICE FOR AIDS PATIENTS

Unanimous agreement to provide generic encouragement on this issue and welcome testimony from service providers.

MOTION 13 - PHYSICIAN SHORTAGES

Unanimous agreement to accept language in draft report encouraging this as an area for further study by a group with strong physician representation.

MOTION 14 - SHORTAGES OF OTHER HEALTH CARE PROFESSIONALS

Unanimous agreement to accept language in draft report, with more commentary on what is being done to alleviate problem, status of nursing profession etc.

NOTE: - A six-month study of this issue has just got under way. This study's findings could be useful to the Commission in making its final recommendations.

MOTION 15 - MANDATED BENEFITS

To recognise mandated benfits as an issue that needs further discussion. More information is needed on the impact of mandated benefits on the health care system.

VOTE In Favor = 10 Against = 1 Abstained = 2

MOTION 16 - APPEAL MECHANISM

Unanimous, with one abstention, to adopt recommendation as outlined in draft report.

MOTION 17 - DISCOUNTS AND DIFFERENTIALS

To adopt draft report recommendation on this issue.

VOTE: In Favor = 10 Against = 2

MOTION 18 - RSB

RSB to be an independent executive agency. Its composition, manner of appointment and duties to be decided at a later date.

VOTE: In Favor = 7 Against = 5

5956m

Maine's Business Advocate

126 Sewall Street ▪ Augusta, Maine 04330 ▪ (207) 623-4568

July 8, 1988

Senator Paul Gauvreau, Chairman
Blue Ribbon Commission on Health Care Expenditures
Office of Policy and Legal Analysis
State House Station 13
Augusta, Maine 04333

Dear Senator Gauvreau:

As you are aware, for many months the Maine Chamber of Commerce and Industry has been actively involved in the health care cost containment issue. We have attempted to follow closely the work of the Blue Ribbon Commission on health care expenditures. Since business, is in our opinion, significantly under-represented on the commission, I am taking the liberty of writing you to express some concerns on behalf of the business community.

Let me note at the outset that we all now recognize that the crisis in the health care field is much broader than it appeared to be when the Blue Ribbon Commision was created. From our conversations, I know you share my frustration that the time available to the commission and its charge do not allow you to address all of the issues. However, unless the commission report is grounded in the fact that all of the problems must be addressed, things will only get worse.

We have identified eleven causes of the increases in medical costs and in insurance premiums. These are as follows:

1. cost shifting (bad debt and indigent, Medicare, and Medicade cost are being shifted to private payers)

2. Mandated Benefits

3. Malpractice Insurance and Defensive Medicine

4. Technology and Service Distribution

5. Technology Growth

6. Inappropriate or Over Utilization

7. Insufficient Peer Review Mechanisms

8. Nursing Shortages

9. The Growing and Changing Population

10. The Aging Population

11. AIDS

Of the eleven, the first seven could be addressed in a way which could favorably impact the cost of care or the cost of insurance.

I have just finished reading the June 23 draft report of the Blue Ribbon Commission. It appears that the report does not address mandated benefits, the tort liability and defensive medicine issue, and questions of utilization and peer review, especially for out-of-hospital settings. While we understand that these things may be out of the purview of the commission, we believe if they are not addressed the commission's efforts will be incomplete. We would ask that your report feature prominently and in the front a section which acknowledges this and proposes a mechanism for addressing the missing issues.

We also have some concerns with the contents of the report. Chief among these is the fact that no one knows the overall cost impact and potential cost shifting resulting from the draft recommendations. Of almost equal concern is the fact that the proposal for funding the pool highlights a payroll tax. We believe the burden of bad debt, charity care, and governmental shortfalls should be spread more broadly.

The Maine Chamber of Commerce and Industry stands ready to assist you in dealing with any and all of these difficult issues.

Sincerely,

John S. Dexter, Jr.
President

JSD: sjc

cc: Members of Blue Ribbon Commission

SENATOR N. PAUL GAUVREAU
DISTRICT 23

State of Maine
Senate Chamber
Augusta, Maine 04333

July 22, 1988

John S. Dexter, Jr.
President, Maine Chamber of Commerce
& Industry
126 Sewall Street
Augusta, Maine 04330

RE: Blue Ribbon Commission on Health Care Expenditures

Dear Jack:

I appreciate your thoughtful correspondence of 7/8/88 outlining the concerns of your association with respect to the developing work product of the Blue Ribbon Commission to Study the Regulation of Health Care Expenditures in the State of Maine ("Blue Ribbon Commission"). I concur that the 11 trends identified in your correspondence have a significant impact upon the escalation of health care expenditures in this state and nationally. As you correctly note, the Blue Ribbon Commission lacks the requisite statutory charge or composition to fully address various of the trend factors you have identified. I will discuss with the Commission and its consultant your suggestion that the Commission observe these and perhaps other trend factors in the Commission report.

The Commission membership is sensitive to the concern you have addressed relating to fiscal consequences of the draft recommendations. In that regard the Commission is seeking out technical information from its consultant and the Maine Health Care Finance Commission to better understand the specific financial implications of the draft recommendations. For example, at its July 13th meeting the Commission received data from Frank McGinty outlining the implications of mechanisms for bad debt, charity care and government shortfalls.

With respect to the use of a payroll tax as a funding mechanism for a pooling mechanism, the Commission is sensitive to the disproportionate share of health care financing currently borne by Maine businesses. It is not the intent of the Commission to exacerbate the situation and the Commission will proceed cautiously in studying and recommending alternative financing mechanisms for our present health care delivery system in Maine.

As you are aware, there are other legislatively established commissions reviewing other critical aspects of health care in the state. The Commission to Study Access to Health Care chaired by former State Representative Bonnie Post has contracted with Lewin Associates to review mechanisms to enhance health care access and curb inappropriate health resource utilization. The Maine Health Advisory Policy Council is reviewing on an ongoing basis technological advances and development of innovative and alternative health care modalities. The Commission to Study Health Care Data chaired by State Representative Charlene Rydell is reviewing the current landscape of health care data available to Maine consumers and businesses in considering possible expansions in this resource to promote more health care resources in the state.

I was pleased to meet with you and Roger Mallar recently to discuss these issues and remain willing to discuss your concerns as the Commission (hopefully) heads into its final stretch in crafting recommendations for the Governor and Legislature. The Commission plans to devote its meeting of August 31 to issues of Certificate of Need and LD 2500 proposed by Representative Boutilier in the last legislative session. We are planning to conduct public hearings on our draft report in the early part of September.

Again, I thank you for your correspondence and look forward to working with you in developing a solution to Maine's health care crisis which addresses the critical needs of Maine business, labor, health care industry, health care professionals and the consuming public.

Very sincerely yours,

N. Paul Gauvreau

NPG/jd

DRAFT REPORT

OF THE

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

August 5, 1988

Prepared for:

The Blue Ribbon Commission on Health Care Expenditures

by

Graham Atkinson, D.Phil.

August 5, 1988

Draft Report of the
Blue Ribbon Commission on Health Care Expenditures

Preface

This draft report of the Blue Ribbon Commission on Health Care Expenditures is being distributed to provide the public with information on the topics being considered by the Commission, and the general approaches being suggested to deal with these topics. It is hoped that this will stimulate discussion and input to the Commission, particularly at the public hearings to be held in Portland and Bangor in the next month.

The report was prepared by the consultant to the Commission. It represents his understanding of the recommendations of the Commission reflecting a general consensus on concepts, the issues the Commission has decided to concentrate on for its report, and the areas which need further exploration. However it should not be taken as representing the views of the individual Commissioners. To expedite making the report publicly available it has not been reviewed by the Commission prior to distribution. Specific details on the recommendations will be filled in after public input and further discussion.

The final report of the Commission can be expected to contain a more detailed discussion of the issues discussed hereafter, and possibly other issues raised in the public hearings. However the Commission realizes that many important issues relating to health care expenditures will not be addressed adequately, and some may not be addressed at all. This is inevitable due to shortage of time and limited resources. Some of the other important issues are being addressed by other Commissions, and in some instances topics have been noted here as requiring further study. Other Commissions and committees studying health care problems of the State of Maine include:

- The Commission to Study Access to Health Care

This Commission is reviewing mechanisms to enhance health care access and curb inappropriate health resource utilization.

- The Maine Health Policy Advisory Council

This Council is reviewing technological advances and development of innovative and alternative health care modalities

- The Commission to Study the Necessity and Feasibility of Establishing a Health Information Record

This Commission is reviewing the health care data currently available to Maine consumers and businesses, and is considering possible expansions to this data collection.

- The Commission to Study the Status of the Nursing and Health Care Professions in Maine

This Commission is conducting a wide-ranging analysis of Maine's health care personnel shortage.

Other areas, such as malpractice insurance rates, tort reform, and mandated benefits, were considered by the Commission to be outside of the scope of work which could be accomplished in the available time. These topics will warrant study in the future.

Summary of Recommendations and Topics for Discussion

Hospital inpatient services

The Commission is recommending that a number of alternative systems be available for the regulation of inpatient hospital rates or revenues:

1) One regulatory option would be a per case payment system, adjusted each year for a market basket inflation factor, plus a factor (to be determined) to reflect changes in technology not covered by Certificate of Need projects, changes in medical practice, and the aging of the population.

2) A Total Revenue System would exist as an option for hospitals with relatively self contained catchment areas, not in direct competition with other hospitals. This total revenue system would cover both inpatient and outpatient services.

3) The Rate Setting Body should encourage demonstration projects which further the goals of accessible, affordable and quality health care. The Rate Setting Body should have the authority to waive any and all regulatory and statutory requirements for demonstration projects which further the overall goals of the system as described in the enabling legislation.

4) Different regulatory systems should be utilized for specialty hospitals (e.g., psychiatric and rehabilitation hospitals) and other hospitals identified by the Rate Setting Body as being unique or different within the Maine health care system.

The Commission is recommending that the regulatory system establish a standard component in the rate, to be phased in over a five year period, but with the standard not to exceed 50% of the payment at the end of the phase-in. This recommendation is intended to reward productivity.

The Commission's recommendation on discounting by hospitals is: Total Patient Revenue system hospitals should only be permitted to give discounts which are approved by the Rate Setting Body. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods, provided that the discounts do not increase the charges to other payors.

An appeal mechanism should be established. This appeal mechanism should be limited to major items, say items having an impact on

costs or revenues of at least 2% of the total costs of the hospital, and which are not taken account of in the formula used to develop the rates. The Rate Setting Body should have the option of recommending that charges be cut if a hospital has filed an appeal and the Rate Setting Body determines that the hospital's charges are too high.

The Commission is recommending that an amount be sought from the General Fund to cover the projected increase in the total shortfalls in Medicare and Medicaid payments in the next year. The amount would be distributed among the hospitals most affected by the shortfalls.

The Commission has not yet reached a conclusion on the issue of pooling of bad debts, charity care and governmental shortfalls, and would welcome input on this subject for its deliberations.

The structure of the Rate Setting Body is an issue which will require further discussion, and on which the Commission is split, but the majority of the Commission consider that the Rate Setting Body should be an independent executive agency. The manner of appointment, composition and duties of the Rate Setting Body are to be discussed at a later date, and this discussion will include discussion of the mechanisms to be used to ensure accountability. Input will be welcomed on this subject.

Hospital Outpatient Services

The Commission is recommending that the revenues from outpatient services would continue to be regulated for hospitals in the Total Revenue Payment system. No decision has been reached on whether outpatient rates should be regulated for other hospitals.

Other questions on hospital outpatient services the Commission is going to have to answer are:

1) Should hospital outpatient departments be cross-subsidized if they are not subject to rate regulation,

2) how should the amount of the subsidy be determined, and

3) how can it be assured that the subsidy is being used for the purpose for which it was provided?

AIDS

Maine, like all other states, has a growing problem with AIDS in some of the major urban areas. The Commission has great concern about this issue and would welcome input on the adequacy of the care currently available for AIDS patients and alternative

mechanisms for caring for AIDS patients, e.g., hospices, which should be considered.

Nursing homes

No change is recommended to the regulation of nursing home rates for non-Medicaid patients. The hospitals in Maine have problems in placing high care Medicaid patients in nursing homes. These problems result in the patients experiencing extended hospital stays when they are not in need of that level of care. This problem may be alleviated in three ways:

1) expansion of the supply of nursing home beds;

2) providing financial incentives to the nursing homes to take the heavier care Medicaid patients; and,

3) eliminating some marginal admissions to nursing homes by pre-admission review and thereby making more beds available for the patients in most need of them.

Physician shortages

More study may be appropriate on the particular problems experienced by physicians practicing in rural areas, and on methods to alleviate these problems. This is an area which should be studied by a group with strong physician representation.

Nurse and other health professionals

On the issue of shortages of nurses and other health professionals, the Blue Ribbon Commission is deferring to the Commission established to discuss this topic specifically.

Mandated benefits

The Commission recognizes that mandated benefits are an issue which requires further discussion, and that more information is needed on the impact of mandated benefits on the health care system.

Regulation of hospital rates or revenues

Inpatient rates or revenues

The Commission is recommending that a number of alternative systems be available for the regulation of inpatient hospital rates or revenues:

1) One regulatory option would be a per case payment system, adjusted each year for a market basket inflation factor, plus a factor to be determined to reflect changes in technology not covered by Certificate of Need projects, changes in medical practice, and the aging of the population.

2) A Total Revenue System would exist as an option for hospitals with relatively self contained catchment areas, not in direct competition with other hospitals. This total revenue system would cover both inpatient and outpatient services.

3) The Rate Setting Body should encourage demonstration projects which further the goals of accessible, affordable and quality health care. The Rate Setting Body should have the authority to waive any and all regulatory and statutory requirements for projects which further the overall goals of the system as described in the enabling legislation.

4) Different regulatory systems should be utilized for specialty hospitals (e.g., psychiatric and rehabilitation hospitals) and other hospitals identified by the Rate Setting Body as being unique or different within the Maine health care system.

Outpatient rates or revenues

The current system of regulating the rates of hospital outpatient services is unsatisfactory because the unit of measure for volume, equivalent inpatient admissions, is inadequate. Some change in the method of regulation is therefore needed. Outpatient services are the fastest growing component of hospital care, but the growth is mainly due to increase in volume and not increase in rates. The Commission has a particular concern to ensure that access to outpatient services is preserved.

Hospitals on the Total patient revenue system:

The total patient revenue payment system would include the revenues from both inpatient and outpatient services. This is essential since there is a shift occurring from inpatient to outpatient settings, and it would be unreasonable to have a system which guaranteed a constant inpatient revenue while inpatient volume was declining, and an increasing outpatient revenue because outpatient volume was increasing. Also, to attempt to separate the inpatient and outpatient costs and revenues would unnecessarily complicate the system.

Hospitals on the rate per case payment or other system for inpatients:

The Commission is still considering the issue of whether outpatient rates should be regulated for hospitals on the per case payment system, or on other systems, apart from the Total Revenue System discussed above. Options which have been discussed include:

1) No regulation of outpatient rates, and

2) Set the rate per unit of service by department.

To date no decision has been made. The decision is complicated by the issue of cross-subsidization of outpatient services which is discussed below. A major topic of discussion has been the question of whether it would be appropriate to allow cross-subsidization of outpatient services by inpatient services if the outpatient rates are not subject to regulation. The issue of separating inpatient and outpatient costs has also been raised.

Input is solicited on the subjects of:

1) Whether hospital outpatient rates should be regulated,

2) The appropriate form of regulation of outpatient rates,

3) Whether hospital inpatient services currently subsidize hospital outpatient services.

Components of the rate setting system.

Standard component or screens

When hospital payment rates are based upon the actual costs of the hospital in a single year then hospitals which were low cost in that year will be required to stay low cost and hospitals which were inefficient in that year will be permitted to stay inefficient, or will be overly rewarded as their efficiency improves. In other words, such a system does not reward efficiency in the base year or penalize inefficiency in the base year. To adjust for this problem it is possible to base the rates of the hospitals partly on hospital specific costs and partly upon a standard.

The Commission is recommending that the regulatory system establish a standard component in the rate, to be phased in over a five year period, but with the standard not to exceed 50% of the payment at the end of the phase-in. This would encourage and reward productivity. The phase-in period would permit high cost hospitals time to adjust to the constraints being placed upon them without undue hardship.

The standard rate could be based on a state (or peer group) average rate, or could be calculated from the Medicare rate, with some adjustments for the inequities of the Medicare payment system. An advantage of basing it on the Medicare rate is that this is already known, while developing a state standard would turn into a complicated exercise as it became necessary to adjust for all the various factors which would be raised and which account for justifiable differences in the cost levels of the hospitals, e.g. direct and indirect medical education costs. Suggestions are welcomed on how the standard rate should be established.

Differentials and discounts

The current system allows for some approved discounts. Blue Cross currently receives such a discount, and the rates of other payors are increased to adjust for the discount provided to Blue Cross. The discount to Blue Cross was quantified through a study which demonstrated the magnitude of the discount that was economically justified. Such justified and approved discounts would continue to be provided.

The major question which must be addressed is whether the hospitals and payors should be permitted to negotiate discounts which are not economically justified, and not reviewed by the Rate Setting Body. Certainly hospitals should not be provided solvency guarantees if they provide unapproved discounts, and

they should not be permitted to increase their charges to other payors to recoup the shortfalls resulting from voluntarily negotiated discounts which are not economically justified or approved.

A major question the Commission is addressing is: Should hospitals be allowed to negotiate discounts and alternative payment methods with payors, without review of these agreements by the Rate Setting Body?

The Commission's recommendation on this question is: Total patient revenue system hospitals should only be permitted to give discounts which are approved by the Rate Setting Body. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods, provided that the discounts do not increase the charges to other payors.

Appeal mechanism

The systems being discussed are largely formula driven, but no formula driven system can anticipate every eventuality. Some mechanism must be built into the system so that a hospital can appeal for changes which are unexpected and not automatically adjusted for. At the same time, the appeals must be limited or they will defeat the purpose of the regulatory system to control costs and charges.

The appeal mechanism should be limited to major items, say items having an impact on costs or revenues of at least 2% of the total costs of the hospital, and which are not taken account of in the formula used to develop the rates. The Rate Setting Body should have the option of recommending that charges be cut if a hospital has filed an appeal and the Rate Setting Body determines that the hospital's charges are too high.

Governmental shortfalls

The Medicare program is paying most hospitals much less than their charges and some less than their costs. Similarly the Medicaid program is underpaying hospitals. The current hospital payment system in Maine ensures that the charges to the other payors can be increased to fully cover any shortfalls between the payments from Medicare and Medicaid and the financial requirements that the Maine Health Care Finance Commission allocates to Medicare and Medicaid. It is expected that these shortfalls will continue to increase over the next several years, and, absent any alternative mechanism to fund these shortfalls, will result in substantial increases in hospital charges.

The Commission is recommending that an amount be sought from the General Fund to cover the projected increase in the total

shortfalls over the next year. The amount would be distributed among the hospitals most affected by the shortfalls.

The Commission has had much discussion on the current level and the distribution of the shortfall, and would welcome proposals for dealing with this problem.

Cross-subsidization

Emergency rooms and clinics are generally priced at substantially below cost. The charges for other services are increased to make up for the shortfall. This underpricing is considered necessary to ensure that the basic emergency room and clinic services remain affordable, and so as not to discourage access to these services. Also, there is a high level of bad debts and charity care in these services, and increasing charges is likely to increase the uncollectible accounts. There is some question as to whether the profits made on other outpatient services are sufficient to cover the shortfall on emergency rooms and clinics, or whether there is also some subsidy currently being provided from inpatient care. The data presently available to the Commission is not sufficient to provide an answer to this question. Any data available to provide this answer would be gratefully received.

The hospitals in the Total revenue system would continue to have their outpatient revenues regulated, and so should continue to have cross subsidization permitted, as at present. For those hospitals in the per case payment system a policy decision must be made.

The questions the Commission is going to have to answer are: Should hospital outpatient departments be cross-subsidized if they are not subject to rate regulation, and, if so, how should the amount of the subsidy be determined, and how can it be assured that the subsidy is being used for the purpose for which it was provided?

Options for the level of cross-subsidy of emergency rooms and clinics include:

1 Eliminate all explicit subsidies from inpatient services

2 Specify a set level of subsidy to be provided as long as the subsidized services were continued at their current level.

3 Have the level of subsidy set each year

The Commission has deferred a decision on this issue pending

further discussion of the issue of deregulation of outpatient rates. Public input on the issue would be welcomed.

Demonstrations

Several different types of demonstrations should be encouraged:

1) hospital payment demonstrations; and,

2) demonstrations on change of a hospital to a lower level of care.

Hospital payment demonstrations:

The current statute allows great flexibility for hospital payment demonstrations. Language should be included in any new hospital rate or revenue regulation statute permitting demonstrations which further the overall goals of the payment system, and hospitals should be encouraged to propose demonstrations. The Rate Setting Body should have the authority of waive any and all regulatory and statutory requirements for such demonstrations.

Lower level facilities:

There are several hospitals in the state that are unlikely to be able to remain viable as acute general hospitals because of low patient volume. When the closure of such a hospital would cause access problems due to no acute general hospital being available within a reasonable travel distance it may be appropriate to have the hospital continue as a health care facility, but at a lower level than a general acute hospital. The State of Montana has a proposal to the Health Care Financing Administration for such lower level facilities, which would provide some basic inpatient care as well as outpatient care, and have lower licensing requirements so that costs could be reduced. Federal waivers would be needed to enable the facilities to be paid by Medicare for basic forms of inpatient care. This model, with some modifications, may be appropriate for Maine.

Legislation should provide for such demonstrations. The precise nature of the lower level facilities, the scope of care they should be permitted to provide, and the licensing requirements to which they should be subject, should be the topic for a task force including hospital, physician and payor representatives.

Pools for bad debts, charity care and governmental shortfalls

Bad debt and charity care pools are desirable where there are major differences in the bad debt and charity care loads of hospitals, and the resulting differential mark-ups from costs to

charges place the hospitals with high bad debt and charity care loads at a disadvantage, for example, in contracting with HMOs or PPOs. At present there are hospitals which are relatively low cost, but which have relatively high charges because their rates include a large component for bad debts, charity care, and governmental shortfalls. In Maine the differences in bad debt and charity care loads among hospitals are not sufficient to justify the establishment of a pool just for the purpose of spreading this more evenly across hospitals. Indeed, this spreading would have the effect of transferring money from less affluent rural areas to more affluent urban areas, which does not seem a very socially desirable result. Including the governmental shortfalls in the pool results in a reallocation which may make more sense from a social policy viewpoint, but will result in large increases and decreases in individual hospital rates, and so may not be palatable.

Several states have established bad debt and charity care pools with the funding source being a tax on the hospitals. The effect of the pools is thus to redistribute these costs uniformly across the hospitals, and so the private payors. However, it is still a case where the insured and the paying sick are being taxed to pay for the costs associated with treatment of the non-paying sick. It would be fairer to obtain a broader base of payment for these costs. The reason for choosing the hospital tax option is that this is the option which has been most politically acceptable, since it does not result in any new taxes, and is a redistribution which is difficult to argue against on social policy grounds.

The Commission has not yet reached a conclusion on this issue, and would welcome input for its deliberations.

Rate Setting Body

The Commission has discussed the issue of the structure of the Rate Setting Body. This could be an independent executive agency or an agency within the executive branch. It usually works better to have the programs administered by an independent executive agency, since such a body has more flexibility in hiring and contracting than a section within the normal state government. It provides a forum for representation by various interested parties and it also provides some independence from the budget concerns of the state Medicaid program, which can result in a conflict of interest if the same organization is determining the payment rates of the hospitals, and then paying the rates for services provided to Medicaid beneficiaries.

The Rate Setting Body must be held accountable for its actions, but is unlikely to be able to operate successfully if every individual decision is subject to review by the legislature or

the executive branch. An overall review of its performance at periodic intervals is necessary to ensure accountability.

This is an issue which will require further discussion, and on which the Commissioners have a variety of views, but the majority of the Commission consider that the Rate Setting Body should be an independent executive agency. The reason for this is to eliminate the potential conflict of interest discussed above in regard to Medicaid expenditures.

The manner of appointment, composition and duties of the Rate Setting Body are to be discussed at a later date, and this discussion will include discussion of the mechanisms to be used to ensure accountability. Input will be welcomed on this subject.

Nursing homes

No change is recommended to the regulation of nursing home rates for non-Medicaid patients. The hospitals in Maine have problems in placing high care Medicaid patients in nursing homes. These problems result in the patients experiencing extended hospital stays when they are not in need of that level of care. This problem may be alleviated in three ways:

1) expansion of the supply of nursing home beds;

2) providing financial incentives to the nursing homes to take the heavier care Medicaid patients; and,

3) eliminating some marginal admissions to nursing homes by pre-admission review and thereby making more beds available for the patients in most need of them.

1. Expansion of the nursing home bed supply.

The state is already taking action to increase the supply of nursing home beds.

2. Providing financial incentives.

The Medicaid program is planning to develop and implement a severity based payment system for nursing home patients. The development and implementation of that system should be expedited.

3. Eliminating marginal admissions.

The Medicaid program should establish some demonstration programs in the use of pre-admission review for all patients, not just patients who are Medicaid eligible on admission to the nursing

home. Such demonstrations have taken place in other states and some of these other demonstrations could be used as models for the program to be developed in Maine.

4. Swing beds for hospitals, subject to overall limits on nursing home beds

A swing bed program is available for small hospitals. This allows the eligible hospitals to use their unoccupied beds as nursing home beds, and be paid on that basis.

There are some particular problems associated with institutions which have both hospital and nursing home components. Care should be taken to ensure that they are not disadvantaged by any changes in the regulations.

Comments are invited on the staffing and other problems being experienced by nursing homes.

Hospice

Maine, like all other states, has a growing problem with AIDS in some of the major urban areas. The Commission has great concern about this issue and would welcome input on the adequacy of the care currently available for AIDS patients and alternative mechanisms, e.g., hospices, which should be considered.

Physician Shortages

The responses to the survey distributed by the Commission indicated that there are shortages of a number of physician specialties in various regions of Maine. These shortages are being exacerbated by the rapid increases in malpractice premiums for certain specialties, particularly obstetrics. Two activities are needed to help to resolve these problems:

1) Some mechanism to reduce the malpractice premium increases, particularly for obstetricians; and,

2) a mechanism to attract physicians, particularly primary care physicians to practice in the medically underserved areas of Maine.

The mechanisms might include forgiveness of student loans tied to practicing in a medically underserved area, or explicit subsidy of the physician's income while the practice is being developed. More study may be appropriate on the particular problems experienced by physicians practicing in rural areas, and on methods to alleviate these problems.

Particular programs which might be beneficial include:

1) Increase Medicaid payments for primary care physicians

2) Start up grants for physicians setting up practices in underserved areas.

3) Loan forgiveness for physicians who practice a certain number of years in underserved areas.

The Medicare payment system for physicians should be carefully watched, and the state should be prepared to respond to the fairly radical changes which can be expected, either to adopt good ideas, or correct perverse incentives.

Tort reform is another area which is deserving of further study.

These are subjects which should be the subject of further study by a group with strong physician representation.

Shortages of other health professionals

Nurses and other health professionals are apparently in short supply in Maine, as in the remainder of the country. The demand for registered nurses is increasing, and at the same time enrollment in nursing education programs is dropping. As a result greater shortages can be anticipated in the future. In the short term hospitals will have to deal with these problems by using the professionals who are available as effectively as possible. In the longer term it is necessary to encourage more people to enter this field. This should start with programs in the high schools to educate the students on the opportunities available and encourage them to train as health professionals.

A separate Commission to study the Status of Nursing and Health Care Professions in Maine has been established, and has just started its deliberations. The findings of this Commission should be useful to the Blue Ribbon Commission in making its final recommendations to the legislature. There have been numerous other legislative initiatives in this area.

The Commission solicits input on other ideas for dealing with the shortages of health care workers.

Mandated benefits

The Commission recognizes that mandated benefits are an issue which requires further discussion, and that more information is needed on the impact of mandated benefits on the health care system.

Data col from non-hospital providers

The Comm as discussed non-hospital services, such as free standing , surgi-centers, and diagnostic centers, and the shift of l provided services to these settings. There has been some sion of extending some regulation to these settings ata collection. The Commission has not yet reached a usions on these issues.

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SUMMARY OF RESPONSES TO THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES DRAFT REPORT

TO: Commission members

FROM: Annika Lane

The following summary is based on testimony submitted in response to the Commission draft report.

I used presentations that seemed to be most relevant to the report's contents. The summary is subdivided into subject areas, so there is some overlap.

I hope this will be useful to you.

INPATIENT RATES OR REVENUES

BLUE CROSS/BLUE SHIELD

a) Supports TR system that regulates both inpatient and outpatient services

b) Supports case mix adjusted charge per case system for total hospital inpatient charges

c) Supports different regulatory system for specialty hospitals - provided these hospitals can be reasonably and readily identified

d) Supports market basket plus an aggregate adjustment factor to account for new technology and services, non CoN projects, and changes in the practice of medicine.

e) Suggests even hospitals subject to TR system should be accountable for maintaining a reasonable patient volume.

f) Suggests hospitals with overlapping or competing service areas should be regulated on both inpatient and outpatient revenues. System should include:

- Incentives for competition amongst hospitals and payors
- Adequate adjustments for increasing volume
- Negotiated discounts in addition to approved discounts should be allowed but not shifted.

g) Hospitals wishing to change to a TR system from a charge per case system must agree to a comprehensive review by the RSB.

MAINE HOSPITAL ASSOCIATION

a) Supports multiple options

b) Suggests options for special regulation or deregulation are made readily available to hospitals seeking different treatment under one of those two approaches

c) Supports special treatment for special and/or unique hospitals

YORK HOSPITAL - FINANCIAL SERVICES

a) Does not support option 1 (per case payment system) unless the system recognizes the differences in the cost of doing business around the state. Suggests state considers using cost-per-case methodology referred to in option 1 to negotiate purchase of services on behalf of those receiving state assistance.

b) Suggests Total Revenue System could work if it was based on local rather than statewide measures. Recommends that any review process of total revenues be a review of the reasonableness of hospital budgets as proposed by hospital boards of trustees.

c) Supports option regarding specialty hospitals, and suggests Commission also recommends that each community be allowed to control its own hospital through its own local board of trustees.

PROJECT HANCOCK - (a consortium of three health care facilities in Hancock county) Supports multiple options. Recommends option of DRG-type system be extended to all hospitals, with the provision that in areas where inter-hospital competition does not exist, an extensive, three-year evaluation of health cost inflation be undertaken.

EASTERN MAINE MEDICAL CENTER

a) Recommends that any per case payment system adopted in the future should include an adjustment for disease severity.

b) Regulated payment for inpatient services should be exclusively for acute care.

c) Concern with limiting appeals to extremely large events of prehaps 2% of a hospital's total costs. Many hospitals have operating losses or margins much below 2%. Common sense and the practice of the appeals body should govern those issues for which an appeal is practical for any hospital to pursue.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL Supports variety of options. Supportive of option 1 (per case payment system), provided there are adequate adjustments for volume changes. Supportive of TR system. Supports proposal for different regulatory systems for specialty hospitals.

STEPHENS MEMORIAL HOSPITAL Recommends that hospitals that have historically demonstrated, and continue to demonstrate a lower than average cost to the consumer, be deregulated.

OUTPATIENT RATES

BLUE CROSS/BLUE SHIELD

a) Suggests continued regulation of outpatient services - e.g. rate per unit

b) If outpatient services not regulated
- not appropriate to allow cross-subsidization of outpatient services from inpatient services
- not appropriate to guarantee funding from statewide pool of charity care/bad debt/governmental shortfalls

MAINE COMMITTEE ON AGING Suggests important to collect data, review trends and regulate costs in this area.

MAINE HOSPITAL ASSOCIATION Suggests system should be provided for deregulation of outpatient rates under certain conditions - not clear what those conditions might be.

COALITION FOR RESPONSIBLE HEALTH CARE recommends that outpatient services should continue to be regulated in all types of hospitals regardless of whether they are under a per-case payment system or a total revenue system. Only way that cross-subsidization can be identified or avoided.

AMERICAN ASSOCIATION OF RETIRED PERSONS Recommends regulation of outpatient rates for hospitals on a per case payment system.

STATE AIDS ADVISORY COMMITTEE/CONSUMERS FOR AFFORDABLE HEALTH CARE/CONCERNED CITIZEN Recommends no deregulation of outpatient services.

YORK HOSPITAL - FINANCIAL SERVICES V.P. Agrees that current system is inadequate because it doesn't measure units of service properly in its application of formulas. Concerned about any attempt to not allow cross-subsidization of outpatient services in emergency rooms. Recommends a competitive model where the consumer has choice to use outpatient resources in hospital setting.

PROJECT HANCOCK -(a consortium of three health care facilities in Hancock county) Notes that smaller hospitals are witnessing increasing utilization of outpatient services, including surgery. This development should be encouraged by regulatory framework, including allowances for cross-subsidization

EASTERN MAINE MEDICAL CENTER Supports idea that hospitals should have the option of removing their outpatient services from rate setting regulation.

EASTERN AREA AGENCY ON AGING Supports continued regulation of outpatient services

NORTHERN CUMBERLAND MEMORIAL HOSPITAL favors unregulated outpatient rates. System should allow for continued cross-subsidization of outpatient services from inpatient services. If outpatient services are to be regulated, then there should be an adjustment to prevent regulatory cost shifting in an effort to control other rates under their jurisdiction.

COMPONENTS OF THE RATE SETTING SYSTEM

BLUE CROSS/BLUE SHIELD:

a) Supports standard component in the rate, phased in over a period of time

b) Supports appeal mechanism limited to major items that have an impact on costs or revenues of at least 2% of the total costs of the hospital.

c) Opposes allowing discounts. Recommends that no discounting on the part of the provider or the payor be permitted at least under the total revenue system or rate per case system.

d) Opposes a limited appeal based on the percentage of a hospital's cost base.

e) Suggests RSB should approve payor differentials on the basis of economic merit

f) Suggests differentials should be included in the revenue limit established by the RSB

g) Hospitals should be able to contract with with payors and grant discounts to such payors provided such discounts are not passed on to other payors

h) System should permit payors to pay on the basis of any type of system which the payor and hospital mutually agree upon - as long as such payment does not result in a discount to that payor that is passed on to other payors.

i) Providing RSB with option of recommending that charges be cut if a hospital has filed an appeal and the RSB finds that the hospital's charges are too high. System should be prospective with no retroactive adjustment. Payors should get sufficient notice of adjustments.

MAINE HOSPITAL ASSOCIATION Supports the use of a standard component for rebasing, but believes that the standard should be from outside the state of Maine and be chosen from a system that represents a level of quality of care equal to the state of Maine. Rebasing should be based on efficiency and productivity and not artificially constrained by budget neutrality.

COALITION FOR RESPONSIBLE HEALTH CARE Supports recommendation for a standard component in the rate to be phased in over a five year period. Supports recommendations with regard to discounts and appeals.

YORK HOSPITAL - FINANCIAL SERVICES V.P. Disagrees with use of formulas, unless it takes into account the local environment. Recommends no discounts by a payer or provider. Agrees with provision of an appeal mechanism, but states that draft report too vague on this subject.

AMERICAN ASSOCIATION OF RETIRED PERSONS Supports recommendation on payor differentials and discounts. Total revenue system hospitals should only be able to give discount which are approved by the RSB. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods, provided that the discounts do not increase the charges to other payors.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL Disagrees that hospitals should only be permitted discounts which are approved by an RSB. Suggest that hospitals should be free to contract with payors for discounts or payment methods provided that the discounts do not increase the charges to other payors. Should be a threshold below which no discounts should be allowed. This threshold should include at least operating costs plus bad debts and charity care, plus a minimum return on equity.

Also disagrees with mechanics of proposed appeal process. Should be no restrictions to hospitals making legitimate appeals and should be separate from RSB.

BAD DEBT/CHARITY CARE, GOVERNMENT SHORTFALLS

BLUE CROSS/SHIELD suggests entire Governmental shortfall should be funded totally from the general fund or more broad-based source, not merely the increase in the shortfall from some given point in time. Medicaid program must fully participate in the payment system by paying its full share

MAINE COMMITTEE ON AGING suggests dangerous precedent to ask legislature to make funding decisions using general fund to cover the projected increase in the total governmental shortfalls over the next year.

MAINE HOSPITAL ASSOCIATION Agrees with concept of a pooling strategy or other similar mechanism to distribute shortfalls among hospitals. Mechanism must distribute burden among hospitals equitably, taking into consideration efficiency and productivity of the hospitals. Current system for reimbursing hospitals should be retained until public funding for the pool is appropriated.

COALITION FOR RESPONSIBLE HEALTH CARE Supports concept of pooling

AMERICAN ASSOCIATION OF RETIRED PERSONS Supports idea of a stand-by fund from which hospitals may cover any governmental shortfall, if the method for determining a shortfall is valid and suitable for challenging Medicare and Medicaid payment decisions.

STATE AIDS ADVISORY COMMITTEE/CONSUMERS FOR AFFORDABLE HEALTH CARE/CONCERNED CITIZEN Opposes proposal to request $20 million from general fund. Suggests a fund generated from all sectors carrying bad debts. E.g. $65 million from Medicare, $5 million from Medicaid, $30 million from hospitals, Unspecified amount from insurance companies and the Legislature.

YORK HOSPITAL - FINANCIAL SERVICES V.P. Supports idea of using general fund to make up for federal shortfall. But, federal responsibilities should be stressed. Maine should send message to Congress on this issue. Also supports idea of general fund use to pay bad debts and charity care in areas where state determines that payers cannot afford burden. Broad-based tax is more appropriate than redistribution through a pool generated from additional charges to patients.

PROJECT HANCOCK - (a consortium of three health care facilities in Hancock county) recommends that hospitals be able to use endowments designated for charity care without fear of regulatory reprisal. Responsibility for managing charity care should be kept at the local level.

EASTERN MAINE MEDICAL CENTER Supports recommendation to use general fund to cover projected shortfalls in Medicare and Medicaid payments.

EASTERN AREA AGENCY ON AGING Is the $ figure to be sought from the General Fund to be a one-time payment or will it become annual? If it is not to become an annual payment, what basic reforms to the health care system will make future payments unnecessary? What will be the impact of such a payment on other health and social service programs that must compete for limited General Revenue funds? Could, and should, these same dollars be used to effect basic changes in the health care delivery system to make health care more accessible and affordable?

NORTHERN CUMBERLAND MEMORIAL HOSPITAL agrees that an amount be sought from general fund to cover projected increases in the total shortfalls over the next year. But, an amount should be distributed among all the hospitals who have had shortfalls.

Support pool mechanism derived from general fund which is derived from state income tax.

BETH KILBRETH - HUMAN SERVICES DEVELOPMENT INSTITUTE, USM

Report does not address question of handling bad debt under a per case payment system. Unless explicit provisions are made, such as a pooling arrangement, the safety valve provided by provisions in the current system may be removed.

The provisions providing a safety net are:

a) The current system recognizes each hospital's experience with bad debt and charity care and provides substantial protection from long term losses associated with uncompensated care.

b) The MHCFC prohibits hospitals from billing any patients who meet Hill Burton charity care guidelines and who have no health insurance coverage.

If general funds are to be used to cover the costs of the medically indigent, why not use them to provide entitlement to the uninsured for an appropriate range of services in appropriate settings, and thus reduce the hospitals charity care experience, rather than pay hospitals after the fact for care they shouldn't have had to provide in the first place. Advocates use of tax dollars to support programs such as:

a) a substantial expansion of Medicaid to a newly eligible population of pregnant women and infants

b) A high risk insurance program to provide coverage to those who can get insurance coverage due to pre-existing medical conditions; and

c) A subsidized comprehensive managed care insurance program for uninsured small businesses and the self-employed (such as Mainecare).

If the bad debt burden is not eased by programs such as these, consider at that time, and not sooner, tax assistance to hospitals.

CROSS-SUBSIDIZATION

BLUE CROSS/SHIELD Controlled, reasonable subsidy. Further study required to determine appropriate level of subsidy. If, however, outpatient services are deregulated, then all subsidies from inpatient to outpatient services should be eliminated.

MAINE HOSPITAL ASSOCIATIONsuggests that cross-subsidization of outpatient services should be allowed to continue at the current level and that some adjustment ought to be available (not necessarily identical to the inpatient adjustment factor) and be incorporated into the rate of growth for outpatient revenues.

EASTERN MAINE MEDICAL CENTER - sees that cross-subsidies will continue to be necessary as long as some populations and some services are underinsured. Cross-subsidization among outpatient departments should be allowed to occur as market conditions allow.

DEMONSTRATIONS

BLUE CROSS/SHIELD Supports demonstration projects under authority of RSB and supports options for lower levels of care within hospitals. Questions whether or not RSB should have authority to waive any or all statutory requirements.

MAINE COMMITTEE ON AGING Supports flexibility to develop demonstration projects if approved by RSB, or for hospitals to convert to lower level facilities.

MAINE HOSPITAL ASSOCIATION Supports demonstration projects

COALITION FOR RESPONSIBLE HEALTH CARE Supports hospital payment demonstrations. However, concerned with broad authority given to RSB to waive any and all statutory requirements. Supportive of idea to let some general hospitals receive licenses to operate as lower level facilities.

YORK HOSPITAL - FINANCIAL SERVICES V.P. Supports this proposal. Recommends adding another option i.e. Option 5, A Border Policy on Regulation - taking into account need for a buffer zone between the Maine and New Hampshire hospital regulatory systems. This option would allow for the RSB for York Hospital be the York Hospital Board of Trustees.

PROJECT HANCOCK - (a consortium of three health care facilities in Hancock county) supportive of this proposal - encourages local hospitals and cooperative hospital service organizations to pool resources and avoid redundancy in service delivery.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL supports demonstration projects

STEPHENS MEMORIAL HOSPITAL Recommends that proposals regarding demonstration projects be expanded to require trials, when requested, of a deregulated status for hospitals who have historically demonstrated the ability to meet low cost, high quality operational standards.

RATE SETTING BODY

BLUE CROSS/SHIELD Supports idea of an independent executive agency.

MAINE COMMITTEE ON AGING Supports idea of fully independent agency

MAINE HOSPITAL ASSOCIATION Supports concept of an accountable, executive body. Should be held accountable in a more immediate way.

SHORTAGES OF HEALTH CARE PROFESSIONALS

BLUE CROSS/SHIELD That long term solutions must be developed

MAINE HOSPITAL ASSOCIATION Any regulatory system should recognize the actual labor costs occurred by hospitals, including wages and benefits.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL Recommends providing more scholarships. Any regulatory system must recognize actual labor costs, including wages and benefits.

MANDATED BENEFITS

BLUE CROSS/SHIELD Suggests mandating benefits and providers is inappropriate. Benefits should be made available as options to those who want to purchase them through their insurance carrier.

MAINE HOSPITAL ASSOCIATION Suggests Commission recommend approaches which allow maximum flexibility to enrollees in the choice of benefits purchased with their health care premiums as opposed to a continuation of mandated benefits.

COALITION FOR RESPONSIBLE HEALTH CARE Supports review of the cost of mandated benefits. Suggests making mandated benefits an option which must be made available to employees in so-called flex-benefit plans but that the decision as to whether or not to elect them be left to the employee.

NON-HOSPITAL PROVIDERS, CoN ISSUES

BLUE CROSS/BLUE SHIELD suggests:

a) Expansion of regulation beyond the hospital setting

b) Scope of CoN process should be expanded so that purchases of Major Medical equipment (over yet to be specified dollar threshold) and establishment of medical facilities such as ambulatory surgical units outside of hospitals will be reviewable, regardless of the sponsor

c) Changes in CoN process should coincide with a comprehensive updating of the State Health Plan.

EASTERN MAINE MEDICAL CENTER

a) suggests that if CoN is to be retained, it should be uniformly applied to all providers of a particular type of health care service.

b) Process should be designed to regulate and avoid duplication of costly services provided by one type of provider while allowing these same services to be provided by an alternative corporate structure.

c) CoN review should be performed by an independent third party.

OTHER RECOMMENDATIONS

1. Mechanism to help hospitals that are having difficulty in attracting or retaining primary care physicians for their communities.

2. Protection for hospitals seeking relief in the event of emergent needs

3. Commission should recommend Tort reform efforts for purposes of health care providers. Utilization review system outside government was also suggested.

4. Consumer representatives should be part of any future task forces

5. Recommendation from York Hospital that the following statement be added to paragraphs 4 on pages 3 and 6 of the Commission's draft and that the same provision be applied to outpatient rates or revenues as well as inpatient.

"Hospitals that are located in identifiable economic/trade regions that ignore state borders and that are also situated within ten miles of that border, will be allowed to design and utilize alternative systems, commensurate with the goals of accessibility, quality and affordability, that will enable those hospitals to competitively provide services in that economic area. Such a system will be designed to provide care for Maine citizens who would otherwise obtain care out of state and to also attract health consumers from across the border."

6. Recognition must be provided in system for capital renewal.

7. Encouragement of use of alternate care facilities such as hospices. Alternate care could be in the form of swing beds in existing facilities, subsidiaries of existing facilities, or totally independent institutional entities.

8. If capital costs are regulated, then commission should recommend rebasing payment for capital to conform with generally accepted accounting principles used throughout the country.

9. That the intent of the Legislature to reward hospitals for low cost, efficient, quality care be made mandatory in any new legislation.

10. That all rules and regulations set forth by any new commission ordered by new legislation be required to be reviewed by an appropriate legislative committee, to guarantee that the intent of the Legislature is being met.

Memorandum

October 31, 1988

To: Blue Ribbon Commissioners

From: Graham Atkinson GA

Regarding: Final report of the Commission

Based on the discussions and decisions at the last two meetings I have revised the draft report which was distributed for public comment to produce the attached draft final report. Sections which would not be included in the final version, or which can be expected to be substantially changed in the final version, are enclosed in [square brackets]. These sections are:

> A caveat on page 1 stating that the draft has not been reviewed by the Commission
>
> Discussion on the amount to be requested in general funds and how that is to be used. This would be revised based on the recommendations of the subcommittee set up to discuss this subject, and the discussion expected at the next Commission meeting.

Sections which have changed substantially from the draft report and to which I would therefore particularly direct your attention are:

Certificate of Need	pages 15, 16
Appeal mechanism	page 11
Outpatient regulation	page 9
Cross-subsidization	page 12
Payment for capital costs	pages 12, 13

The two major outstanding questions are 1) pooling/request for general funds/use of pooled funds and 2) the structure of the rate setting body.

October 31, 1988

DRAFT

Final Report of the Blue Ribbon Commission on Health Care Expenditures

Preface

This report of the Blue Ribbon Commission on Health Care Expenditures has been prepared for presentation to the Committee on Human Services of the Maine Legislature, pursuant to the charge made to the Blue Ribbon Commission on Health Care Expenditures. It presents the recommendations of the Commission, the rationale behind these recommendations, and suggestions of which areas require further study because the Commission was not able to deal adequately with them given the time available.

[This draft report was prepared by the consultant to the Commission. It represents his understanding of the recommendations of the Commission reflecting a general consensus on concepts, and the areas which need further exploration. However it should not be taken as representing the views of the individual Commissioners. This report has not yet been reviewed by the Commission.]

The Commission realizes that many important issues relating to health care expenditures are not addressed adequately in this report, and some may not be addressed at all. This is inevitable due to shortage of time and limited resources. Some of the other important issues are being addressed by other Commissions, and in some instances topics have been noted here as requiring further study. Other Commissions and committees studying health care problems of the State of Maine include:

- The Commission to Study Access to Health Care

This Commission is reviewing mechanisms to enhance health care access and curb inappropriate health resource utilization.

- The Maine Health Policy Advisory Council

This Council is in the process of developing a forecast of major health care issues in Maine over the next five years and an agenda of issues for next year.

- The Commission to Study the Necessity and Feasibility of Establishing a Health Information Record

This Commission is reviewing the health care data currently available to Maine consumers and businesses, and is considering possible expansions to this data collection.

- The Commission to Study the Status of the Nursing and Health Care Professions in Maine

This Commission is conducting a wide-ranging analysis of Maine's health care personnel shortage.

Other areas, such as malpractice insurance rates, tort reform, and mandated benefits, were considered by the Commission to be outside of the scope of work which could be accomplished in the available time. These topics will warrant study in the future.

Executive Summary of Recommendations

Hospital inpatient services

The Commission is recommending that a number of alternative systems be available for the regulation of inpatient hospital rates or revenues:

1) One regulatory option would be a per case payment system, adjusted each year for a market basket inflation factor, plus a factor (in the range of one to one and three quarters percent (1 to 1.75%)) to reflect changes in technology (including changes in drugs and supplies) not covered by Certificate of Need projects, changes in medical practice, the aging of the population, and increased severity of illness not accounted for by the case mix measure.

2) Outpatient services in hospitals on the per case payment system described in paragraph 1) above would be regulated on a charge per unit of service system. The units to be used for this purpose would be negotiated between the Rate Setting Body and the hospital based on historical experience.

3) A Total Revenue System would exist as an option for hospitals with relatively self contained catchment areas, not in direct competition with other hospitals. This total revenue system would cover both inpatient and outpatient services.

4) The Rate Setting Body should encourage demonstration projects which further the goals of accessible, affordable and quality health care. The Rate Setting Body should have the authority to waive any and all regulatory and statutory requirements for demonstration projects which further the overall goals of the system as described in the enabling legislation.

5) Different regulatory systems should be utilized for specialty hospitals (e.g., psychiatric and rehabilitation hospitals) and other hospitals identified by the Rate Setting Body as being unique or different within the Maine health care system.

The Commission is recommending that the regulatory system establish a standard component in the rate, to be phased in over a five year period, but with the standard not to exceed 50% of the payment at the end of the phase-in. This recommendation is intended to reward productivity.

The Commission's recommendation on discounting by hospitals is:

Total Patient Revenue system hospitals should only be permitted to give discounts which are approved by the Rate Setting Body. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods, provided that the discounts do not increase the charges to other payors.

An appeal mechanism should be established. This appeal mechanism should be limited to major items, that is, items having an impact on costs or revenues greater than the lesser of $1,000,000 or 1.5% of the total costs of the hospital, and which are not taken account of in the formula and factors used to develop the rates. The Rate Setting Body should have the option of recommending that charges be cut if a hospital has filed an appeal and the Rate Setting Body determines that the hospital's charges are too high.

[The Commission is recommending that an amount be sought from the General Fund to cover the projected increase in the total shortfalls in Medicare and Medicaid payments in the next year. The amount would be distributed among the hospitals most affected by the shortfalls.]

The majority of the Commission consider that the Rate Setting Body should be an independent executive agency. This agency should be required to report annually to the Human Resources Committee on the impact of revenue regulation on the hospital industry in Maine, and the magnitude of and rationale for the automatic adjustment provided to the hospitals in addition to input price inflation.

Hospital Outpatient Services

The Commission is recommending that the revenues from outpatient services would continue to be regulated. For hospitals in the per case payment system for inpatient services the outpatient services shall be regulated on a rate per unit of service basis.

AIDS

Maine, like all other states, has a growing problem with AIDS in some of the major urban areas. The Commission has great concern about this issue and suggests further study on the adequacy of the care currently available for AIDS patients and alternative mechanisms for caring for AIDS patients, e.g., hospices, which should be considered.

Nursing homes

No change is recommended to the regulation of nursing home rates for non-Medicaid patients. The hospitals in Maine have problems in placing high care Medicaid patients in nursing homes. These problems result in the patients experiencing extended hospital stays when they are not in need of that level of care. This problem may be alleviated by providing financial incentives to the nursing homes to take the heavier care Medicaid patients. For this reason the Commission encourages the Department of Human Services to expedite the development and implementation of a Medicaid payment system for nursing home services which takes account of the care requirement of the patients (sometimes referred to as a "case mix payment system").

Physician shortages

More study may be appropriate on the particular problems experienced by physicians practicing in rural areas, and on methods to alleviate these problems. This is an area which should be studied by a group with strong physician representation.

Nurse and other health professionals

On the issue of shortages of nurses and other health professionals the Blue Ribbon Commission is deferring to the Commission to Study the Status of the Nursing and Health Care Professions in Maine.

Mandated benefits

The Commission recognizes that mandated benefits are an issue which requires further discussion, and that more information is needed on the impact of mandated benefits on the health care system.

Certificate of Need

The Commission is recommending that the Certificate of Need process be retained, but that the scope should be changed for hospital and other acute care services. The following types of projects should be subject to Certificate of Need review:

Any hospital renovation or expansion project with a capital cost of $1,000,000 or more.

Purchase of movable equipment costing $1,000,000 or

more, whatever the setting for that equipment.

Any increase in licensed bed capacity.

The threshold of $1,000,000 should be reviewed periodically (but not more frequently than annually) and adjusted to account for the impact of inflation.

Introduction and Background

THIS WILL BE THE INTRODUCTION AND BACKGROUND FROM THE DRAFT REPORT WHICH WAS DISTRIBUTED FOR PUBLIC COMMENT

Regulation of hospital rates or revenues

Inpatient rates or revenues

The Commission recognizes that hospitals in Maine are in a variety of circumstances which make it unlikely that a single regulatory mechanism would be appropriate for all hospitals. Some hospitals are in areas of expanding population and require a payment system which allows revenues to respond quickly to changes in the need for care. Other hospitals are small, and in areas of stable or declining population. Such hospitals may require more stability in their revenue streams than could be provided through a volume sensitive payment system.

For these reasons the Commission is recommending that a number of alternative systems be available for the regulation of inpatient hospital rates or revenues:

1) One regulatory option would be a per case payment system, adjusted each year for a market basket inflation factor, plus a factor in the range of one to one and three quarters percent to reflect changes in technology not covered by Certificate of Need projects (including changes in drugs and supplies), changes in medical practice, increased severity of illness not accounted for by the case mix system, and the aging of the population.

2) A Total Revenue System would exist as an option for hospitals with relatively self contained catchment areas, not in direct competition with other hospitals. This total revenue system would cover both inpatient and outpatient services. The Rate Setting Body should develop criteria for which hospitals would be allowed to choose this option. The criteria examined should include, but not necessarily be limited to: distance in miles and travel time from the nearest other hospital, percentage of patients from the primary catchment area of the hospital which receive care at the hospital, taking account of the services existing at the hospital.

3) The Rate Setting Body should encourage demonstration projects and experiments which further the goals of accessible, affordable and quality health care. The Rate Setting Body should have the authority to waive any and all regulatory and statutory requirements for projects which further the overall goals of the system as described in the enabling legislation.

4) Different regulatory systems should be utilized for

specialty hospitals (e.g., psychiatric and rehabilitation hospitals) and other hospitals identified by the Rate Setting Body as being unique or different within the Maine health care system.

There has been considerable discussion of the particular problems experienced by border hospitals. Items 3) and 4) should provide some flexibility to deal with these problems.

Outpatient rates or revenues

The current system of regulating the rates of hospital outpatient services is unsatisfactory because the unit of measure for volume, equivalent inpatient admissions, is inadequate. Some change in the method of regulation is therefore needed. Outpatient services are the fastest growing component of hospital care, and the payment system should accurately measure and adjust for these changes. The Commission has a particular concern to ensure that access to outpatient services is preserved.

Hospitals on the Total patient revenue system:

The total patient revenue payment system would include the revenues from both inpatient and outpatient services. This is essential since there is a shift occurring from inpatient to outpatient settings, and it would be unreasonable to have a system which guaranteed a constant inpatient revenue while inpatient volume was declining, and an increasing outpatient revenue because outpatient volume was increasing. Also, to attempt to separate the inpatient and outpatient costs and revenues would unnecessarily complicate the system for the small hospitals which are expected to the regulated by means of this system.

Hospitals on the rate per case payment system for inpatients:

The Commission is recommending that the outpatient rates of hospitals on the per case payment system should continue to be regulated, but that the system of regulation should be changed to more accurately adjust for changes in outpatient volume. To this end the Commission recommends setting the rate per unit of service by department for outpatient services. The units of measure to be used should be negotiated between the Rate Setting Body and each hospital based on historical experience. The rates will be established taking into account the historical level of cross-subsidy of the outpatient services.

Components of the rate setting system.

Standard component or screens

When hospital payment rates are based upon the actual costs of the hospital in a single year then hospitals which were low cost in that year will be required to stay low cost and hospitals which were inefficient in that year will be permitted to stay inefficient, or will be overly rewarded as their efficiency improves. In other words, such a system does not reward efficiency in the base year or penalize inefficiency in the base year. To adjust for this problem it is possible to base the rates of the hospitals partly on hospital specific costs and partly upon a standard.

The Commission is recommending that the regulatory system establish a standard component in the rate, to be phased in over a five year period, but with the standard not to exceed 50% of the payment at the end of the phase-in. This would encourage and reward productivity. The phase-in period would permit high cost hospitals time to adjust to the constraints being placed upon them without undue hardship. The standard component should include operating costs and the costs of movable equipment, but should exclude costs associated with buildings and fixed equipment, which would continue to be paid entirely on the basis of the hospital's own costs of buildings and fixed equipment.

The standard rate could be based on a state (or peer group) average rate, or could be calculated from the Medicare rate, with some adjustments for the inequities of the Medicare payment system. An advantage of basing it on the Medicare rate is that this is already known, while developing a state standard would turn into a complicated exercise as it became necessary to adjust for all the various factors which would be raised and which account for justifiable differences in the cost levels of the hospitals, e.g. direct and indirect medical education costs.

Differentials and discounts

The current system allows for some approved discounts. Blue Cross currently receives such a discount, and the rates of other payors are increased to adjust for the discount provided to Blue Cross. The discount to Blue Cross was quantified through a study which demonstrated the magnitude of the discount that was economically justified. Such justified and approved discounts should continue to be provided.

The major question which must be addressed is whether the hospitals and payors should be permitted to negotiate discounts which are not economically justified, and not reviewed by the

Rate Setting Body. Certainly hospitals should not be provided solvency guarantees if they provide unapproved discounts, and they should not be permitted to increase their charges to other payors to recoup the shortfalls resulting from voluntarily negotiated discounts which are not economically justified or approved.

The Commission's recommendation on this question is: Total patient revenue system hospitals should only be permitted to give discounts which are approved by the Rate Setting Body. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods, provided that the discounts do not increase the charges to other payors.

Appeal mechanism

The systems being discussed are largely formula driven, but no formula driven system can anticipate every eventuality. Some mechanism must be built into the system so that a hospital can appeal for changes which are unexpected and not automatically adjusted for. At the same time, the appeals must be limited or they will defeat the purpose of the regulatory system to control costs and charges, and the Rate Setting Body could be swamped with appeals.

The appeal mechanism should be limited to major items, i.e., items having an impact on costs or revenues of at least 1.5% of the total costs[1] of the hospital or $1,000,000, whichever is less, and which are not taken account of in the factors and formula used to develop the rates. The Rate Setting Body should have the option of recommending that charges be cut if a hospital has filed an appeal and the Rate Setting Body determines that the hospital's charges are too high.

Hospitals would be permitted to accumulate limited numbers of major items in any one payment year to satisfy the appeal threshold, provided that the items were not accounted for in the system, either through the allowances for inflation or the additional factor. The additional factor is intended to cover increased severity of illness within DRGs, the aging of the population, changes in technology and changes in medical practice, and projects which do not reach the CoN threshold. Appeal items must be unusual or unexpected items which do not impact on a substantial number of other hospitals in Maine.

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[1] Total costs in this context should be taken to mean the previous year's financial requirements of the hospital adjusted by the market basket factor.

Governmental shortfalls

The Medicare program is paying most hospitals much less than their charges and some less than their costs. Similarly the Medicaid program is underpaying hospitals. The current hospital payment system in Maine ensures that the charges to the other payors can be increased to fully cover any shortfalls between the payments from Medicare and Medicaid and the financial requirements that the Maine Health Care Finance Commission allocates to Medicare and Medicaid. It is expected that these shortfalls will continue to increase over the next several years, and, absent any alternative mechanism to fund these shortfalls, will result in substantial increases in hospital charges.

[The Commission is recommending that an amount be sought from the General Fund to cover the projected increase in the total shortfalls over the next year. The amount would be distributed among the hospitals most affected by the shortfalls. The current level of the shortfalls should continue to be built into the rates of the hospitals.]

Cross-subsidization

Emergency rooms and clinics are generally priced at substantially below cost. The charges for other services are increased to make up for the shortfall. This underpricing is considered necessary to ensure that the basic emergency room and clinic services remain affordable, and so as not to discourage access to these services. Also, there is a high level of bad debts and charity care in these services, and increasing charges is likely to increase the uncollectible accounts. There is some question as to whether the profits made on other outpatient services are sufficient to cover the shortfall on emergency rooms and clinics, or whether there is also some subsidy currently being provided from inpatient care. The data presently available to the Commission is not sufficient to provide an answer to this question.

The Commission has recommended above that hospitals should continue to have their outpatient revenues regulated, and also recommends that cross subsidization between inpatient and outpatient services, and among outpatient services, should continue to be permitted based on the historical levels of such cross-subsidization.

Payments for capital costs

The Commission is recommending that the payment for capital costs of buildings, fixed equipment and movable equipment should be on the basis of depreciation and interest payments, as defined by Medicare principles of reimbursement, less interest on debt

service reserve funds. Hospitals should be required to fund depreciation, and use their funded depreciation as a first source of funds for payment for capital projects.

The Maine Health Care Finance Commission currently pays for movable equipment on the basis of price level depreciation, and for buildings and fixed equipment on a formula allowance which generally provides the hospital with its cash requirements for capital for buildings and fixed equipment. The net impact of the proposed changes will be to add approximately $6,000,000 in cost to the payment system. This is being done because the current system results in many hospitals having losses on their financial statements due to the fact that their depreciation on buildings and fixed equipment is greater than their cash requirements for capital for buildings and fixed equipment. These losses, described as paper losses by proponents of the current system, have been one of the major criticisms against the current payment system by the hospital industry.

The movable equipment costs should be included in the standard component of the rates, and so be subject to a blend of the hospital's own historical costs and a standard cost, but the building and fixed equipment costs should continue to be paid entirely on the basis of the hospital's own costs for buildings and fixed equipment.

Demonstrations

Several different types of demonstrations and experiments should be encouraged:

1) hospital payment demonstrations and experiments; and,

2) demonstrations on change of a hospital to a lower level of care.

Hospital payment demonstrations and experiments:

The current statute allows great flexibility for hospital payment demonstrations. Language should be included in any new hospital rate or revenue regulation statute permitting demonstrations and experiments which further the overall goals of the payment system, and hospitals should be encouraged to propose such. The Rate Setting Body should have the authority of waive any and all regulatory and statutory requirements for such projects.

Lower level facilities:

There are several hospitals in the state that are unlikely to be able to remain viable as acute general hospitals because of low patient volume. When the closure of such a hospital would cause access problems due to no acute general hospital being available

within a reasonable travel distance it may be appropriate to have the hospital continue as a health care facility, but at a lower level than a general acute hospital. The State of Montana has a proposal to the Health Care Financing Administration for such lower level facilities, which would provide some basic inpatient care as well as outpatient care, and have lower licensing requirements so that costs could be reduced. Federal waivers would be needed to enable the facilities to be paid by Medicare for basic forms of inpatient care. This model, with some modifications, may be appropriate for Maine.

A task force should be established to define the parameters of the demonstration on change of a hospital to a lower level of care. This task force should define, among other factors, the licensing requirements for the lower level facility, the type of care that the facility would provide, and the payment mechanism. It should also be responsible for preparing an application to the Health Care Financing Administration to permit Medicare and Medicaid to pay these facilities. The Health Care Financing Administration has deadlines for the submission of such applications of May 1, 1989 for application requiring a waiver of Medicare and Medicaid payment principles, but without any funding, and November 6, 1989 for applications requesting both waivers and funding. The review of such applications normally takes from 6 to 9 months.

Pools for bad debts, charity care and governmental shortfalls

Bad debt and charity care pools are desirable where there are major differences in the bad debt and charity care loads of hospitals, and the resulting differential mark-ups from costs to charges place the hospitals with high bad debt and charity care loads at a disadvantage, for example, in contracting with HMOs or PPOs. At present there are hospitals which are relatively low cost, but which have relatively high charges because their rates include a large component for bad debts, charity care, and governmental shortfalls. This problem is likely to increase in magnitude over the next two years.

In Maine the differences in bad debt and charity care loads among hospitals are not sufficient to justify the establishment of a pool just for the purpose of spreading this more evenly across hospitals. Indeed, this spreading would have the effect of transferring money from less affluent rural areas to more affluent urban areas, which does not seem a very socially desirable result. Including the governmental shortfalls in the pool results in a reallocation which may make more sense from a social policy viewpoint, but would result in large increases and decreases in individual hospital rates, and so may not be palatable. There is a range of options for such pools.

*** SOME DISCUSSION OF THE OPTIONS TO BE INSERTED HERE

Several states have established bad debt and charity care pools with the funding source being a tax on the hospitals. The effect of the pools is thus to redistribute these costs uniformly across the hospitals, and so the private payors. However, it is still a case where the insured and the paying sick are being taxed to pay for the costs associated with treatment of the non-paying sick. It would be fairer to obtain a broader base of payment for these costs. The reason States have chosen the hospital tax option is that this is the option which has been most politically acceptable, since it does not result in any new taxes, and is a redistribution which is difficult to argue against on social policy grounds. However, this option does not address the problem that the shortfall is causing the price of health insurance to inflate rapidly, and so may result in problems of affordability of health insurance.

Rate Setting Body

The Rate Setting Body should be an independent executive agency. The rationale behind this recommendation is that it usually works better to have the programs administered by an independent executive agency, since such a body has more flexibility in hiring and contracting than a section within the normal state government. It provides a forum for representation by various interested parties and it also provides some independence from the budget concerns of the state Medicaid program, which can result in a conflict of interest if the same organization is determining the payment rates of the hospitals, and then paying the rates for services provided to Medicaid beneficiaries.

The Rate Setting Body must be held accountable for its actions, but is unlikely to be able to operate successfully if every individual decision is subject to review by the legislature or the executive branch. An overall review of its performance at periodic intervals is necessary to ensure accountability. The Rate Setting Body should be required to make an annual report of its activities and effects to the Human Resources Committee on an annual basis. This report should include an explanation of the means by which the Rate Setting Body quantified the factor provided to hospitals in addition to the allowance for input price inflation.

Certificate of Need

The Commission is recommending that the Certificate of Need process be retained, but that the scope should be changed for hospital and other acute care services. The following types of projects should be subject to Certificate of Need review:

Any hospital renovation or expansion project with a capital cost of $1,000,000 or more.

Purchase of movable equipment costing $1,000,000 or more, whatever the setting for that equipment.

Any increase in licensed bed capacity.

The threshold of $1,000,000 should be reviewed periodically (but not more frequently than annually) and adjusted to account for the impact of inflation.

The increase in the thresholds will exempt many projects from review which would have been subject to review under the thresholds currently in use. It will thus substantially reduce the number of projects for which hospitals have to apply for CoN approval.

The Commission considers that the current situation in which hospitals are required to obtain CoN approval before purchasing major movable equipment, but other providers are not subject to this requirement, to be unfair. The result is that the equipment becomes available in the non-hospital setting before it is available in the hospital setting, and this may not always be in the best public interest.

Nursing homes

No change is recommended to the regulation of nursing home rates for non-Medicaid patients. The hospitals in Maine have problems in placing high care Medicaid patients in nursing homes. These problems result in the patients experiencing extended hospital stays when they are not in need of that level of care. This problem could be alleviated by providing financial incentives to the nursing homes to take the heavier care Medicaid patients. The Medicaid program is planning to develop and implement a severity based payment system for nursing home patients, and such a system could provide the required incentives. The development and implementation of that system should be expedited.

There are some particular problems associated with institutions which have both hospital and nursing home components. Care should be taken to ensure that they are not disadvantaged by any changes in the regulations.

Hospice

Maine, like all other states, has a growing problem with AIDS in some of the major urban areas. The Commission has great concern

about this issue and recommends further study on the adequacy of the care currently available for AIDS patients and alternative mechanisms, e.g., hospices, which should be considered.

Physician Shortages

The responses to the survey distributed by the Commission indicated that there are shortages of a number of physician specialties in various regions of Maine. These shortages are being exacerbated by the rapid increases in malpractice premiums for certain specialties, particularly obstetrics.

The Medicare payment system for physicians should be carefully watched, and the state should be prepared to respond to the fairly radical changes which can be expected, either to adopt good ideas, or correct perverse incentives.

Tort reform is another area which is deserving of further study.

These are subjects which should be the subject of further study by a group with strong physician representation.

Shortages of other health professionals

Nurses and other health professionals are apparently in short supply in Maine, as in the remainder of the country. The demand for registered nurses is increasing, and at the same time enrollment in nursing education programs is dropping. As a result greater shortages can be anticipated in the future.

A separate Commission to study the Status of Nursing and Health Care Professions in Maine has been established. The Blue Ribbon Commission defers to this Commission on the subject of the shortages of health professionals.

Mandated benefits

The Commission recognizes that mandated benefits are an issue which requires further discussion, and that more information is needed on the impact of mandated benefits on the health care system.

Data collection from non-hospital providers

The Blue Ribbon Commission defers to the Commission to Study the Necessity and Feasibility of Establishing a Health Information Record on this topic.

STATE OF MAINE
113TH LEGISLATURE

D R A F T

Blue Ribbon Commission on the Regulation of Health Care Expenditures

December, 1988

MEMBERS:
Sen. N. Paul Gauvreau, Chair
Rep. Margaret P. Clark
Rep. Susan J. Pines
Dr. Edward C. Andrews, Jr.
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A P P E N D I C E S

I. Preface

This report of the Blue Ribbon Commission Health Care Expenditures has been prepared for presentation to the Committee on Human Services of the Maine Legislature, pursuant to the charge made to the Blue Ribbon Commission on Health Care Expenditures. It presents the recommendations of the Commission, the rationale behind these recommendations, and suggestions of which areas require further study because the Commission was not able to deal adequately with them given the time available.

(This draft report was prepared by the consultant to the Commission. It represents his understanding of the recommendations of the Commission reflecting a general consensus on concepts, and the areas which need further exploration. However it should not be taken as representing the views of the individual Commissioners. This report has not yet been approved by the Commission.)

The Commission realizes that many important issues relating to health care expenditures are not addressed adequately in this report, and some may not be addressed at all. This is inevitable due to shortage of time and limited resources. Some of the other important issues are being addressed by other Commissions, and in some instances topics have been noted here as requiring further study. Other Commissions and committees studying health care problems of the State of Maine include:

- The Commission to Study Access to Health Care

This Commission is reviewing mechanisms to enhance health care access and curb inappropriate health resource utilization. The Blue Ribbon Commission understands that this Commission may be producing a recommendation for a subsidized insurance product which is similar to the recommendation presented later in this report.

- The Maine Health Policy Advisory Council

This Council is in the process of developing a forecast of major health care issues in Maine over the next five years and an agenda of issues for next year. The Blue Ribbon Commission wishes to express its concern at the lack of a current State Health Plan, and suggests that the Health Policy Advisory Council may wish to address the questions of what agency should be responsible for the development of such a plan, and the structure and uses of the plan.

- The Commission to Study the Necessity and Feasibility of Establishing a Health Information Record

This Commission is reviewing the health care data currently available to Maine consumers and businesses, and is considering possible expansions to this data collection.

- The Commission to Study the Status of the Nursing and Health Care Professions in Maine

This Commission is conducting a wide-ranging analysis of Maine's health care personnel shortage.

Other areas, such as malpractice insurance rates, tort reform, and mandated benefits, were considered by the Commission to be outside of the scope of work which could be accomplished in the available time. These topics will warrant study in the future.

There is a major problem of inequity in the current system. Medicare and Medicaid payments are increasing at a slower rate than the financial requirements of the hospitals, and as a result the charges to the other payors are increasing at a substantially faster rate than the increase in costs. This inequity is becoming more and more of a problem, and is one of the components causing insurance premiums to increase fast. These insurance premium increases are likely to cause problems with the affordability of health insurance, and are unfair to the businesses and individuals responsible for paying the premiums. This was a major issue of discussion by the Blue Ribbon Commission, and a number of the recommendations address this problem.

II. Executive Summary of Recommendations

Hospital inpatient services

The Commission is recommending that a number of alternative systems be available for the regulation of inpatient hospital rates or revenues:

A. One regulatory option would be an average revenue per case mix adjusted discharge payment system, adjusted each year for a market basket inflation factor, plus a factor (in the range of one to one and three quarters percent (1 to 1.75%)) to reflect changes in technology (including changes in drugs and supplies) not covered by Certificate of Need projects, changes in medical practice, the aging of the population, and increased severity of illness not accounted for by the case mix measure.

B. Outpatient services in hospitals on the per case payment system described in paragraph A above would be regulated on a charge per unit of service system. The units to be used for this purpose would be negotiated between the Rate Setting Body and the hospital based on historical experience.

C. A Total Revenue System would exist as an option for hospitals with relatively self contained catchment areas, not in direct competition with other hospitals. This total revenue system would cover both inpatient and outpatient services.

D. The Rate Setting Body should encourage demonstration projects which further the goals of accessible, affordable and quality health care. The Rate Setting Body should have the authority to waive any and all regulatory and statutory requirements for demonstration projects which further the overall goals of the system as described in the enabling legislation.

E. Different regulatory systems should be utilized for specialty hospitals (e.g., psychiatric and rehabilitation hospitals) and other hospitals identified by the Rate Setting Body as being unique or different within the Maine health care system.

The Commission is recommending that the regulatory system establish a standard component in the rate, to be phased in over a five year period, but with the standard not to exceed 50% of the payment at the end of the phase-in. This recommendation is intended to reward productivity.

The Commission's recommendation on discounting by hospitals is:

Total Patient Revenue system hospitals should only be permitted to give discounts which are approved by the Rate Setting Body. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods provided that the discounts do not increase the charges to other payors.

An appeal mechanism should be established. This appeal mechanism should be limited to major items, that is, items having an impact on costs or revenues greater than the lesser of $1,000,000 or 1.5% of the total costs of the hospital, and which are not taken account of in the formula and factors used to develop the rates. The Rate Setting Body should have the option of reducing the charges if a hospital has filed an appeal and the Rate Setting Body determines that the hospital's charges are too high.

The Commission is recommending that $30,000,000 be sought from the General Fund as a contribution to a pool to alleviate the worst of the problems resulting from Medicare and Medicaid shortfalls and bad debts and charity care. The amount would be distributed among the hospitals most affected by the shortfalls. An additional $30,000,000 is requested to establish a subsidized insurance product in order to make health insurance more accessible and affordable. Similar amounts would be required in subsequent years.

The majority of the Commission consider that the Rate Setting Body should be an independent executive agency. This agency should be required to report annually to the Human Resources Committee on the impact of revenue regulation on the hospital industry in Maine, and the magnitude of and rationale for the automatic adjustment provided to the hospitals in addition to input price inflation.

Hospital outpatient services

The Commission is recommending that the revenues from outpatient services would continue to be regulated. For hospitals in the average revenue per case mix adjusted discharge payment system for inpatient services the outpatient services shall be regulated on a rate per unit of service basis.

AIDS

Maine, like all other states, has a growing problem with AIDS in some of the major urban areas. The Commission has great concern about this issue and suggests further study on the adequacy of the care currently available for AIDS patients and alternative mechanisms for caring for AIDS patients, e.g., hospices, which should be considered.

Nursing homes

No change is recommended to the regulation of nursing home rates for non-Medicaid patients. The hospitals in Maine have problems in placing high care Medicaid patients in nursing homes. These problems result in the patients experiencing extended hospital stays when they are not in need of that level of care. This problem may be alleviated by providing financial incentives to the nursing homes to take the heavier care Medicaid patients. For this reason the Commission encourages the Department of Human Services to expedite the development and implementation of a Medicaid payment system for nursing home services which takes account of the care requirements of the patients (sometimes referred to as a "case mix payment system").

Physician shortages

More study may be appropriate on the particular problems experienced by physicians practicing in rural areas, and on methods to alleviate these problems. This is an area which should be studied by a group with strong physician representation.

Nursing and other health professionals

On the issue of shortages of nurses and other health professionals the Blue Ribbon Commission is deferring to the Commission to Study the Status of the Nursing and Health Care Professions in Maine.

Mandated benefits

The Commission recognizes that mandated benefits are an issue which requires further discussion, and that more information is needed on the impact of mandated benefits on the health care system. The Blue Ribbon Commission urges the legislature to exercise extreme caution in approving any further mandated benefits or providers.

Certificate of Need

The Commission is recommending that the Certificate of Need process be retained, but that the scope should be changed for hospitals and other acute care services. The following types of projects should be subject to Certificate of Need review:

Any hospital renovation or expansion project with a capital cost of $1,000,000 or more.

Purchase of movable equipment costing $1,000,000 or more, whatever the setting for that equipment.

Any increase in licensed bed capacity.

The threshold of $1,000,000 should be reviewed periodically (but not more frequently than annually) and adjusted to account for the impact of inflation.

State health plan

The Blue Ribbon Commission recommends that some agency be assigned responsibility for developing and maintaining a current State Health Plan. This Plan would then be used by both the CoN review agency and the Rate Setting Body.

III. Introduction and Background

The Blue Ribbon Commission on Health Care Expenditures was established in 1987 during the first regular session of the 113th Legislature in response to growing criticism of Maine's health care regulatory system.

During the first regular session the Joint Standing Committee on Human Resources heard testimony on a bill that sought to alter the composition of the Maine Health Care Finance Commission (MHCFC) to include a health care practitioner, someone already employed in the health care field. The original bill was replaced entirely by a committee amendment. The new version (LD 290), sunseted the Maine Health Care Finance Commission, effective October 1, 1989 and created the Blue Ribbon Commission on Health Care Expenditures to report on Maine's health care system 9 months prior to the termination of the MHCFC.

STUDY DESCRIPTION:

The Commission's purpose was to study the regulation of health care expenditures. The study specifies that the goals of the health care system must include the provision of quality care, the accessibility to care and the affordability of care. The Commission was requested to:

A. Evaluate the current and anticipated market for health care services

B. Study the current methods and impending trends in the financing and delivery of health care

C. Study the current and anticipated environment for health care delivery systems

D. Study the various methods of regulating health care and health care expenditures, including, but not limited to, the present regulatory system under the Maine Health Care Finance Commission.

MEMBERSHIP:

The Commission consists of 17 members, representing large, medium and small hospitals, the business, labor and consumer communities, commercial health insurers, Blue Cross/Blue Shield, the Indigent, the Department of Human Services, the Legislature, and the Maine Health Care Finance Commission.

BACKGROUND

A BRIEF HISTORY OF HEALTH CARE REGULATION:

In the 1930's, public health insurance was virtually non existent and private health insurance was still rare. Hospitals, in conjunction with the American Hospital Association developed Blue Cross group insurance plans in response to drastic decreases in hospital revenues during the Great Depression.

During World War II, employers began to turn to non-wage benefits such as health insurance to attract a scarce labor force. By 1950, approximately half of hospital revenues were derived from health insurance. Now, in the 1980's, more than 90% of all hospital revenue comes from health insurance.

During the post World War II era, governmental involvement in health care began. In 1947, Congress enacted the Hill-Burton Act which provided grants to states for constructing hospitals, and increased federal investment in health care research and education.

Medicare and Medicaid programs were established in 1966, which gave the elderly and the poor access to and financial support for a broad range of health care services. These programs increased the demand for health care services. The method of payment used was retrospective cost-based reimbursement. Payments to providers were based on actual costs incurred, i.e. the charges the providers made for the services. If a provider became more efficient, the payments from Medicare and Medicaid were reduced. If the costs increased, payments increased. This method resulted in tremendous incentives to increase the costs of medical care.

By the late 1970's it became apparent that health care costs were continuing to rise. Retrospective cost-based reimbursement was contributing to this increase.

In 1978, Maine enacted its Certificate of Need program, which required hospitals and other designated health care facilities to obtain approval for projects which are subject to Certificate of Need review. Projects include certain major medical equipment, capital expenditures, development of new services and facilities and other circumstances specified in the law. (22 MRSA @ 302 sub-@ 1).

In 1983, Medicare payment for hospital inpatient services was changed to a prospective payment system. In the same year, Maine established a prospective payment system for hospitals and created the Health Care Finance Commission to implement this system (22 MRSA @ 381 sub-@ 1).

The prospective payment system requires the determination of the financial requirements of each health care provider and the aggregate amount the provider must charge to meet those requirements. This is determined in advance by the Health Care Finance Commission. If the provider actually spends less to provide those services, it may keep the extra. The next year's financial requirements are based on the previous year's financial requirements, with adjustments, and not on the actual costs. The hospital is not penalized for saving by a reduction in financial requirements. Under the cost based system, the hospital would have received its actual costs, which, if less, would have resulted in less revenues for the hospital.

At the same time it enacted the Health Care Finance Commission Act, the Legislature required that all Certificate of Need projects that were approved be automatically added to a hospital's financial requirements (which are based on the costs of existing equipment and programs, adjusted each year to account for inflation and other items). The costs of these services were automatically passed on to the payors under the payment system established by the Health Care Finance Commission Act. Hospital regulation through the Commission would control the costs of existing services. Certificate of Need approval would be the cost containment tool for control of new services, construction and equipment. It would help control health care costs by requiring a state agency to review each new service, construction project, or purchase of new equipment and grant approval to only those projects which were actually necessary. Existing programs were held to a budget and any new programs added to that budget had to be found necessary or the system would not allow increases to a hospital's charges to pay for that service or equipment. (1)

TODAY'S HEALTH CARE ENVIRONMENT

Over the past 10 years, many changes have occurred in the nature and delivery of health services. Many of these have adversely affected universal access to affordable, quality health care. These changes include:

A. Significant advances in medical technology

B. Dramatic and rapid increases in health care costs

C. Declining Federal payments

D. An increasing number of uninsured and underinsured individuals

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1. Much of this background has been summarized from information provided in the 1986 Certificate of Need study of the Human Resources Committee of the 112th Legislature.

E. Maldistribution and shortage of health care personnel

F. Development of alternative delivery systems such as PPOs, HMOs, ambulatory service centers etc.

G. Increase in Medicare/Medicaid cost shifting, bad debts and charity care.

The Blue Ribbon Commission on Health Care Expenditures feels that Maine's current regulatory system was designed in a very different environment. A regulatory system designed several years ago may not be appropriate in the current environment, just as a regulatory system designed today may not be appropriate five years from now. The Commission does not necessarily believe that the present regulatory system designed in 1982/1983 was designed in error, but simply that Maine's health care environment has changed. It is quite likely that Maine will have to go through a similar process of evaluation five years from now.

COMMISSION PROCEDURE

The Commission held its first meeting in September 1987, and devoted the first few months of its existence exploring the current regulatory environment in Maine and in other states. James Graham Atkinson, D. Phil, was hired in February 1988, as a consultant to the Commission to assist in the process of assessing and developing change to the current system.

The Commission also received technical assistance from the National Conference of State Legislatures (NCSL), and held two meetings with David Landes of NCSL, who has substantial knowledge about other states' regulatory systems.

A questionnaire was sent out to interested parties to solicit written testimony on health care issues so that the Commission members could assess the current health care environment.

The Commission also held two retreats in order to devote concentrated time and effort on the issues and develop a set of recommendations that would comply with the goals of the health care system - to provide quality care, access to care and affordable care.

Public hearings were held in Portland and Bangor in September 1988 to hear testimony in response to the Commission's draft report.

HEALTH CARE REGULATION TIMELINE

'Government'	'Private'
-1930-	
Public health insurance virtually nonexistent	Private health insurance still rare. Hospitals and AHA developed Blue Cross plans
-1945-	
	Employers turning to non-wage benefits such as insurance
-1946-	
• 1st Federal involvement in health facility planning • Hill-Burton Act provided grants to states for constructing public health centers and hospitals • Increased federal investment in a) research b) education	
-1950-	
	Approx. 50% hospital revenue now derived from insurance - nationwide
-1956-	
Partnership for Health Act - created 3 agencies a) State Comprehensive Planning Agency (Maine Dept. of Health & Welfare) b) Statewide Citizens' Advisory Council to advise planning agency c) local or regional planning agencies - 5 established in Maine	
-1965-	
• Enactment of Medicare & Medicaid (social security amendments of 1965) • Regional Medical Program (RMP) (subsidized university medical center projects)	
-1966-	
Funding authorized for a National Network of State & Local Comprehensive Health Planning Agencies (CHPs)	
-1972-	
• Congress adopted CON concept • PSROs created (Professional Standards Review Organizations) - to review quality and appropriateness of hospital services provided to beneficiaries of medicare and medicaid • changes in medicare reimbursement laws a) study authorized of prospective payment concept b) prospective limits on 'reasonable costs' under Medicare - limits based on estimates of the cost necessary for efficient delivery of needed health services	

-1974-

National Health Planning & Resources Development Act
- replaced Partnership for Health Act
- created 3 agencies
  1) HSA - local health systems agency - Maine created MHSA
  2) SHPDA - State Health Planning & Development Agency
  3) SHCC - State Health Coordinating Council
- This Act superseded CHP, RMP and Hill-Burton.
- Single program combining planning, developmental & regulatory functions

-1975-

Maine HMO Act established HMOs

-1978-

Maine enacted CON program
- already in effect in 38 states

-1980-

Omnibus Reconcilation Act
- reduced Federal support for local health planning efforts

-1982-

Maine Certificate of Need Advisory Committee established
- replaced MHSA

-1983-

Federal Social Security Amendments comes
- Medicare payment for hospital inpatient services changed to prospective payment system rather than on a reasonable cost basis
- discharges classified according to DRAs
- Maine established prospective payment system
- Maine created Health Care Finance Commission
- Maine Certificate of Need Development Account established
- More than 90% of hospital revenues from health insurance - nationwide
- HMOs beginning to grow in number & size - nationwide

-1986-

Maine Provider Arrangement Act establishing preferred provider arrangements in Maine and cash reserve requirements for HMOs

IV. Regulation of Hospital Rates or Revenues

Inpatient rates or revenues

The Commission recognizes that hospitals in Maine are in a variety of circumstances which make it unlikely that a single regulatory mechanism would be appropriate for all hospitals. Some hospitals are in areas of expanding population and require a payment system which allows revenues to respond quickly to changes in the need for care. Other hospitals are small, and in areas of stable or declining population. Such hospitals may require more stability in their revenue streams than could be provided through a volume sensitive payment system.

For these reasons the Commission is recommending that a number of alternative systems be available for the regulation of inpatient hospital rates or revenues:

A. One regulatory option would be an average revenue per case mix adjusted admission payment system, adjusted each year for a market basket inflation factor, plus a factor in the range of one to one and three quarters percent to reflect changes in technology not covered by Certificate of Need projects (including changes in drugs and supplies), changes in medical practice, increased severity of illness not accounted for by the case mix system, and the aging of the population. Volume adjustments would be made in subsequent years using a marginal cost factor in the range of 80 to 100%. A more detailed description of how such a system would work is included as Appendix B, for illustrative purposes.

B. A Total Revenue System would exist as an option for hospitals with relatively self contained catchment areas, not in direct competition with other hospitals. This total revenue system would cover both inpatient and outpatient services. The Rate Setting Body should develop criteria for which hospitals would be allowed to choose this option. The criteria examined could include, but not necessarily be limited to: distance in miles and travel time from the nearest other hospital, and the percentage of patients from the primary catchment area of the hospital which receive care at the hospital, taking account of the services existing at the hospital.

C. The Rate Setting Body should encourage demonstration projects and experiments which further the goals of accessible, affordable and quality health care. The Rate Setting Body should have the authority to waive any and all regulatory and statutory requirements for projects which further the overall goals of the system as described in the enabling legislation.

The Rate Setting Body shall have specific authority to permit hospitals to be essentially deregulated for inpatient or outpatient services whenever the hospital can demonstrate that it is a low cost provider of services. Such hospitals would continue to be subject to reasonable oversight by the RSB. This oversight would include data collection to monitor performance, and compliance adjustments if the conditions of the deregulation were contravened.

D. Different regulatory systems should be utilized for specialty hospitals (e.g., psychiatric and rehabilitation hospitals) and other hospitals identified by the Rate Setting Body as being unique or different within the Maine health care system.

There has been considerable discussion of the particular problems experienced by border hospitals. The exception request mechanism and items C. and D. should provide sufficient flexibility to deal with these problems.

Outpatient rates or revenues

The current system of regulating the rates of hospital outpatient services is unsatisfactory because the unit of measure for volume, equivalent inpatient admissions, is inadequate. Some change in the method of regulation is therefore needed. Outpatient services are the fastest growing component of hospital care, and the payment system should accurately measure and adjust for these changes. The Commission has a particular concern to ensure that access to outpatient services is preserved.

Hospitals on the Total patient revenue system:

The total patient revenue payment system would include the revenues from both inpatient and outpatient services. This is essential since there is a shift occurring from inpatient to outpatient settings, and it would be unreasonable to have a system which guaranteed a constant inpatient revenue while inpatient volume was declining, and an increasing outpatient revenue because outpatient volume was increasing. Also, to attempt to separate the inpatient and outpatient costs and revenues would unnecessarily complicate the system for the small hospitals which are expected to the regulated by means of this system.

Hospitals on the average revenue per case mix adjusted discharge payment system for inpatients:

The Commission is recommending that the outpatient rates of hospitals on the average revenue per case mix adjusted discharge payment system should continue to be regulated, but that the system of regulation should be changed to more accurately adjust for changes in outpatient volume. To this

end the Commission recommends setting the rate per unit of service by department for outpatient services. The units of measure to be used should be negotiated between the Rate Setting Body and each hospital based on historical experience. The rates will be established taking into account the historical level of cross-subsidy of the outpatient services.

Appendix A provides an example of how the outpatient rate setting system could function.

Components of the rate setting system.

Standard component or screens

When hospital payment rates are based upon the actual costs of the hospital in a single year then hospitals which were low cost in that year will be required to stay low cost and hospitals which were inefficient in that year will be permitted to stay inefficient, or will be overly rewarded as their efficiency improves. In other words, such a system does not reward efficiency in the base year or penalize inefficiency in the base year. To adjust for this problem it is possible to base the rates of the hospitals partly on hospital specific costs and partly upon a standard.

The Commission is recommending that the regulatory system establish a standard component in the rate, to be phased in over a five year period, but with the standard not to exceed 50% of the payment at the end of the phase-in. This would encourage and reward productivity. The phase-in period would permit high cost hospitals time to adjust to the constraints being placed upon them without undue hardship. The standard component should include operating costs and the costs of movable equipment, but should exclude costs associated with buildings and fixed equipment, which would continue to be paid entirely on the basis of the hospital's own costs of buildings and fixed equipment.

The standard rate could be based on a state (or peer group) average rate, or could be calculated from the Medicare payment rate, with some adjustments for the inequities of the Medicare payment system. An advantage of basing it on the Medicare rate is that this is already known, while developing a state standard would turn into a complicated exercise as it became necessary to adjust for all the various factors which would be raised and which account for justifiable differences in the cost levels of the hospitals, e.g. direct and indirect medical education costs. However, there would be some complications for hospitals classified as sole community providers by Medicare. Such hospitals have a Medicare payment which is based 75% on the hospital's own costs. The Medicare payment system thus does not embody the desired efficiency standard in this instance. The RSB would determine the standard for such hospitals consistent with the standard developed for the other hospitals in the state.

The intent of the inclusion of a standard component is to reward hospitals which have low costs and to penalize hospitals which have high costs. The intent is not to reduce or increase the total revenue in the system as a whole. While it would be technically difficult to ensure precise budget neutrality, the standard should be developed in such a way as to have little or no impact on the approved gross revenues of the hospital system as a whole. The RSB may either develop a new standard each year, or may adjust the standard from one year to the next.

Hospitals in the Total Revenue system would have a standard component in their rates in the same way as hospitals on the average revenue per case mix adjusted admission system, but the RSB would have the authority to modify or waive the standard component for Total Revenue System hospitals which were determined to be required for access, which would be substantially disadvantaged by the incorporation of a standard, and which could not avoid this disadvantage by management action.

Differentials and discounts

The current system allows for some approved discounts. Blue Cross currently receives such a discount, and the rates of other payors are increased to adjust for the discount provided to Blue Cross. The discount to Blue Cross was quantified through a study which demonstrated the magnitude of the discount that was economically justified. Such justified and approved discounts should continue to be provided.

The major question which must be addressed is whether the hospitals and payors should be permitted to negotiate discounts which are not economically justified, and not reviewed by the Rate Setting Body. Certainly hospitals should not be provided solvency guarantees if they provide unapproved discounts, and they should not be permitted to increase their charges to other payors to recoup the shortfalls resulting from voluntarily negotiated discounts which are not economically justified or approved.

The Commission's recommendation on this question is: Total patient revenue system hospitals should only be permitted to give discounts which are approved by the Rate Setting Body. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods, provided that the discounts do not increase the charges to other payors.

Exception requests

The systems being discussed are largely formula driven, but no formula driven system can anticipate every eventuality. Some mechanism must be built into the system so that a hospital can request adjustments to its approved revenue for changes which are unexpected and not automatically adjusted for. At

the same time, such exception requests must be limited or they will defeat the purpose of the regulatory system to control costs and charges, and the Rate Setting Body could be swamped with appeals.

Exception requests should be limited to major items, i.e., items having an impact on costs or revenues of at least 1.5% of the total costs[1] of the hospital or $1,000,000, whichever is less, and which are not taken account of in the factors and formula used to develop the rates. The Rate Setting Body should have the option of reducing the charges if a hospital has filed an exception request and the Rate Setting Body determines that the hospital's charges are too high.

Hospitals would be permitted to accumulate limited numbers of major items in any one payment year to satisfy the exception request threshold, provided that the items were not accounted for in the system, either through the allowances for inflation or the additional factor. The additional factor is intended to cover increased severity of illness within DRGs, the aging of the population, changes in technology and changes in medical practice, and projects which do not reach the CoN threshold. Exception request items must be unusual or unexpected items which do not impact on a substantial number of other hospitals in Maine.

Hospitals would be permitted to appeal to the RSB for correction of technical errors in the calculation of their rates without any dollar threshold on such technical corrections.

Governmental shortfalls

The Medicare program is paying most hospitals much less than their charges and some less than their costs. Similarly the Medicaid program is underpaying hospitals. The current hospital payment system in Maine ensures that the charges to the other payors can be increased to fully cover any shortfalls between the payments from Medicare and Medicaid and the financial requirements that the Maine Health Care Finance Commission allocates to Medicare and Medicaid. It is expected that these shortfalls will continue to increase over the next several years, and, absent any alternative mechanism to fund these shortfalls, would result in substantial increases in hospital charges.

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[1] Total costs in this context should be taken to mean the previous year's financial requirements of the hospital adjusted by the market basket factor.

The Commission is recommending that $30,000,000 be provided from the General Fund as a contribution to a pool to alleviate the worst of the problems associated with governmental shortfalls and charity and bad debts. The amount would be distributed among the hospitals most affected by the shortfalls. The balance of the shortfalls not paid from pools should continue to be built into the rates of the hospitals. This recommendation is closely tied to the recommendation on the establishment of a subsidized insurance product for the uninsured and underinsured. Both these topics are discussed in more detail later in this report.

Cross-subsidization

Emergency rooms and clinics are generally priced at substantially below cost. The charges for other services are increased to make up for the shortfall. This underpricing is considered necessary to ensure that the basic emergency room and clinic services remain affordable, and so as not to discourage access to these services. Also, there is a high level of bad debts and charity care in these services, and increasing charges is likely to increase the uncollectible accounts. There is some question as to whether the profits made on other outpatient services are sufficient to cover the shortfall on emergency rooms and clinics, or whether there is also some subsidy currently being provided from inpatient care. The data presently available to the Commission is not sufficient to provide an answer to this question.

The Commission has recommended above that hospitals should continue to have their outpatient revenues regulated, and also recommends that cross subsidization between inpatient and outpatient services, and among outpatient services, should continue to be permitted based on the historical levels of such cross-subsidization.

Payments for capital costs

The Commission is recommending that the payment for capital costs of buildings, fixed equipment and movable equipment should be on the basis of depreciation and interest payments, as defined by Generally Accepted Accounting Principles, less interest on debt service reserve funds. Hospitals should be required to fund depreciation, and use their funded depreciation as a first source of funds for payment for capital projects. Movable equipment costs will be included in the standard cost to be blended with the hospital's own historical cost. Movable equipment costs will be treated as a pass-through cost in the historical cost component of the rate.

The Maine Health Care Finance Commission currently pays for movable equipment on the basis of price level depreciation, and for buildings and fixed equipment on a formula allowance which provides the hospital with its cash requirements for capital

for buildings and fixed equipment plus a contribution towards the replacement cost of the needed portion of the facility. The net impact of the proposed changes will be to add approximately $6,000,000 in cost to the payment system. This is being done because the current system results in many hospitals having losses on their financial statements due to the fact that their depreciation on buildings and fixed equipment is greater than their cash requirements for capital for buildings and fixed equipment. These losses, described as paper losses by proponents of the current system, have been one of the major criticisms against the current payment system by the hospital industry.

The movable equipment costs should be included in the standard component of the rates, and so be subject to a blend of the hospital's own historical costs and a standard cost, but the building and fixed equipment costs should continue to be paid entirely on the basis of the hospital's own costs for buildings and fixed equipment.

Demonstrations

Several different types of demonstrations and experiments should be encouraged:

A. hospital payment demonstrations and experiments; and,

B. demonstrations on change of a hospital to a lower level of care.

Hospital payment demonstrations and experiments:

The current statute allows great flexibility for hospital payment demonstrations. Language should be included in any new hospital rate or revenue regulation statute permitting demonstrations and experiments which further the overall goals of the payment system, and hospitals should be encouraged to propose such. The Rate Setting Body should have the authority of waive any and all regulatory and statutory requirements for such projects.

Lower level facilities:

There are several hospitals in the state that are unlikely to be able to remain viable as acute general hospitals because of low patient volume. When the closure of such a hospital would cause access problems due to no acute general hospital being available within a reasonable travel distance it may be appropriate to have the hospital continue as a health care facility, but at a lower level than a general acute hospital. The Montana Hospital Association has been awarded a development grant by the Health Care Financing Administration to develop the licensing and other requirements for such lower level facilities, which would provide some basic inpatient care as well as outpatient care, and have lower licensing requirements

so that costs could be reduced. Federal waivers would be needed to enable the facilities to be paid by Medicare and Medicaid for basic forms of inpatient care.

This model, with some modification, may be appropriate for Maine.

A task force should be established to define the parameters of the demonstration on change of a hospital to a lower level of care. This task force should define, among other factors, the licensing requirements for the lower level facility, the type of care that the facility would provide, and the payment mechanism. It should also be responsible for preparing an application to the Health Care Financing Administration to permit Medicare and Medicaid to pay these facilities. The Health Care Financing Administration has deadlines for the submission of such applications of May 1, 1989 for application requiring a waiver of Medicare and Medicaid payment principles, but without any funding, and November 6, 1989 for applications requesting both waivers and funding. The review of such applications normally takes from 6 to 9 months. This option should be brought to the attention of the state agency responsible for hospital licensure.

Pools for bad debts, charity care and governmental shortfalls

Shortfalls in governmental payments relative to the financial requirements of the hospitals are becoming an ever increasing problem for the health care system in Maine, as elsewhere in the U.S.. The governmental payments are increasing at a much lower rate than hospital financial requirements. The result is that the charges to non-governmental payors have to be increased substantially more than the increase in financial requirements in order to make up the difference. This effect can best be illustrated with the actual data for the State of Maine. Between the first and the fifth payment year under the MHCFC financial requirements rose by 41%, public insurance payments rose by 15%, and private payments rose by 62%. This effect is likely to increase further, with resulting large increases in hospital charges to private payors, with resulting large increases in hospital charges to private payors, and corresponding increases in insurance premiums. There are two distinct problems associated with this effect:

A. Hospitals which have a high proportion of Medicare and Medicaid patients, and also a high bad debt and charity care load, have very high charges, as their costs are marked up to recover the governmental shortfalls and the charity and bad debt losses. This can reach a level at which the hospital feels that it cannot charge the full approved rate.

"B. Health insurance premiums will continue to rise at a high rate reflecting the large increases in hospital charges required to compensate for the increasing shortfalls. As this happens individuals and businesses will find health insurance less affordable. This will in turn add to the number of individuals without insurance.

In the past payment year the Medicare shortfall amounted to $60,000,000, the Medicaid shortfall to $11,000,000, and the cost of bad debts and charity care to $40,000,000, for a total shortfall of about $110,000,000.

The Commission is recommending a two pronged attack on this problem. The first prong is the establishment of a subsidized health insurance plan for the uninsured and the underinsured. This would be done by an extension of the current Medicaid program, allowing individuals not currently eligible for Medicaid to purchase Medicaid type coverage by paying a premium which varied with the level of income. The result of this program on hospitals would be to reduce their level of bad debts and charity care. This would in turn reduce the mark-up required in the rates of the hospital, and so make the hospital's services more affordable. A general fund contribution of $30,000,000 is being requested for this purpose. A similar amount would be required in each subsequent year.

The second prong of this attack would be a pool which would make contributions to the hospitals most affected by the various shortfalls. There would be two sources of funds for this pool: 1) A general fund contribution of $30,000,000 which is being requested for this purpose, and 2) if this is insufficient to deal with the problem then the Rate Setting Body would have the authority to levy a small tax on the hospitals, say of 0.75%, which would be added to the pool.

It is important to note the different effect of the funds from these two different sources. The effect of the general fund contribution to the pool will be to reduce the overall increase in the charges of the hospitals. The effect of the tax on hospitals would be to equalize the effect of shortfalls across hospitals, so that hospitals with a high proportion of Medicare and Medicaid patients, and a high bad debt and charity care load do not have to recover all these shortfalls from their own charges to paying private patients. The tax thus does not reduce the level of charges overall, it just redistributes the shortfall among the hospitals.

The payments from the pool should account for the impact of the proportion of Medicare and Medicaid patients, the particular disadvantages of the Medicare payment system for rural hospitals, and disproportionate share of poor patients. The payments are not intended to pay for inefficiency in the

hospitals. The Rate Setting Body should devise the mechanism to be used to distribute the funds in the pool, and determine the definition of efficiency for this purpose.

Several states have established bad debt and charity care pools with the funding source being a tax on the hospitals. The effect of the pools is to redistribute these costs uniformly across the hospitals, and so the private payors. However, this results in the insured and the paying sick being taxed to pay for the costs associated with the treatment of the non-paying sick. It would be fairer to obtain a broader base of payment for these costs. The reason States have chosen the hospital tax option is that this is the option which has been most politically acceptable, since it does not result in any new taxes, and is a redistribution which is difficult to argue against on social policy grounds, and businesses and payors have not objected too strongly to this solution. However, as discussed above, this option does not address at all the problem that the shortfall is causing the price of health insurance to inflate rapidly, and so may result in problems of affordability of health insurance.

Rate Setting Body

The Rate Setting Body should be an independent executive agency. The rationale behind this recommendation is that it usually works better to have the rate setting programs administered by an independent executive agency, since such a body has more flexibility in hiring and contracting than a section within the normal state government. It provides a forum for representation by various interested parties and it also provides some independence from the budget concerns fo the state Medicaid program, which can result in a conflict of interest if the same organization is determining the payment rates of the hospitals, and then paying the rates for services provided to Medicaid beneficiaries.

The Rate Setting Body must be held accountable for its actions, but is unlikely to be able to operate successfully if every individual decision is subject to review by the legislature or the executive branch. An overall review of its performance at periodic intervals is necessary to ensure accountability. The Rate Setting Body should be required to make an annual report of its activities and effects to the Human Resources Committee. This report should include an explanation of the means by which the Rate Setting Body quantified the factor provided to hospitals in addition to the allowance for input price inflation.

Certificate of Need

The Commission is recommending that the Certificate of Need process be retained, but that the scope should be changed for hospital and other acute care services. The following types of projects should be subject to Certificate of Need review:

Any hospital renovation or expansion project with a capital cost of $1,000,000 or more.

Purchase of movable equipment costing $1,000,000 or more, whatever the setting for that equipment.

Any increase in licensed bed capacity.

The threshold of $1,000,000 should be reviewed periodically (but not more frequently than annually) and adjusted to account for the impact of inflation.

The increase in the thresholds will exempt many projects from review which would have been subject to review under the thresholds currently in use. It will thus substantially reduce the number of projects for which hospitals have to apply for CoN approval.

The Commission considers that the current situation in which hospitals are required to obtain CoN approval before purchasing major movable equipment, but other providers are not subject to this requirement, to be unfair. The result is that the equipment becomes available in the non-hospital setting before it is available in the hospital setting, and this may not always be in the best public interest.

A State Health Plan should be developed, and maintained so that it remains current. The Certificate of Need review agency and the Rate Setting Body should take that plan into account in their activities.

Nursing homes

No change is recommended to the regulation of nursing home rates for non-Medicaid patients. The hospitals in Maine have problems in placing high care Medicaid patients in nursing homes. These problems result in the patients experiencing extended hospital stays when they are not in need of that level of care. This problem could be alleviated by providing financial incentives to the nursing homes to take the heavier care Medicaid patients. The Medicaid program is planning to develop and implement a severity based payment system for nursing home patients, and such a system could provide the required incentives. The development and implementation of that system should be expedited.

There are some particular problems associated with institutions which have both hospital and nursing home components. Care should be taken to ensure that they are not disadvantaged by any changes in the regulations.

Hospice

Maine, like all other states, has a growing problem with AIDS in some of the major urban areas. The Commission has great concern about this issue and recommends further study on the adequacy of the care currently available for AIDS patients and alternative mechanisms, e.g., hospices, which should be considered.

Physician Shortages

The responses to the survey distributed by the Commission (Appendix F) indicated that there are shortages of a number of physician specialties in various regions of Maine. These shortages are being exacerbated by the rapid increases in malpractice premiums for certain specialties, particularly obstetrics.

The Medicare payment system for physicians should be carefully watched, and the state should be prepared to respond to the fairly radical changes which can be expected, either to adopt good ideas, or correct perverse incentives.

Tort reform is another area which is deserving of further study.

These are subjects which should be the subject of further study by a group with strong physician representation.

Shortages of other health professionals

Nurses and other health professionals are apparently in short supply in Maine, as in the remainder of the country. The demand for registered nurses is increasing, and at the same time enrollment in nursing education programs is dropping. As a result greater shortages can be anticipated in the future.

A separate Commission to study the Status of Nursing and Health Care Professions in Maine has been established. The Blue Ribbon Commission defers to this Commission on the subject of the shortages of health professionals.

Mandated benefits

The Commission recognizes that mandated benefits are an issue which requires further discussion, and that more information is needed on the impact of mandated benefits on the health care system. Given the substantial increases in health care premiums that can be anticipated in the next several

years, the Blue Ribbon Commission urges the legislature to exercise extreme caution in approving any further mandated benefits or providers.

Data collection from non-hospital providers

The Blue Ribbon Commission defers to the Commission to Study the Necessity and Feasibility of Establishing a Health Information Record on this topic.

A P P E N D I C E S

Appendix A

Outpatient Rate per Unit of Service System

Appendix A

Outpatient Rate per Unit of Service System

Introduction

This appendix will describe in outline how the rate per unit of service regulatory system for outpatient services could work. This explanation is for illustrative purposes and is not intended to constrain the RSB in how it actually regulates outpatient services or to be a comprehensive description of all steps of the process.

Units of service

The first task for the RSB will be to establish a unit of service for each outpatient revenue center for each hospital. The units would not have to be the same for all hospitals. In fact, it is unlikely that all hospitals currently collect the same measures of volume in all their departments. Examples of volume measures which could be used are:

Revenue center	Units
Laboratory	Workload units of College of American Pathologists or tests
Radiology	Relative Value Units of American College of Radiologists or procedures
Operating room	Minutes
Anesthesia	Minutes
Therapies	15 minutes intervals

A comprehensive list of departments with possible units can be found in the SHUR manual, or the regulations of the Maryland Health Services Cost Review Commission.

The RSB would have to survey the hospitals to determine which units are currently collected.

Data collection

The RSB would have to discuss with each hospital which unit of service they collect for each of their outpatient revenue centers. For example, some hospitals may only collect the number of procedures in radiology, and some will collect relative value units. The RSB may want to standardize the units eventually, but this is not necessary for the initial setting of rates.

If a hospital wishes to change the unit of measure that it uses then it will be required to collect both the old unit and the new unit for a bridge year. This data would be used to calculate a conversion factor from the old unit to the new unit.

For the initial rate setting the RSB will require that the hospital's costs be separated into inpatient and outpatient costs, probably using standard Medicare apportionment techniques.

Some data will also be required on the level of cross-subsidy currently incorporated in the outpatient rates.

The hospitals will have to submit, on at least an annual basis, the number of units of service provided to outpatients and the total charges for these outpatient services, by revenue center.

Rate setting

The RSB would use the base year unit and cost data to establish a rate per unit of service which would be adjusted for allowable cross subsidies, inflation, and other factors. Since different hospitals will have been collecting different units of measure it would not be possible at the outset to compare the rates of different hospitals and apply efficiency rewards and penalties. Over time the RSB could require the hospitals to collect consistent statistics, and then use these consistent statistics to set the rates, with some adjustments for relative efficiency and inefficiency.

This approach controls both the rate of increase in the costs of outpatient services and the mark-up from costs to charges.

In subsequent years the rates would be developed using volumes of service from the most recent full year available. While no adjustment will be made to the unit rate in the year in which the volume changes, the rates would be adjusted for changes in volume using a variable cost factor in subsequent years.

Adjustment for volume change

Assume that the rate of a particular center was developed with a volume of 1,000 units, and a cost of $1,000, and that the mark-up to account for bad debts, cross-subsidy, etcetera was 25%. Then the rates per unit of service would be $1.25.

If the hospital actually generated 1500 units of service in the year for which this rate was set then the hospital would be permitted to keep all the additional revenue generated from the additional volume. However, one year after the end of this year the 1500 units would be used in establishing the new rate. The rate would be calculated using a marginal cost

factor, say of 80%. If we assume the impact of inflation is 10% and the new mark-up is 30%., then the rate for this new year would be calculated as follows:

Cost adjusted for inflation	$1,000 x 1.1 = $1,100
Cost adj. for inflation and volume	$1,100 + $1.10 x 0.8 x 500 = $1,540
New cost per unit	$1,027
New rate per unit	$1,027 x 1.3 = $1,335

Compliance

Compliance can be assessed on a center by center basis or in total over outpatient services.

For compliance in total the hospital will submit after the end of the rate year the number of units of service provided to outpatients and the revenue charged for those units, by revenue center. The actual revenue generated from the outpatient services would be compared with the sum over all the outpatient revenue centers of the product of the actual number of units of service times the approved rate. If the actual revenue exceeds this amount then the hospital has overcharged in total for outpatient services and the difference, plus any overcharge penalty, would be subtracted from the subsequent year's revenue.

For compliance on a center by center basis the actual revenue generated in the center would be compared with the revenue which would have been generated if the hospital had charged the approved rate for each unit of service actually provided.

Appendix B

Inpatient Regulatory Systems

Appendix B

Inpatient Regulatory Systems

Introduction

This appendix will describe in outline how the inpatient regulatory systems could work. This explanation is for illustrative purposes and is not intended to constrain the RSB in how it actually regulates inpatient services or to be a comprehensive description of all steps of the process.

For ease of expression the term rate will be used generally in place of the term "average approved revenue per case mix adjusted discharge" and cost will be used in place of "financial requirements".

Average Revenue per Case Mix Adjusted Discharge System

Units of service

The first task for the RSB will be to establish the base number of inpatient units of service for each hospital. This is the number of case mix adjusted discharges from the hospital in the base year, with the case mix adjustment being done by DRG.

Data collection

For the initial rate setting the RSB will require that the hospital's costs be separated into inpatient and outpatient costs, probably using standard Medicare apportionment techniques.

Some data will also be required on the level of cross-subsidy currently incorporated in the outpatient rates.

The hospitals will have to submit, on at least an annual basis, the number of case mix adjusted discharges of inpatients and the total charges for inpatient services.

Rate setting

The RSB would use the base year unit and cost data to establish an average cost per case mix adjusted discharge which would be adjusted for allowable cross subsidies, inflation, and other factors. This rate would be blended with a standard rate to arrive at the average revenue per case mix adjusted admission which the hospital would be approved to charge.

This approach controls both the rate of increase in the costs of inpatient services and the mark-up from costs to charges.

In subsequent years the rates would be developed using volumes of service from the most recent full year available. While no adjustment will be made to the unit rate in the year in which the volume changes, the rates would be adjusted for changes in volume using a variable cost factor in subsequent years.

Adjustment for volume change

Assume that the rate for a particular center was developed with a volume of 1,000 units, and a cost of $2,000,000, and that the mark-up to account for bad debts, cross-subsidy, etcetera was 25%. Then the approved average revenue per case mix adjusted discharge would be $2,500.

If the hospital actually treated 1200 case mix adjusted discharges in the year for which this rate was set then the hospital would be permitted to keep all the additional revenue generated form the additional volume. However, one year after the end of this year the 1200 units would be used in establishing the new rate. The rate would be calculated using a marginal cost factor, say of 80%. If we assume the adjustment for inflation and other factors is 10% and the new mark-up is 30%, then the rate for this new year would be calculated as follows:

Cost adjusted for inflation	$2,000,000 x 1.1 = $2,200,000
Cost adj. for inflation & volume	$2,200,000 + $2,200 x 0.8 x 200 = $2,552,000
New cost per unit	$2,126.67
New rate per unit	$2,126.67 x 1.3 = $2,764.67

Compliance

Compliance would be assessed in total over inpatient services.

For compliance the hospital will submit after the end of the rate year the number of units of service provided to inpatients and the revenue charged to these inpatients. The actual revenue generated from the inpatient services would be compared with the product of the actual number of units of service times the approved rate. If the actual revenue exceeds this amount then the hospital has overcharged for inpatient services and the difference, plus any overcharge penalty, would be subtracted from the subsequent year's revenue.

Total Revenue System

For the total revenue system the RSB would take the costs in the base year, adjust these forwards for inflation and other factors, build in the effect of the standard component of the rate, and establish the total allowable revenue for inpatient and outpatient services based on that figure. Compliance would be done by comparing the actual inpatient revenue generated by the hospital with this approved revenue.

In subsequent years an adjustment would be made for change in volume of service, but using a lower variable cost factor than that used for hospitals on the other regulatory system.

The basic difference between the two systems are the method of assessing compliance and the variable cost factor to be used for volume adjustments.

Appendix C

Evaluating the Performance of the Maine Health Care Finance Commission

Appendix C

(Note: This may be updated for the final report - depending on availability of AHA data)

EVALUATING THE PERFORMANCE OF THE MAINE HEALTH CARE FINANCE COMMISSION (MHCFC).

Factors which can be evaluated at this point are:

A. Cost containment effects:

Since the start of MHCFC regulation the cost per adjusted admission in Maine hospitals has increased slightly less than the national average. In the prior six years the increase was slightly higher than the national average. Total expenses were increasing at just under the national average, and are now under the national average increase by a slightly larger amount. On average, over a three year period the rate of cost increase has been about 1% below the national average.

The MHCFC appears to have had a slight moderating effect on the rate of hospital cost inflation

B. Revenue containment effects:

Gross revenues increased much less in the period 1984 through 1986 than in the U.S. as a whole. This effect appears to have reversed in the past two years, and the increase in the mark-up from costs to charges appears to be greater in Maine than in the U.S.

The charge to cost ratio of the hospitals is an important measure of the impact of the regulation on patients or payors who pay charges. This is a measure of the mark-up applied by the hospital to its costs to obtain its charges. For example, if the average cost per case at a hospital is $2,000 and the charge to cost ratio is 1.25, then the average charge per case will be $2,500 ($2,000 x 1.25).

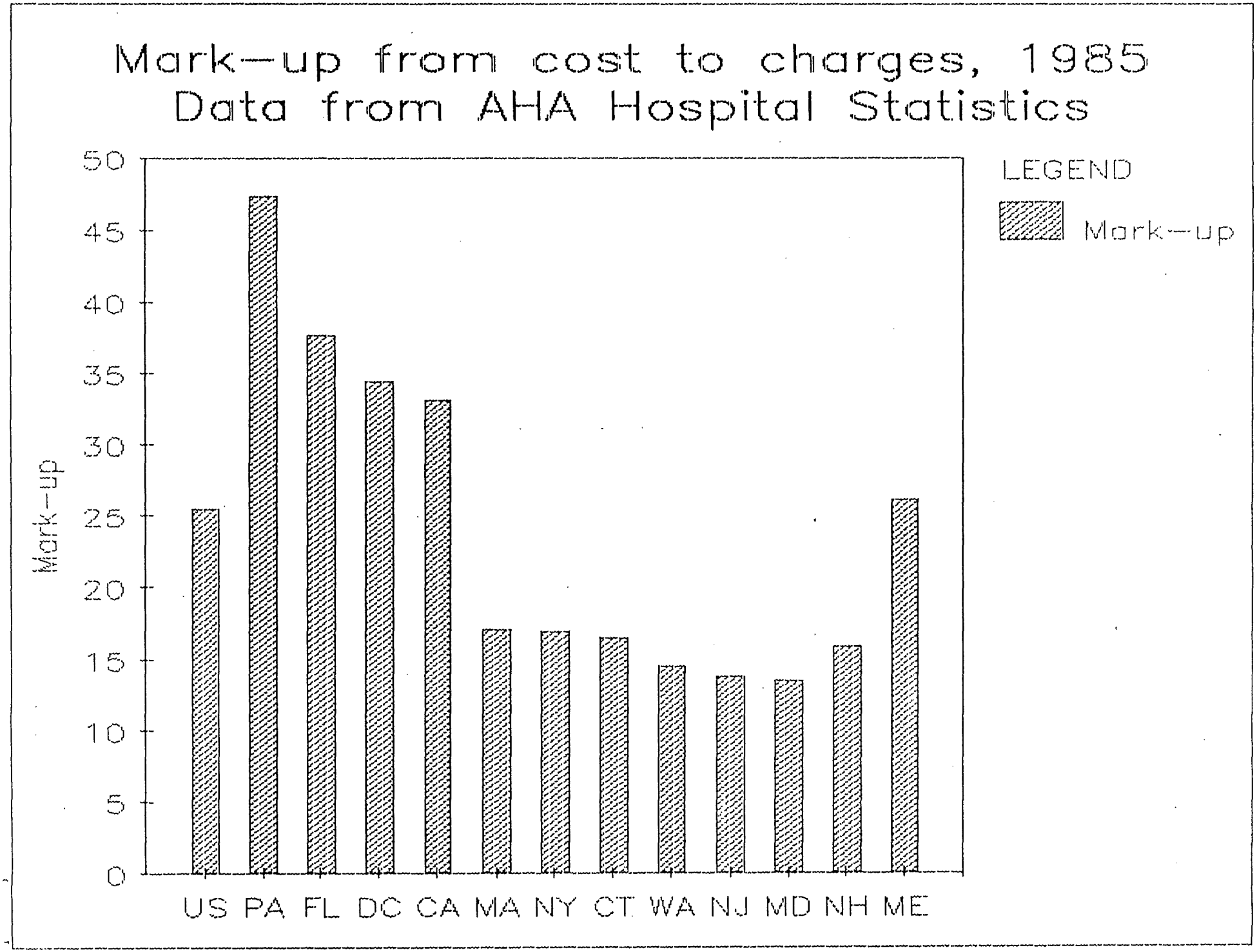
The MHCFC had a dramatic downward effect on the cost to charge ratio in the first few years of operation. The requirement that all of the Medicare and Medicaid shortfalls be included in the rates of the other payors has resulted in large increases in charges in the past two years, balancing this effect.

Net revenues increased at less than the national average.

Conclusions:

While the data is for far too short a time period, and the margins are too small to draw any very definite conclusions, regulation by the MHCFC does appear to have had a slight moderating effect on the rate of cost increases in hospitals in Maine, and a dramatic, if temporary, effect on the cost to charge ratio of the hospitals.

NOTE: This evaluation was prepared by Graham Atkinson. Most of the data used in the evaluation is contained in Atkinson's paper entitled "Costs, Revenue and Utilization Data, Maine and the U.S", prepared for the Commission January 31, 1988.


Mark—up from cost to charges, 1985
Data from AHA Hospital Statistics
Mark—up
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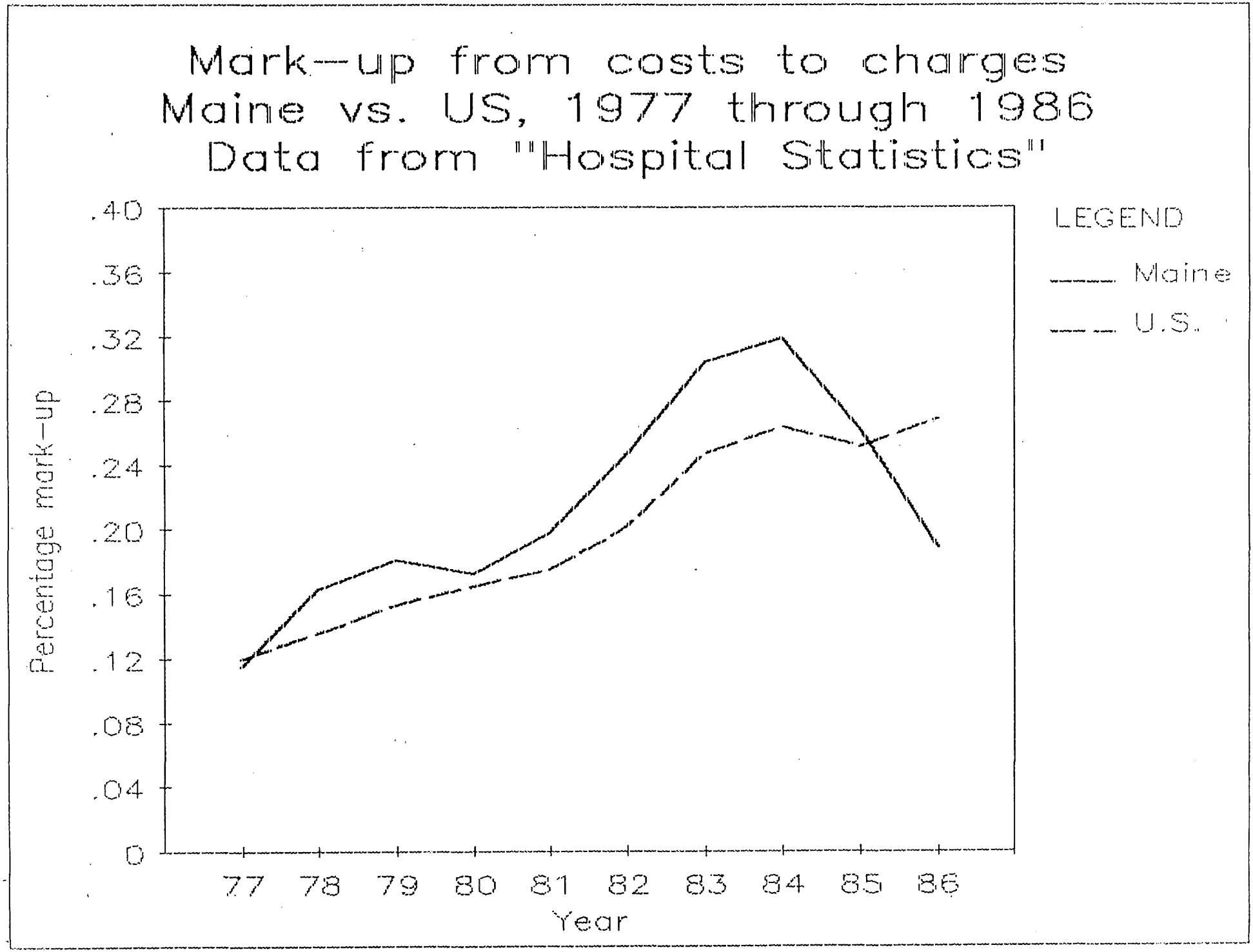
45
40
35
30
25
20
15
10
5
0
US PA FL DC CA MA NY CT WA NJ MD NH ME
LEGEND
Mark—up


Mark-up from costs to charges
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"
Percentage mark-up
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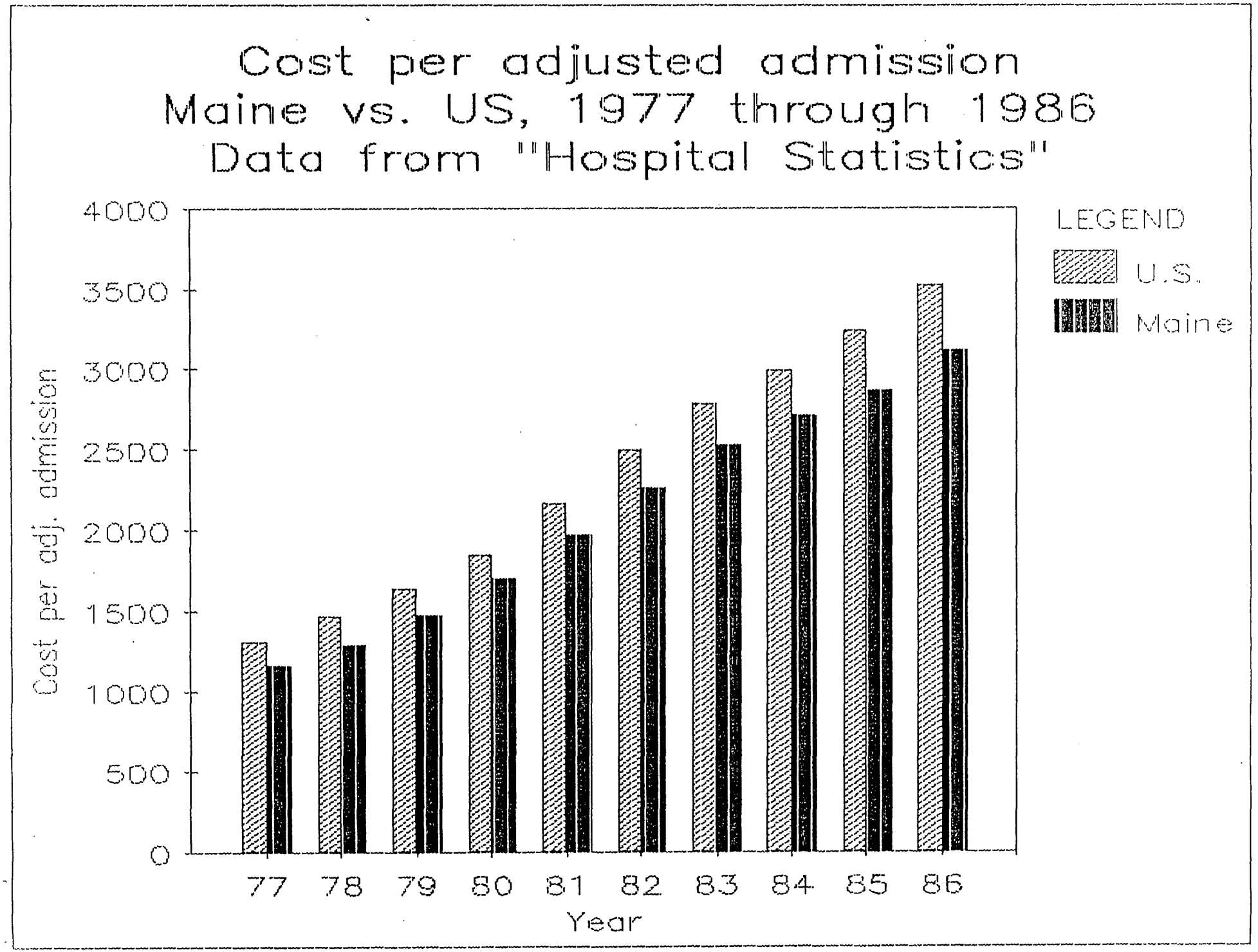
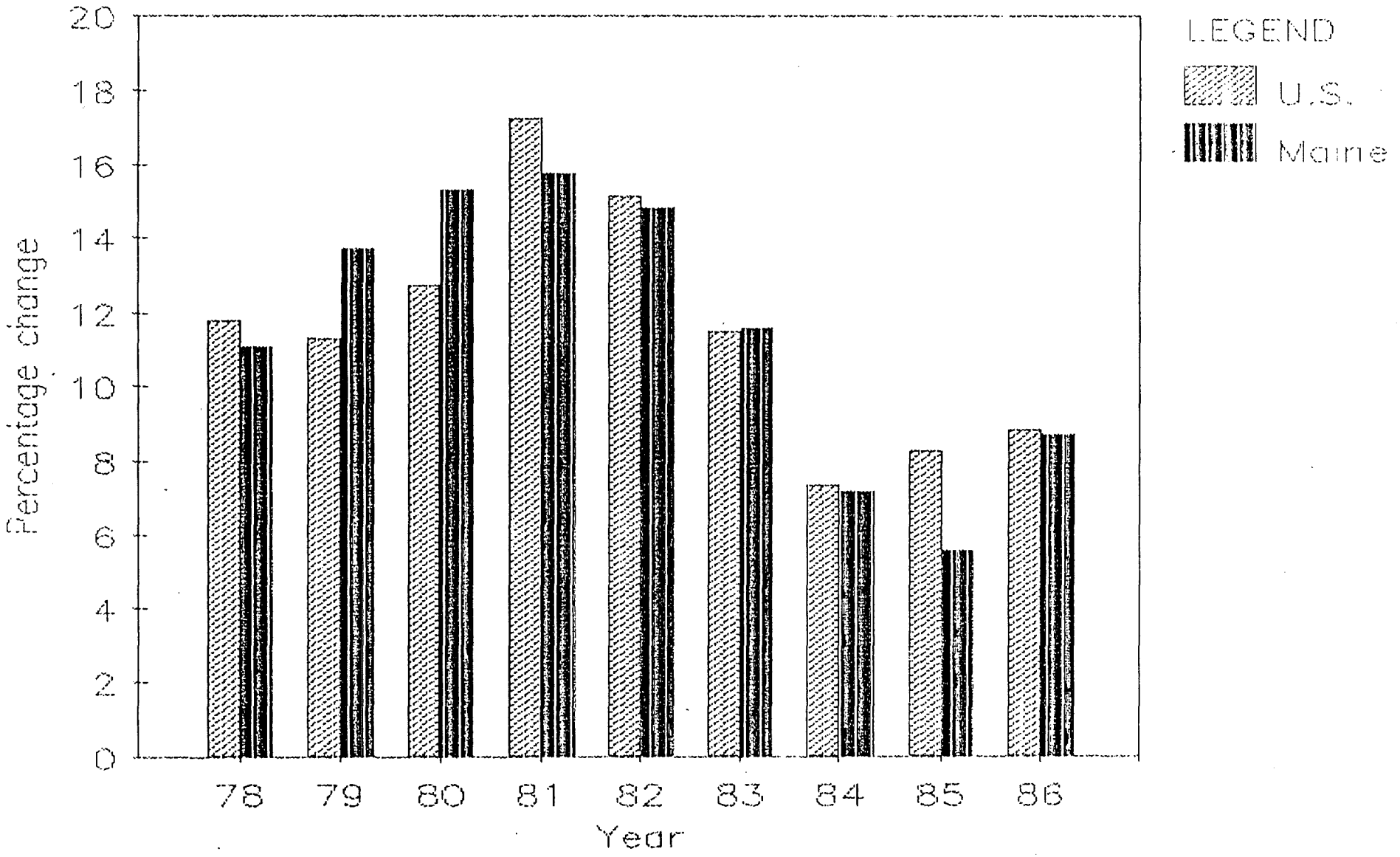
.36
.32
.28
.24
.20
.16
.12
.08
.04
0
77
78
79
80
81
82
83
84
85
86
Year
LEGEND
Maine
U.S.

3.


Cost per adjusted admission
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"
Cost per adj. admission
4000
3500
3000
2500
2000
1500
1000
500
0
77
78
79
80
81
82
83
84
85
86
Year
LEGEND
U.S.
Maine

% change in cost per adj. admission
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"



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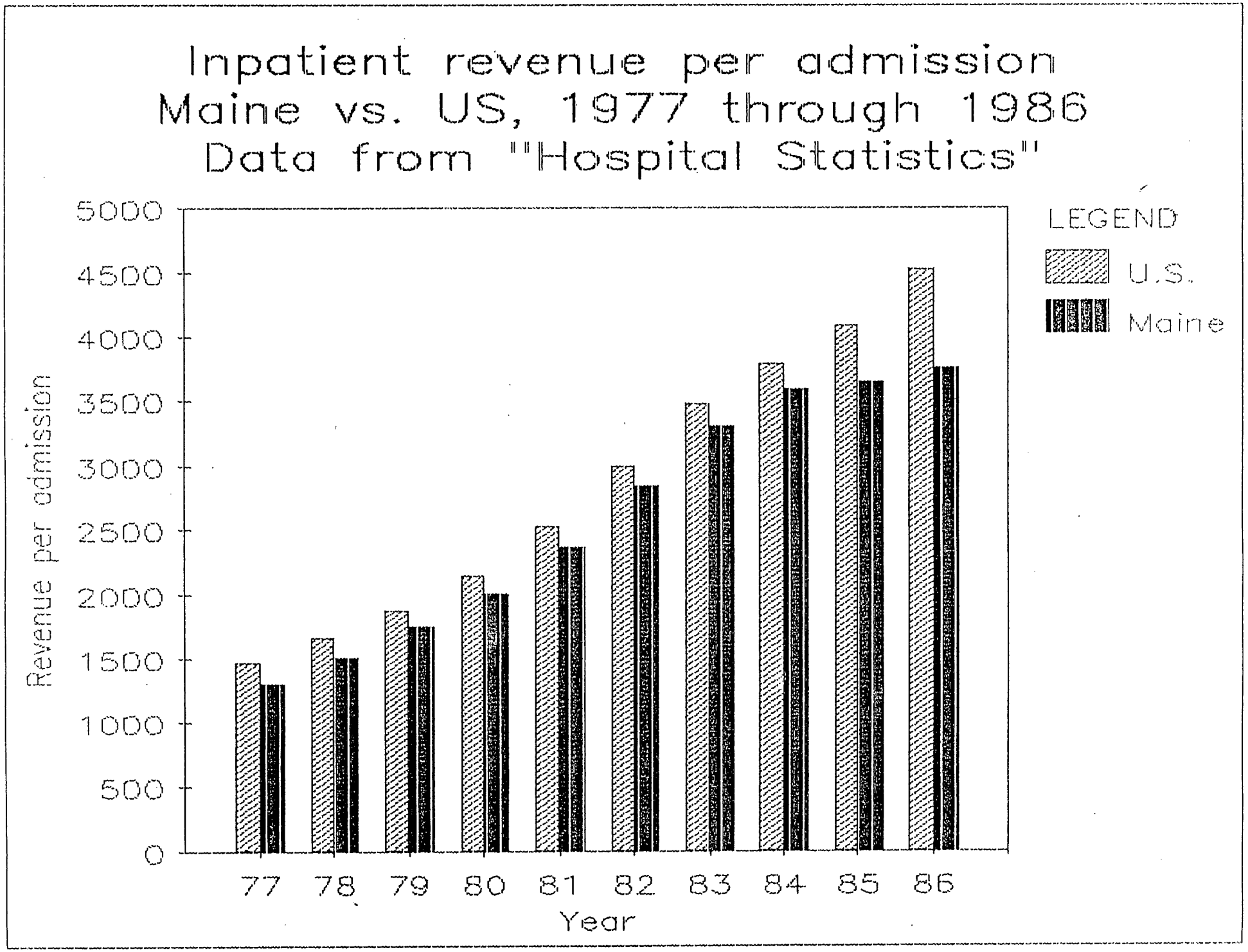
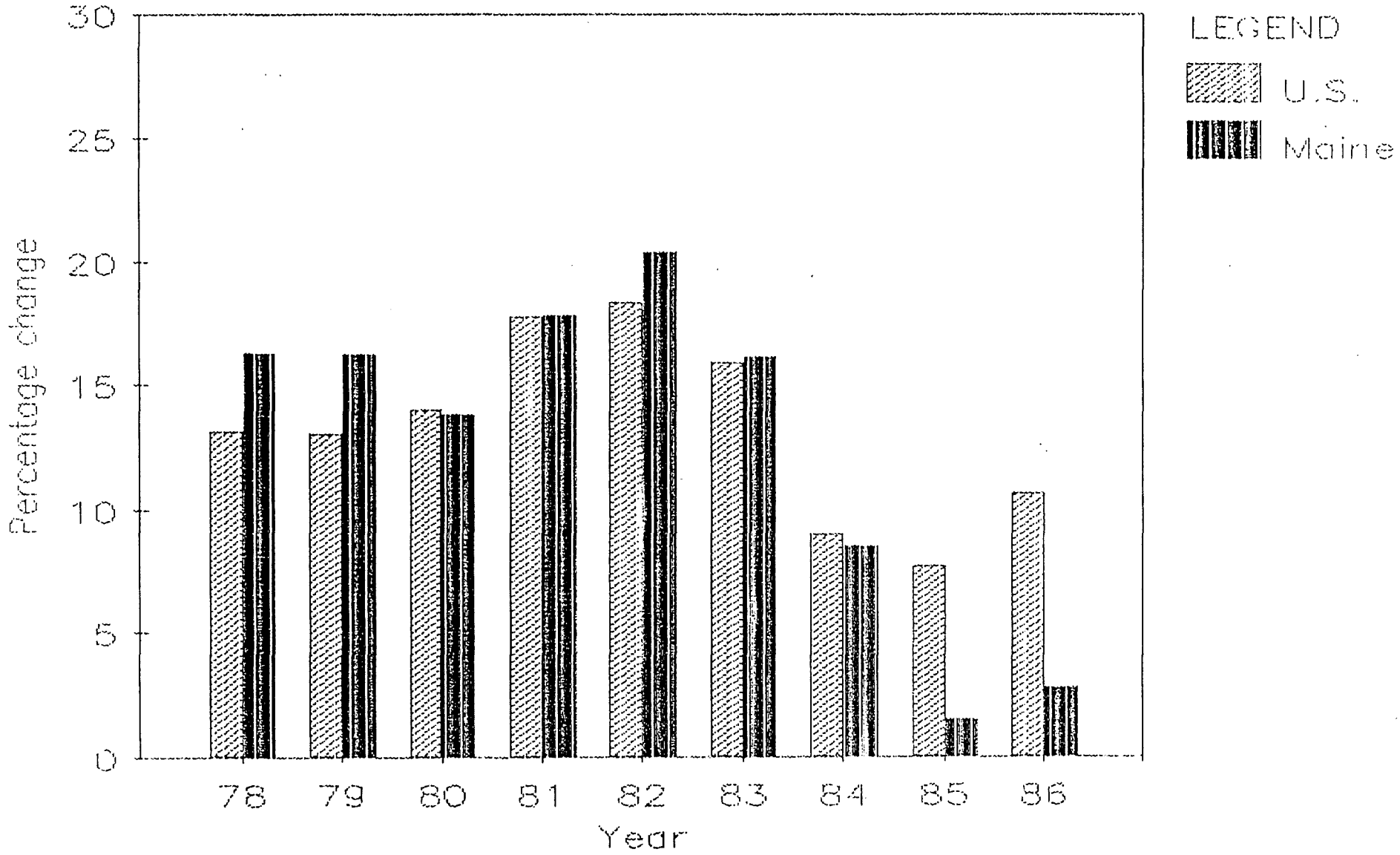

Inpatient revenue per admission
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"
Revenue per admission
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
77
78
79
80
81
82
83
84
85
86
Year
LEGEND
U.S.
Maine

% change in revenue per admission Maine vs. US, 1977 through 1986 Data from "Hospital Statistics"



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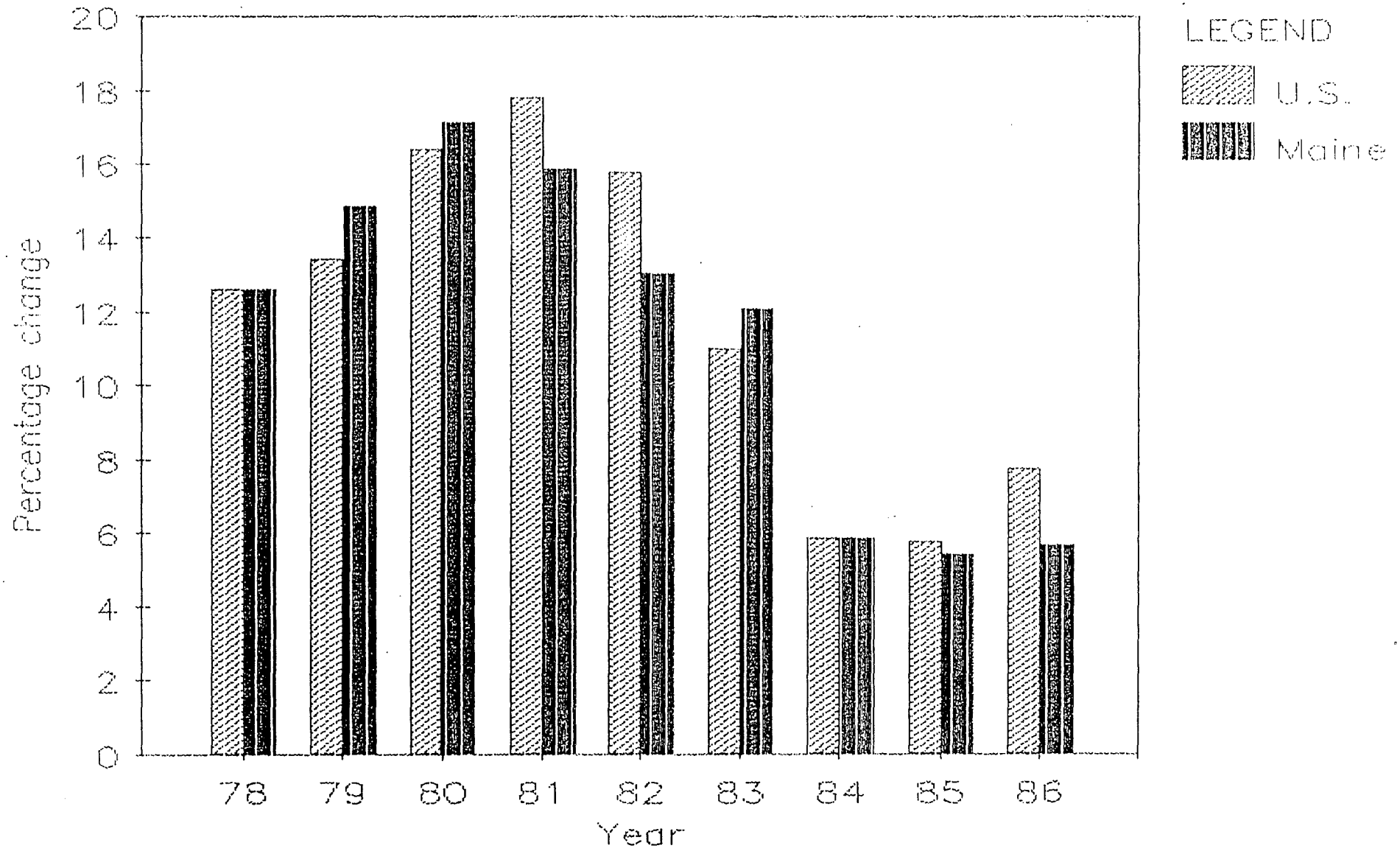
Percentage change in cost
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"



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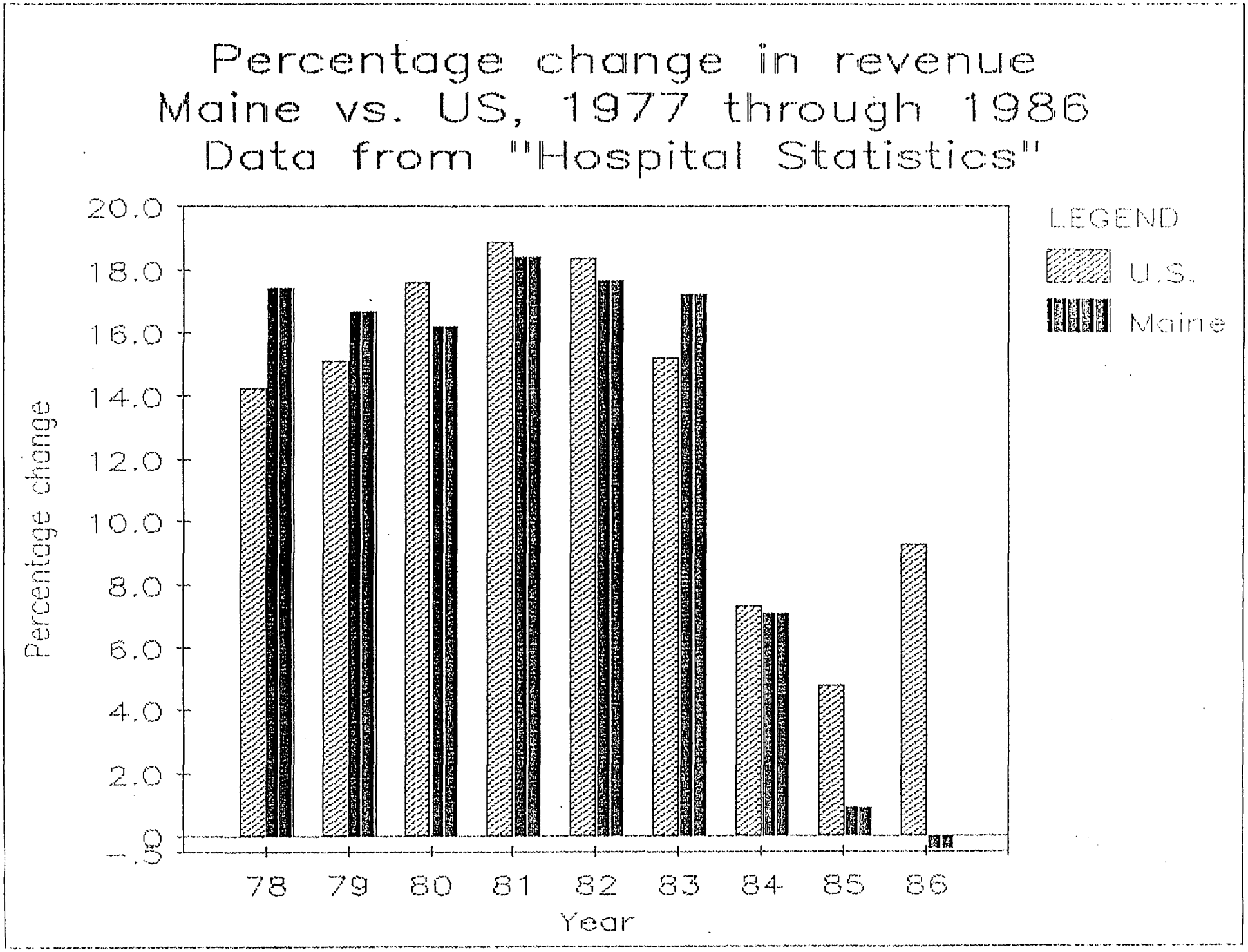
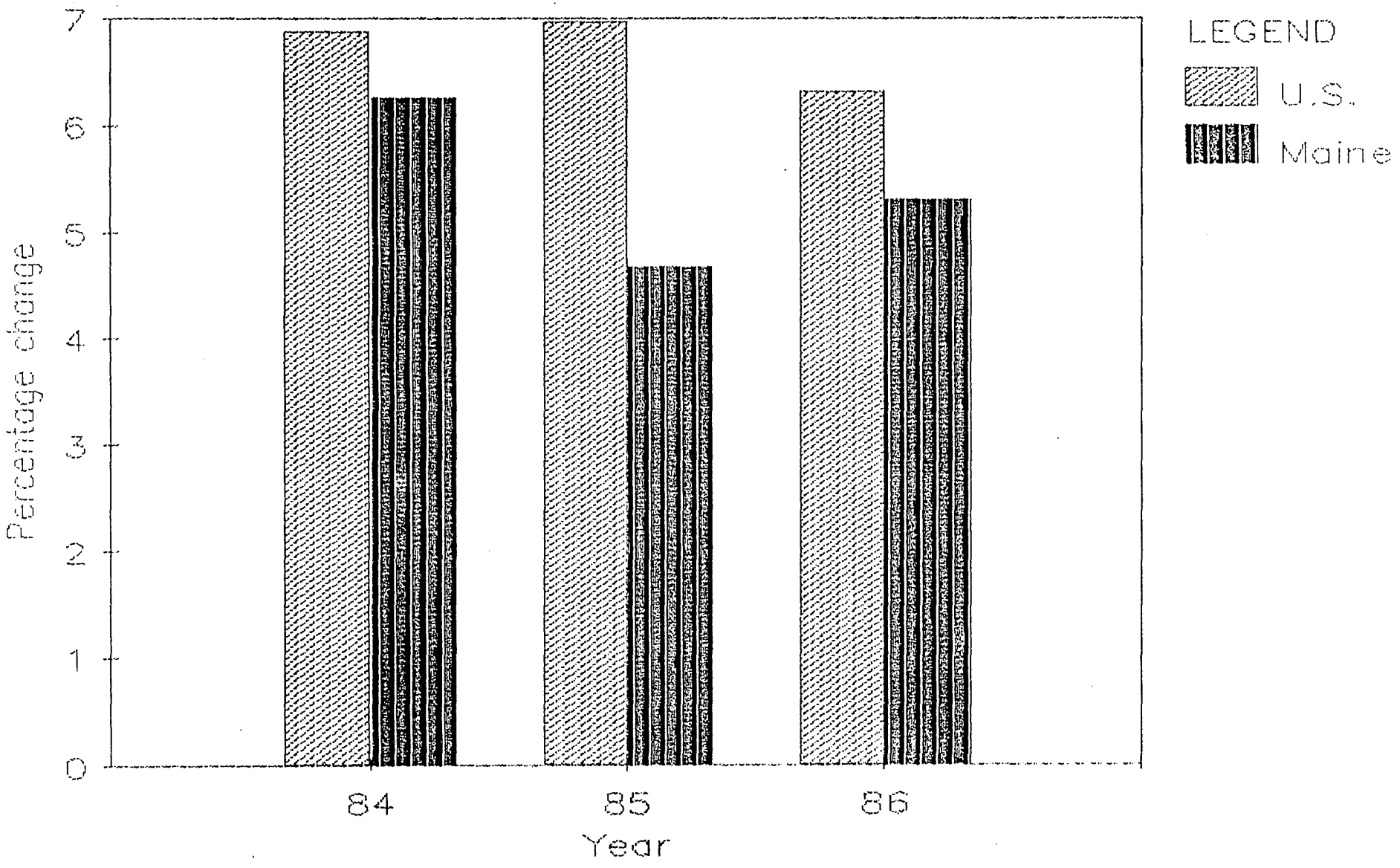
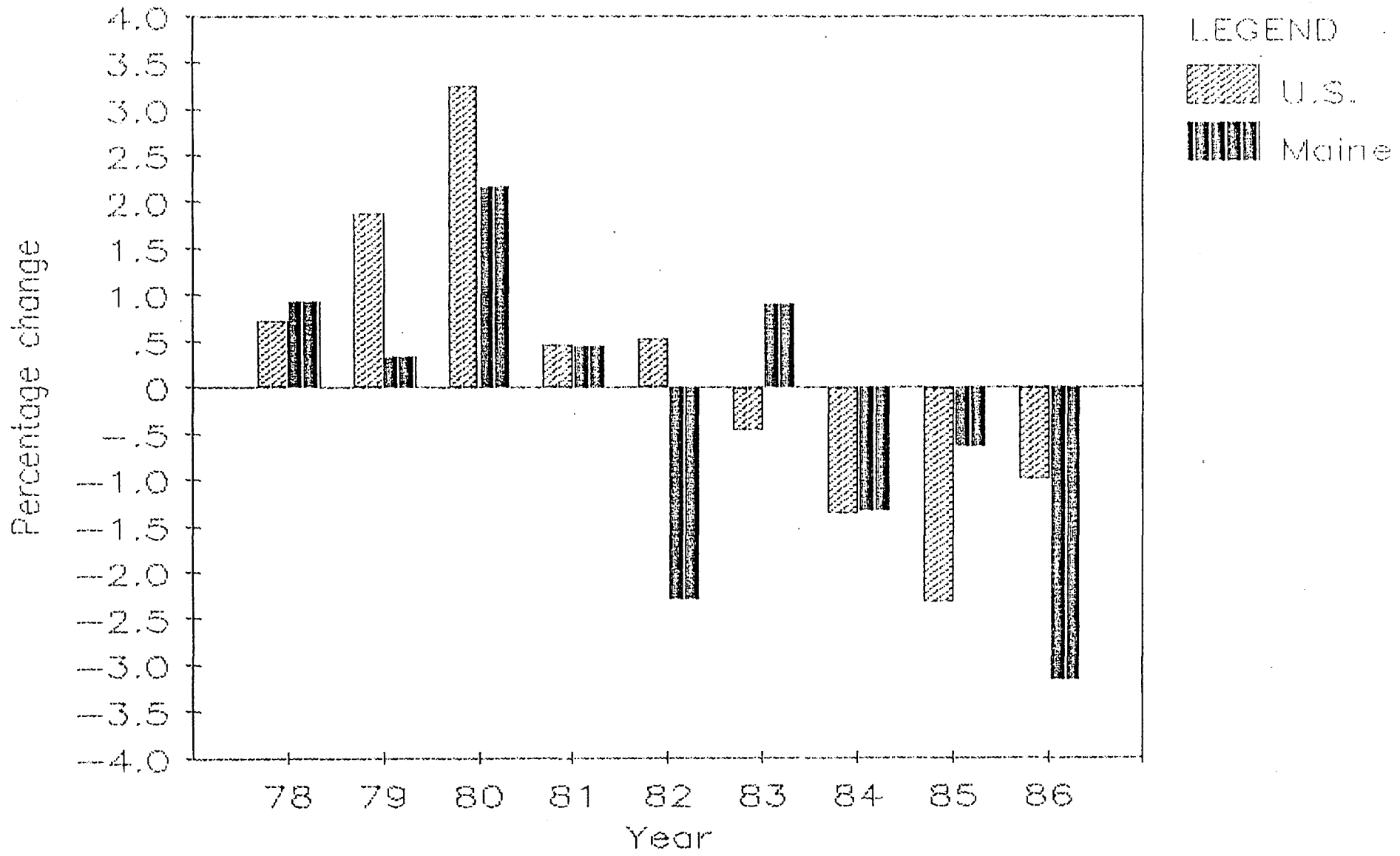

Percentage change in revenue
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
.00
Percentage change
78
79
80
81
82
83
84
85
86
Year
LEGEND
U.S.
Maine

Percentage change in net revenue Maine vs. US, 1983 through 1986 Data from "Hospital Statistics"



Percentage change in adjusted admissions Maine vs. US, 1977 through 1986 Data from "Hospital Statistics"



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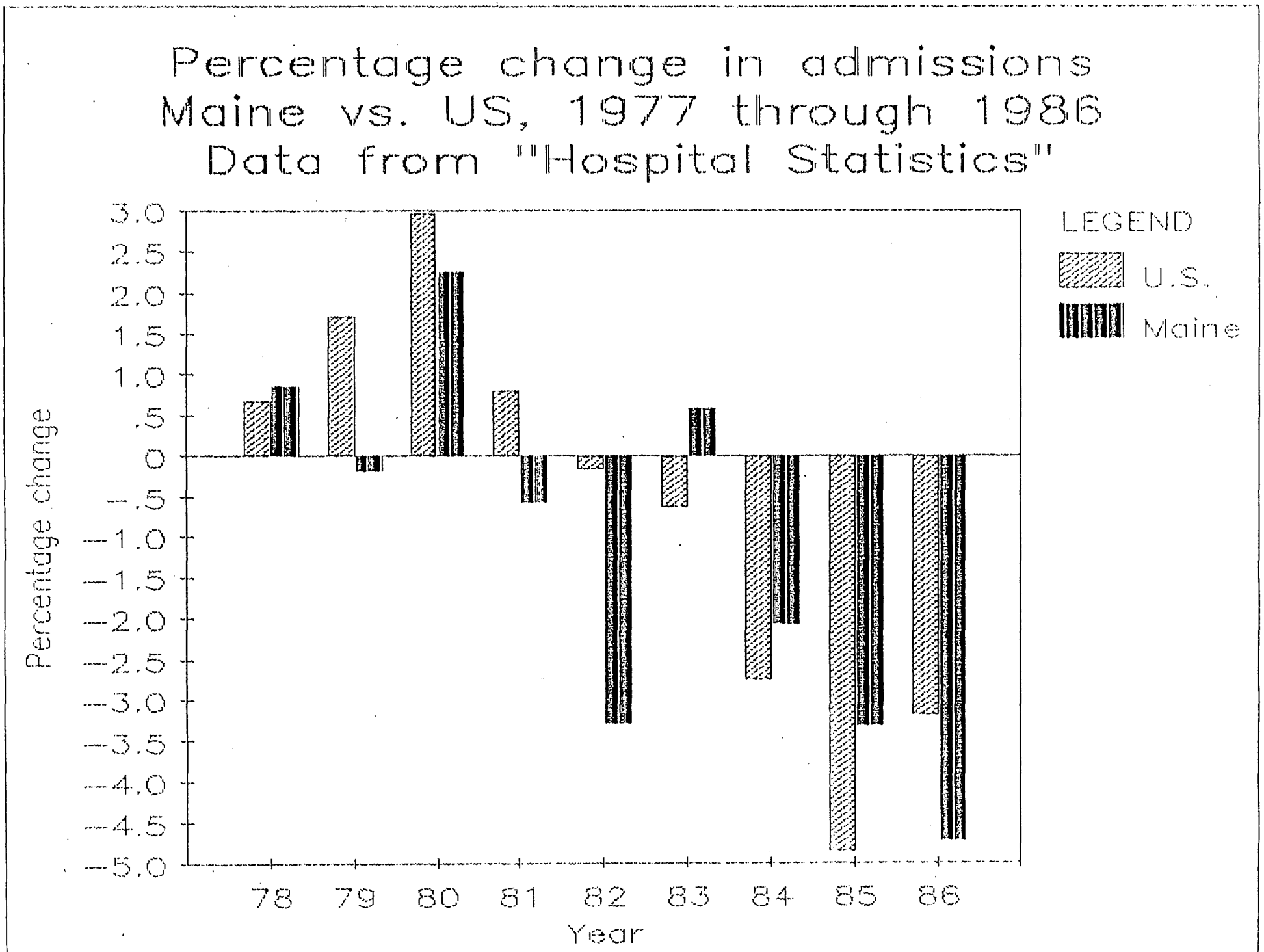
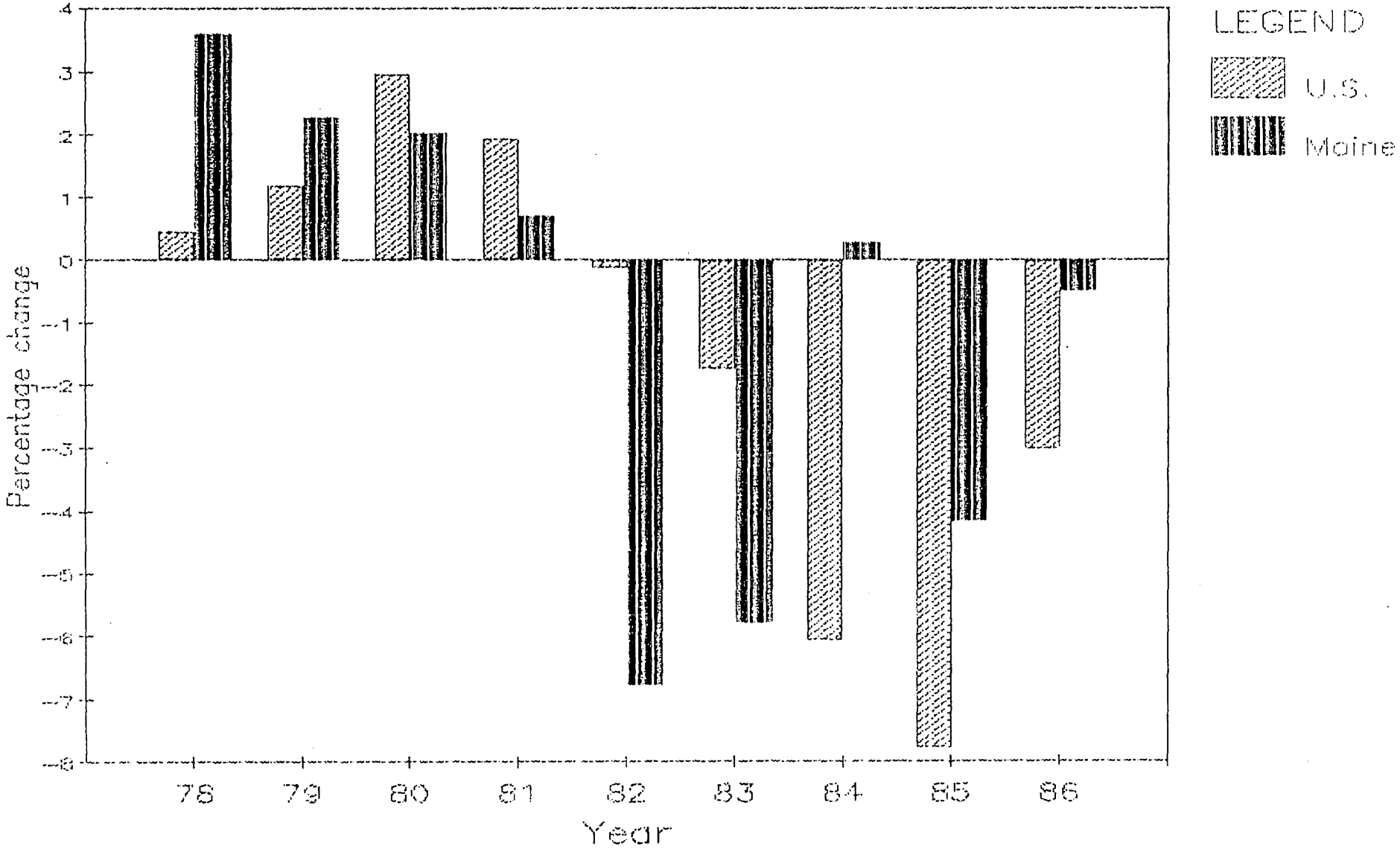
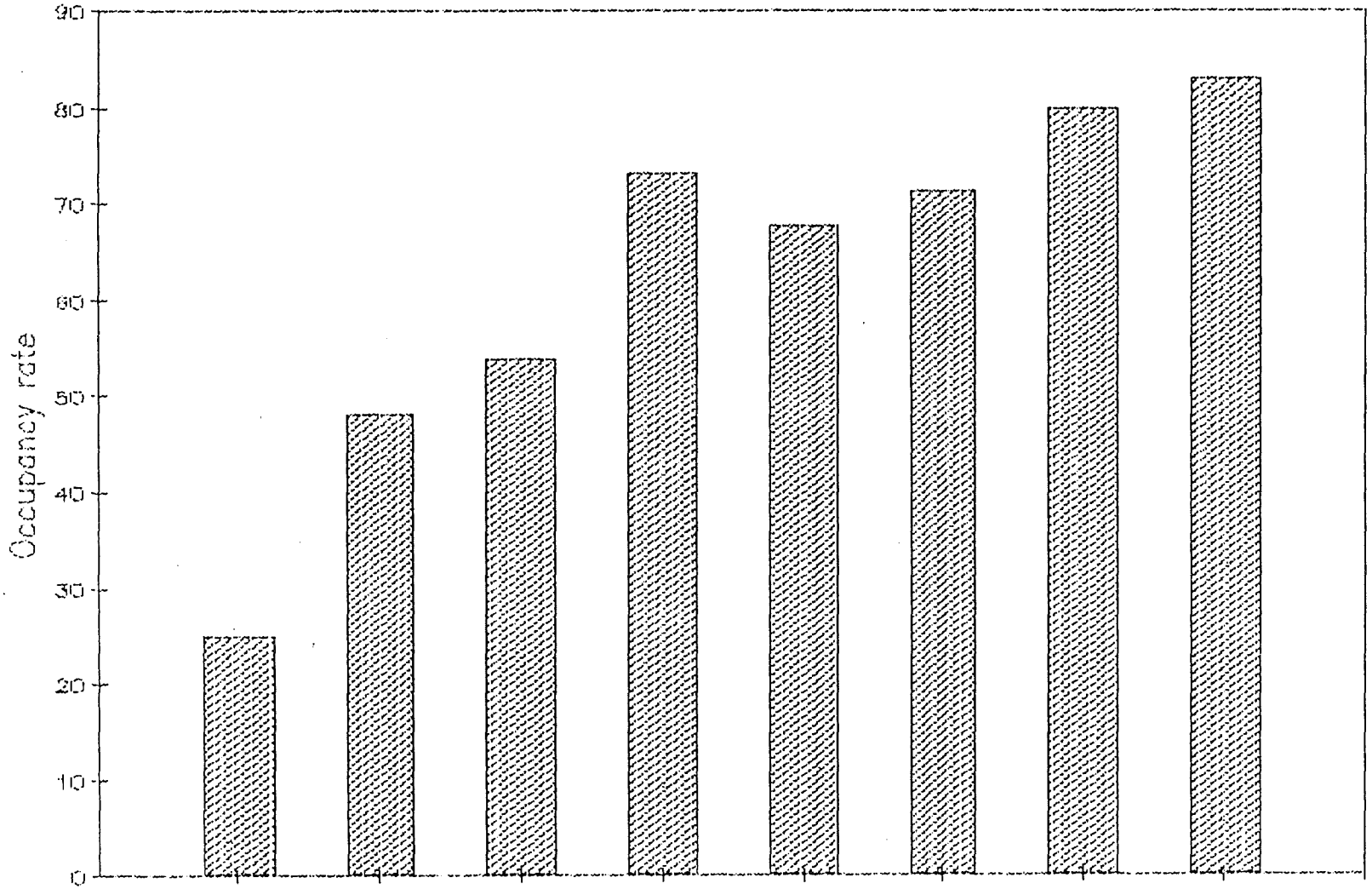

Percentage change in admissions
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"
LEGEND
U.S.
Maine
Percentage change
3.0
2.5
2.0
1.5
1.0
.5
0
-.5
-1.0
-1.5
-2.0
-2.5
-3.0
-3.5
-4.0
-4.5
-5.0
78
79
80
81
82
83
84
85
86
Year

Percentage change in patient days
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"



Occupancy rate by bed size
Maine 1986
Data from "Hospital Statistics"



Appendix D

A List of Issue Papers
Prepared for the Blue Ribbon Commission
by James Graham Atkinson, D. Phil.

Appendix D

1988 ISSUE PAPERS PREPARED FOR THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES BY GRAHAM ATKINSON, D. PHIL.

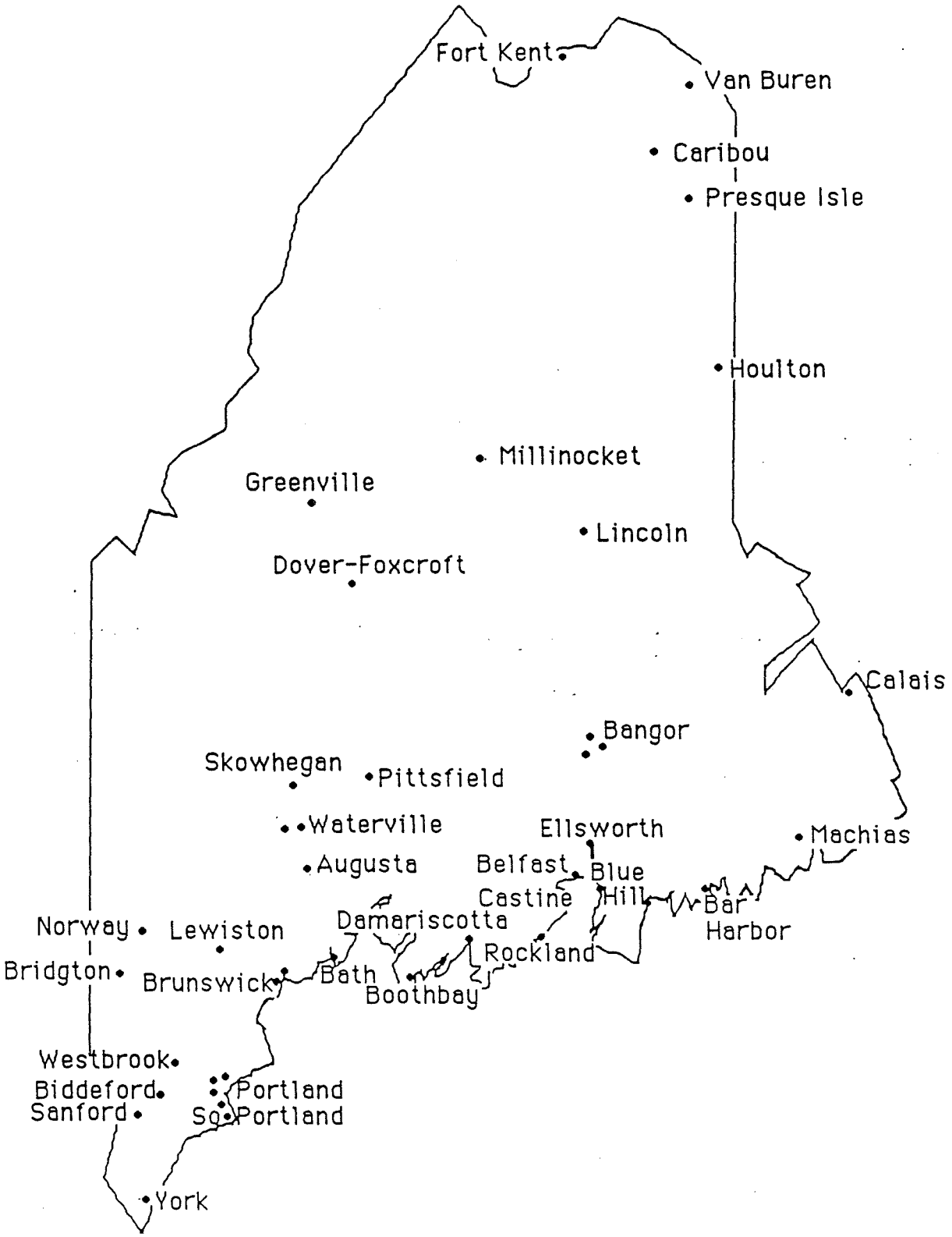
January 31	Costs, Revenue and Utilization, Maine and the U.S.
February 15	Definition of Quality, Access, Affordability. A Discussion of Some Aspects
February 15	Discussion of Major Issues
February 22	Description of Some State Regulatory Systems for Hospitals and Nursing Homes
March 10	The Collection and Use of Health Care Data
March 30	Options for Regulation of Health Care in Maine
May 5	Projections on the Financing Systems for the 1990's
June 7	Discussion Paper on Pooling
June 7	Discussion Paper for Second Retreat
August 8	Discussion Paper on Cross-Subsidization
October 17	The Interaction of CON and the Payment System
October 18	Outpatient Rate Deregulation, Cross-Subsidization and Pooling

NOTE: Issue papers are on file in the State House Law Library

Appendix E

Locations of Maine Hospitals, and Size by Medicare Definitions

LOCATIONS OF MAINE HOSPITALS



MAINE'S COMMUNITY HOSPITALS

NO.	HOSPITAL	TOWN	COUNTY	BEDS	SIZE	FY END
1	Maine Medical Center	Portland	Cumberland	598	Large	9/30
2	Eastern Maine Medical Center	Bangor	Penobscot	416	Large	9/30
3	Mid-Maine Medical Center	Waterville	Kennebec	308	Large	3/31
4	Central Maine Medical Center	Lewiston	Androscoggin	250	Large	6/30
5	St. Mary's General Hospital	Lewiston	Androscoggin	233	Large	12/31
6	Kennebec Valley Medical Center	Augusta	Kennebec	201	Large	6/30
7	Mercy Hospital	Portland	Cumberland	200	Large	6/30
8	Osteo. Hospital of Maine	Portland	Cumberland	160	Large	8/31
9	So. Maine Medical Center	Biddeford	York	150	Large	4/30
10	The Aroostook Medical Center	Presque Isle	Aroostook	133	Large	12/31
11	St. Joseph Hospital	Bangor	Penobscot	130	Large	12/31
12	Pen Bay Medical Center	Rockland	Knox	106	Medium	3/31
13	Rumford Community Hospital	Rumford	Oxford	97	Medium	6/30
14	Jackson Brook Institute	S. Portland	Cumberland	96	Medium	6/30
15	Redington-Fairview Hospital	Skowhegan	Somerset	92	Medium	6/30
16	Regional Memorial Hospital	Brunswick	Cumberland	90	Medium	9/30
17	Waterville Osteopathic Hospital	Waterville	Kennebec	78	Medium	12/31
18	Calais Regional Hospital	Calais	Washington	77	Medium	12/31
19	H.D. Goodall Hospital	Sanford	York	73	Medium	5/31
20	Franklin Memorial Hospital	Farmington	Franklin	70	Medium	6/30
21	No. Maine Medical Center	Fort Kent	Aroostook	70	Medium	9/30
22	Cary Medical Center	Caribou	Aroostook	65	Medium	12/31
23	Houlton Regional Hospital	Houlton	Aroostook	65	Medium	9/30
24	Maine Coast Memorial	Ellsworth	Hancock	64	Medium	6/30
25	York Hospital	York	York	61	Medium	6/30
26	Taylor Hospital	Bangor	Penobscot	60	Medium	8/31
27	Bath Memorial Hospital	Bath	Sagadahoc	59	Medium	9/30
28	Parkview Memorial Hospital	Brunswick	Cumberland	55	Small	6/30
29	Mayo Regional Hospital	Dover-Foxcroft	Piscataquis	52	Small	9/30
30	Millinocket Regional Hospital	Millinocket	Penobscot	50	Small	6/30
31	Stephens Memorial Hospital	Norway	Oxford	50	Small	12/31
32	Mt. Desert Island Hospital	Bar Harbor	Hancock	49	Small	4/30
33	Waldo County General Hospital	Belfast	Waldo	49	Small	6/30
34	Penobscot Valley Hospital	Lincoln	Penobscot	44	Small	12/31
35	No. Cumberland Hospital	Bridgton	Cumberland	40	Small	10/31
36	Down East Community Hospital	Machias	Washington	38	Small	12/31
37	Sebasticook Valley Hospital	Pittsfield	Somerset	36	Small	11/30
38	St. Andrews Hospital	Boothbay Harbor	Lincoln	32	Small	9/30
39	Westbrook Community Hosp.	Westbrook	Cumberland	30	Small	12/31
40	Van Buren Community Hosp.	Van Buren	Aroostook	29	Small	12/31
41	Miles Health Care Center	Damariscotta	Lincoln	27	Small	4/30
42	Blue Hill Memorial Hospital	Blue Hill	Hancock	26	Small	6/30
43	New England Rehab. Hospital	Portland	Cumberland	25	Small	8/31
44	Castine Community Hospital	Castine	Hancock	12	Small	1/31
All				4646		

Note: Mid-Maine Medical Center includes C.A.Dean Hospital in Greenville (14 acute beds)

MAINE'S COMMUNITY HOSPITALS

Medicare Urban Hospitals

Definition:

Any hospital located in an urban area as defined by:

a) a Metropolitan Statistical Area (MSA) or New England County Statistical Area (NECMA), as defined by the Executive Office of Management and Budget **or**

b) certain New England counties (including both York and Sagadahoc Counties), deemed to be urban areas under section 601(g) of the Social Security Admendments of 1983 (Public Law 98-21, 42 USC 1395ww(note)).

NO.	HOSPITAL	TOWN	COUNTY	BEDS	SIZE	FY END
1	Maine Medical Center	Portland	Cumberland	598	Large	9/30
2	Eastern Maine Medical Center	Bangor	Penobscot	416	Large	9/30
4	Central Maine Medical Center	Lewiston	Androscoggin	250	Large	6/30
5	St. Mary's General Hospital	Lewiston	Androscoggin	233	Large	12/31
7	Mercy Hospital	Portland	Cumberland	200	Large	6/30
8	Osteo. Hospital of Maine	Portland	Cumberland	160	Large	8/31
9	So. Maine Medical Center	Biddeford	York	150	Large	4/30
11	St. Joseph Hospital	Bangor	Penobscot	130	Large	12/31
14	Jackson Brook Institute	S. Portland	Cumberland	96	Medium	6/30
16	Regional Memorial Hospital	Brunswick	Cumberland	90	Medium	9/30
19	H.D. Goodall Hospital	Sanford	York	73	Medium	5/31
25	York Hospital	York	York	61	Medium	6/30
26	Taylor Hospital	Bangor	Penobscot	60	Medium	8/31
27	Bath Memorial Hospital	Bath	Sagadahoc	59	Medium	9/30
28	Parkview Memorial Hospital	Brunswick	Cumberland	55	Small	6/30
30	Millinocket Regional Hospital	Millinocket	Penobscot	50	Small	6/30
34	Penobscot Valley Hospital	Lincoln	Penobscot	44	Small	12/31
35	No. Cumberland Hospital	Bridgton	Cumberland	40	Small	10/31
39	Westbrook Community Hosp.	Westbrook	Cumberland	30	Small	12/31
43	New England Rehab. Hospital	Portland	Cumberland	25	Small	8/31
All				2820		

MAINE'S COMMUNITY HOSPITALS

Sole Community Providers

Definition:

Any hospital that:

a) is located in a rural area as defined by 42 CFR 412.62.f. -- which translated to Maine means any county other than Androscoggin, Cumberland, Penobscot, Sagadahoc, and York County **and**

b) meets one of the following criteria:

1 . the hospital is more than 50 miles away from a like hospital **or**

2 . the hospital is more than 25 miles but less than 50 miles away from a like hospital, and either:

A. less than 25% of the residents in the service area are admitted to other like hospitals for care **or**

B. the hospital has less than 50 beds and the fiscal intermediary certifies that the hospital would have met the critera in 2.A. above except that residents were forced to recieve care outside the area due to the unavailability of services at the local community hospital **or**

C. local topography or weather conditions make services at other like hospitals inaccessible to residents for at least one month a year; **or**

3 . the hospital is more than 15 miles but less than 25 miles away from a like hospital but local topography or weather conditions make services at other like hospitals inaccessible to residents for at least one month a year

NO.	HOSPITAL	TOWN	COUNTY	BEDS	SIZE	FY END
3	Mid-Maine Medical Center	Waterville	Kennebec	308	Large	3/31
12	Pen Bay Medical Center	Rockland	Knox	106	Medium	3/31
13	Rumford Community Hospital	Rumford	Oxford	97	Medium	6/30
18	Calais Regional Hospital	Calais	Washington	77	Medium	12/31
20	Franklin Memorial Hospital	Farmington	Franklin	70	Medium	6/30
21	No. Maine Medical Center	Fort Kent	Aroostook	70	Medium	9/30
23	Houlton Regional Hospital	Houlton	Aroostook	65	Medium	9/30
33	Waldo County General Hospital	Belfast	Waldo	49	Small	6/30
36	Down East Community Hospital	Machias	Washington	38	Small	12/31
All				586		

Note: C.A.Dean Hospital is the only part of Mid-Maine Medical Center considered a sole community provider. C.A.Dean Hospital, located in Greenville, has 14 acute care beds. The total of 586 beds has included just those 14 beds.

Appendix F

February 19 Blue Ribbon Commission Survey and Responses

MARTHA E. FREEMAN, DIRECTOR
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9/20/88
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SUMMARY OF RESPONSES TO THE BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES DRAFT REPORT

TO: Commission members

FROM: Annika Lane

The following summary is based on testimony submitted in response to the Commission draft report.

I used presentations that seemed to be most relevant to the report's contents. The summary is subdivided into subject areas, so there is some overlap.

I hope this will be useful to you.

INPATIENT RATES OR REVENUES

BLUE CROSS/BLUE SHIELD

a) Supports TR system that regulates both inpatient and outpatient services

b) Supports case mix adjusted charge per case system for total hospital inpatient charges

c) Supports different regulatory system for specialty hospitals - provided these hospitals can be reasonably and readily identified

d) Supports market basket plus an aggregate adjustment factor to account for new technology and services, non CoN projects, and changes in the practice of medicine.

e) Suggests even hospitals subject to TR system should be accountable for maintaining a reasonable patient volume.

f) Suggests hospitals with overlapping or competing service areas should be regulated on both inpatient and outpatient revenues. System should include:

- Incentives for competition amongst hospitals and payors
- Adequate adjustments for increasing volume
- Negotiated discounts in addition to approved discounts should be allowed but not shifted.

g) Hospitals wishing to change to a TR system from a charge per case system must agree to a comprehensive review by the RSB.

MAINE HOSPITAL ASSOCIATION

a) Supports multiple options

b) Suggests options for special regulation or deregulation are made readily available to hospitals seeking different treatment under one of those two approaches

c) Supports special treatment for special and/or unique hospitals

YORK HOSPITAL - FINANCIAL SERVICES

a) Does not support option 1 (per case payment system) unless the system recognizes the differences in the cost of doing business around the state. Suggests state considers using cost-per-case methodology referred to in option 1 to negotiate purchase of services on behalf of those receiving state assistance.

b) Suggests Total Revenue System could work if it was based on local rather than statewide measures. Recommends that any review process of total revenues be a review of the reasonableness of hospital budgets as proposed by hospital boards of trustees.

c) Supports option regarding specialty hospitals, and suggests Commission also recommends that each community be allowed to control its own hospital through its own local board of trustees.

PROJECT HANCOCK - (a consortium of three health care facilities in Hancock county) Supports multiple options. Recommends option of DRG-type system be extended to all hospitals, with the provision that in areas where inter-hospital competition does not exist, an extensive, three-year evaluation of health cost inflation be undertaken.

EASTERN MAINE MEDICAL CENTER

a) Recommends that any per case payment system adopted in the future should include an adjustment for disease severity.

b) Regulated payment for inpatient services should be exclusively for acute care.

c) Concern with limiting appeals to extremely large events of prehaps 2% of a hospital's total costs. Many hospitals have operating losses or margins much below 2%. Common sense and the practice of the appeals body should govern those issues for which an appeal is practical for any hospital to pursue.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL Supports variety of options. Supportive of option 1 (per case payment system), provided there are adequate adjustments for volume changes. Supportive of TR system. Supports proposal for different regulatory systems for specialty hospitals.

STEPHENS MEMORIAL HOSPITAL Recommends that hospitals that have historically demonstrated, and continue to demonstrate a lower than average cost to the consumer, be deregulated.

OUTPATIENT RATES

BLUE CROSS/BLUE SHIELD

a) Suggests continued regulation of outpatient services - e.g. rate per unit

b) If outpatient services not regulated
- not appropriate to allow cross-subsidization of outpatient services from inpatient services
- not appropriate to guarantee funding from statewide pool of charity care/bad debt/governmental shortfalls

MAINE COMMITTEE ON AGING Suggests important to collect data, review trends and regulate costs in this area.

MAINE HOSPITAL ASSOCIATION Suggests system should be provided for deregulation of outpatient rates under certain conditions - not clear what those conditions might be.

COALITION FOR RESPONSIBLE HEALTH CARE recommends that outpatient services should continue to be regulated in all types of hospitals regardless of whether they are under a per-case payment system or a total revenue system. Only way that cross-subsidization can be identified or avoided.

AMERICAN ASSOCIATION OF RETIRED PERSONS Recommends regulation of outpatient rates for hospitals on a per case payment system.

STATE AIDS ADVISORY COMMITTEE/CONSUMERS FOR AFFORDABLE HEALTH CARE/CONCERNED CITIZEN Recommends no deregulation of outpatient services.

YORK HOSPITAL - FINANCIAL SERVICES V.P. Agrees that current system is inadequate because it doesn't measure units of service properly in its application of formulas. Concerned about any attempt to not allow cross-subsidization of outpatient services in emergency rooms. Recommends a competitive model where the consumer has choice to use outpatient resources in hospital setting.

PROJECT HANCOCK -(a consortium of three health care facilities in Hancock county) Notes that smaller hospitals are witnessing increasing utilization of outpatient services, including surgery. This development should be encouraged by regulatory framework, including allowances for cross-subsidization

EASTERN MAINE MEDICAL CENTER Supports idea that hospitals should have the option of removing their outpatient services from rate setting regulation.

EASTERN AREA AGENCY ON AGING Supports continued regulation of outpatient services

NORTHERN CUMBERLAND MEMORIAL HOSPITAL favors unregulated outpatient rates. System should allow for continued cross-subsidization of outpatient services from inpatient services. If outpatient services are to be regulated, then there should be an adjustment to prevent regulatory cost shifting in an effort to control other rates under their jurisdiction.

COMPONENTS OF THE RATE SETTING SYSTEM

BLUE CROSS/BLUE SHIELD:

a) Supports standard component in the rate, phased in over a period of time

b) Supports appeal mechanism limited to major items that have an impact on costs or revenues of at least 2% of the total costs of the hospital.

c) Opposes allowing discounts. Recommends that no discounting on the part of the provider or the payor be permitted at least under the total revenue system or rate per case system.

d) Opposes a limited appeal based on the percentage of a hospital's cost base.

e) Suggests RSB should approve payor differentials on the basis of economic merit

f) Suggests differentials should be included in the revenue limit established by the RSB

g) Hospitals should be able to contract with with payors and grant discounts to such payors provided such discounts are not passed on to other payors

h) System should permit payors to pay on the basis of any type of system which the payor and hospital mutually agree upon - as long as such payment does not result in a discount to that payor that is passed on to other payors.

i) Providing RSB with option of recommending that charges be cut if a hospital has filed an appeal and the RSB finds that the hospital's charges are too high. System should be prospective with no retroactive adjustment. Payors should get sufficient notice of adjustments.

MAINE HOSPITAL ASSOCIATION Supports the use of a standard component for rebasing, but believes that the standard should be from outside the state of Maine and be chosen from a system that represents a level of quality of care equal to the state of Maine. Rebasing should be based on efficiency and productivity and not artificially constrained by budget neutrality.

COALITION FOR RESPONSIBLE HEALTH CARE Supports recommendation for a standard component in the rate to be phased in over a five year period. Supports recommendations with regard to discounts and appeals.

YORK HOSPITAL - FINANCIAL SERVICES V.P. Disagrees with use of formulas, unless it takes into account the local environment. Recommends no discounts by a payer or provider. Agrees with provision of an appeal mechanism, but states that draft report too vague on this subject.

AMERICAN ASSOCIATION OF RETIRED PERSONS Supports recommendation on payor differentials and discounts. Total revenue system hospitals should only be able to give discount which are approved by the RSB. Hospitals on the per case payment system should be permitted to contract freely with payors for discounts or payment methods, provided that the discounts do not increase the charges to other payors.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL Disagrees that hospitals should only be permitted discounts which are approved by an RSB. Suggest that hospitals should be free to contract with payors for discounts or payment methods provided that the discounts do not increase the charges to other payors. Should be a threshold below which no discounts should be allowed. This threshold should include at least operating costs plus bad debts and charity care, plus a minimum return on equity.

Also disagrees with mechanics of proposed appeal process. Should be no restrictions to hospitals making legitimate appeals and should be separate from RSB.

BAD DEBT/CHARITY CARE, GOVERNMENT SHORTFALLS

BLUE CROSS/SHIELD suggests entire Governmental shortfall should be funded totally from the general fund or more broad-based source, not merely the increase in the shortfall from some given point in time. Medicaid program must fully participate in the payment system by paying its full share

MAINE COMMITTEE ON AGING suggests dangerous precedent to ask legislature to make funding decisions using general fund to cover the projected increase in the total governmental shortfalls over the next year.

MAINE HOSPITAL ASSOCIATION Agrees with concept of a pooling strategy or other similar mechanism to distribute shortfalls among hospitals. Mechanism must distribute burden among hospitals equitably, taking into consideration efficiency and productivity of the hospitals. Current system for reimbursing hospitals should be retained until public funding for the pool is appropriated.

COALITION FOR RESPONSIBLE HEALTH CARE Supports concept of pooling

AMERICAN ASSOCIATION OF RETIRED PERSONS Supports idea of a stand-by fund from which hospitals may cover any governmental shortfall, if the method for determining a shortfall is valid and suitable for challenging Medicare and Medicaid payment decisions.

STATE AIDS ADVISORY COMMITTEE/CONSUMERS FOR AFFORDABLE HEALTH CARE/CONCERNED CITIZEN Opposes proposal to request $20 million from general fund. Suggests a fund generated from all sectors carrying bad debts. E.g. $65 million from Medicare, $5 million from Medicaid, $30 million from hospitals, Unspecified amount from insurance companies and the Legislature.

YORK HOSPITAL - FINANCIAL SERVICES V.P. Supports idea of using general fund to make up for federal shortfall. But, federal responsibilities should be stressed. Maine should send message to Congress on this issue. Also supports idea of general fund use to pay bad debts and charity care in areas where state determines that payers cannot afford burden. Broad-based tax is more appropriate than redistribution through a pool generated from additional charges to patients.

PROJECT HANCOCK - (a consortium of three health care facilities in Hancock county) recommends that hospitals be able to use endowments designated for charity care without fear of regulatory reprisal. Responsibility for managing charity care should be kept at the local level.

EASTERN MAINE MEDICAL CENTER Supports recommendation to use general fund to cover projected shortfalls in Medicare and Medicaid payments.

EASTERN AREA AGENCY ON AGING Is the $ figure to be sought from the General Fund to be a one-time payment or will it become annual? If it is not to become an annual payment, what basic reforms to the health care system will make future payments unnecessary? What will be the impact of such a payment on other health and social service programs that must compete for limited General Revenue funds? Could, and should, these same dollars be used to effect basic changes in the health care delivery system to make health care more accessible and affordable?

NORTHERN CUMBERLAND MEMORIAL HOSPITAL agrees that an amount be sought from general fund to cover projected increases in the total shortfalls over the next year. But, an amount should be distributed among all the hospitals who have had shortfalls.

Support pool mechanism derived from general fund which is derived from state income tax.

BETH KILBRETH - HUMAN SERVICES DEVELOPMENT INSTITUTE, USM

Report does not address question of handling bad debt under a per case payment system. Unless explicit provisions are made, such as a pooling arrangement, the safety valve provided by provisions in the current system may be removed.

The provisions providing a safety net are:

a) The current system recognizes each hospital's experience with bad debt and charity care and provides substantial protection from long term losses associated with uncompensated care.

b) The MHCFC prohibits hospitals from billing any patients who meet Hill Burton charity care guidelines and who have no health insurance coverage.

If general funds are to be used to cover the costs of the medically indigent, why not use them to provide entitlement to the uninsured for an appropriate range of services in appropriate settings, and thus reduce the hospitals charity care experience, rather than pay hospitals after the fact for care they shouldn't have had to provide in the first place. Advocates use of tax dollars to support programs such as:

a) a substantial expansion of Medicaid to a newly eligible population of pregnant women and infants

b) A high risk insurance program to provide coverage to those who can get insurance coverage due to pre-existing medical conditions; and

c) A subsidized comprehensive managed care insurance program for uninsured small businesses and the self-employed (such as Mainecare).

If the bad debt burden is not eased by programs such as these, consider at that time, and not sooner, tax assistance to hospitals.

CROSS-SUBSIDIZATION

BLUE CROSS/SHIELD Controlled, reasonable subsidy. Further study required to determine appropriate level of subsidy. If, however, outpatient services are deregulated, then all subsidies from inpatient to outpatient services should be eliminated.

MAINE HOSPITAL ASSOCIATIONsuggests that cross-subsidization of outpatient services should be allowed to continue at the current level and that some adjustment ought to be available (not necessarily identical to the inpatient adjustment factor) and be incorporated into the rate of growth for outpatient revenues.

EASTERN MAINE MEDICAL CENTER - sees that cross-subsidies will continue to be necessary as long as some populations and some services are underinsured. Cross-subsidization among outpatient departments should be allowed to occur as market conditions allow.

DEMONSTRATIONS

BLUE CROSS/SHIELD Supports demonstration projects under authority of RSB and supports options for lower levels of care within hospitals. Questions whether or not RSB should have authority to waive any or all statutory requirements.

MAINE COMMITTEE ON AGING Supports flexibility to develop demonstration projects if approved by RSB, or for hospitals to convert to lower level facilities.

MAINE HOSPITAL ASSOCIATION Supports demonstration projects

COALITION FOR RESPONSIBLE HEALTH CARE Supports hospital payment demonstrations. However, concerned with broad authority given to RSB to waive any and all statutory requirements. Supportive of idea to let some general hospitals receive licenses to operate as lower level facilities.

YORK HOSPITAL - FINANCIAL SERVICES V.P. Supports this proposal. Recommends adding another option i.e. Option 5, A Border Policy on Regulation - taking into account need for a buffer zone between the Maine and New Hampshire hospital regulatory systems. This option would allow for the RSB for York Hospital be the York Hospital Board of Trustees.

PROJECT HANCOCK - (a consortium of three health care facilities in Hancock county) supportive of this proposal - encourages local hospitals and cooperative hospital service organizations to pool resources and avoid redundancy in service delivery.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL supports demonstration projects

STEPHENS MEMORIAL HOSPITAL Recommends that proposals regarding demonstration projects be expanded to require trials, when requested, of a deregulated status for hospitals who have historically demonstrated the ability to meet low cost, high quality operational standards.

RATE SETTING BODY

BLUE CROSS/SHIELD Supports idea of an independent executive agency.

MAINE COMMITTEE ON AGING Supports idea of fully independent agency

MAINE HOSPITAL ASSOCIATION Supports concept of an accountable, executive body. Should be held accountable in a more immediate way.

SHORTAGES OF HEALTH CARE PROFESSIONALS

BLUE CROSS/SHIELD That long term solutions must be developed

MAINE HOSPITAL ASSOCIATION Any regulatory system should recognize the actual labor costs occurred by hospitals, including wages and benefits.

NORTHERN CUMBERLAND MEMORIAL HOSPITAL Recommends providing more scholarships. Any regulatory system must recognize actual labor costs, including wages and benefits.

MANDATED BENEFITS

BLUE CROSS/SHIELD Suggests mandating benefits and providers is inappropriate. Benefits should be made available as options to those who want to purchase them through their insurance carrier.

MAINE HOSPITAL ASSOCIATION Suggests Commission recommend approaches which allow maximum flexibility to enrollees in the choice of benefits purchased with their health care premiums as opposed to a continuation of mandated benefits.

COALITION FOR RESPONSIBLE HEALTH CARE Supports review of the cost of mandated benefits. Suggests making mandated benefits an option which must be made available to employees in so-called flex-benefit plans but that the decision as to whether or not to elect them be left to the employee.

NON-HOSPITAL PROVIDERS, CoN ISSUES

BLUE CROSS/BLUE SHIELD suggests:

a) Expansion of regulation beyond the hospital setting

b) Scope of CoN process should be expanded so that purchases of Major Medical equipment (over yet to be specified dollar threshold) and establishment of medical facilities such as ambulatory surgical units outside of hospitals will be reviewable, regardless of the sponsor

c) Changes in CoN process should coincide with a comprehensive updating of the State Health Plan.

EASTERN MAINE MEDICAL CENTER

a) suggests that if CoN is to be retained, it should be uniformly applied to all providers of a particular type of health care service.

b) Process should be designed to regulate and avoid duplication of costly services provided by one type of provider while allowing these same services to be provided by an alternative corporate structure.

c) CoN review should be performed by an independent third party.

OTHER RECOMMENDATIONS

1. Mechanism to help hospitals that are having difficulty in attracting or retaining primary care physicians for their communities.

2. Protection for hospitals seeking relief in the event of emergent needs

3. Commission should recommend Tort reform efforts for purposes of health care providers. Utilization review system outside government was also suggested.

4. Consumer representatives should be part of any future task forces

5. Recommendation from York Hospital that the following statement be added to paragraphs 4 on pages 3 and 6 of the Commission's draft and that the same provision be applied to outpatient rates or revenues as well as inpatient.

"Hospitals that are located in identifiable economic/trade regions that ignore state borders and that are also situated within ten miles of that border, will be allowed to design and utilize alternative systems, commensurate with the goals of accessibility, quality and affordability, that will enable those hospitals to competitively provide services in that economic area. Such a system will be designed to provide care for Maine citizens who would otherwise obtain care out of state and to also attract health consumers from across the border."

6. Recognition must be provided in system for capital renewal.

7. Encouragement of use of alternate care facilities such as hospices. Alternate care could be in the form of swing beds in existing facilities, subsidiaries of existing facilities, or totally independent institutional entities.

8. If capital costs are regulated, then commission should recommend rebasing payment for capital to conform with generally accepted accounting principles used throughout the country.

9. That the intent of the Legislature to reward hospitals for low cost, efficient, quality care be made mandatory in any new legislation.

10. That all rules and regulations set forth by any new commission ordered by new legislation be required to be reviewed by an appropriate legislative committee, to guarantee that the intent of the Legislature is being met.

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

PUBLIC HEARINGS

Portland September 6, 1988

Speaker	Representing
David Crowley Director, Hospital Payments	Blue Cross and Blue Shield of Maine
Brian Rines, Ph.D Chairman	Maine Hospital Association Trustee Advisory Group
Edward David, M.D., J.D. President	Maine Medical Association
Bill Spolyar Chairman elect	Maine Hospital Association
Jack S. Dexter, Jr. Chairman	Coalition for Responsible Health Care
John DiMatteo Trustee	Maine Medical Center Finance Committee Chairman
Stuart Ferguson	Maine Committee on Aging
Richard Morrell Chairman of the Board	Mid Coast Health Services
Clifford H. West Chairman	The Maine State Legislative Committee of the American Association of Retired Persons
Janet Corbett Director	Miles Memorial Hospital Nursing & Asst. Administrator
Joe Ditre	Maine People's Alliance
Howard Buckley Chief Executive Officer and President	Mercy Hospital
Dale McCormick	A member of the State AIDS Advisory Committee and Consumers for Affordable Healthcare

Speaker	Representing
Jud Knox President	York Hospital
Pamela Prodan Secretary	Maine National Organization for Women (NOW)
Burt Wilner	Stevens Memorial
Dr. Harris J. Bixler Trustee and Treasurer	Northeast Health
Michael Cavanagh	AFL-CIO
Beth Kilbreth	Human Services Development Institute - HSDI
Gloria Leach President	Adolescent Pregnancy Coalition
Rev. Lewis Beckford	Southern Maine Area Agency on Aging
Kay Mishkin	Family day provider
Elizabeth Rothberg Assistant Director	HIAA
Charles Landry	York Chamber of Commerce
Mike Poulin	Counsel for Central Maine Medical Center
Rep. Peter Manning	D - Cumberland
Jill Fargo Vice President of Nursing	York Hospital
Stephen Pelletier Director of Human Resources	York Hospital
Russell A. Peterson Vice President of Financial Services	York Hospital

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

PUBLIC HEARINGS

Bangor September 7, 1988

Speaker	Representing
Bonnie Brooks	Opportunity Housing
Brian Rines, Ph.D Chairman	Maine Hospital Association Trustee Advisory Group
Lisa Miller President Elect	Maine Public Health Assoc.
Richard Fredericks Chief Executive Officer	Maine Coast Memorial Hospital
Dave Crowley	Blue Cross & Blue Shield
George James Trustee	Aroostook Medical Center
Mary Bennett Williams, R.N.,Ph.D. Center Vice President for Patient Care	Eastern Maine Medical
Kenneth P. Trevett President	Project Hancock
Roger Mallar	Coalition for Responsible Health Care
Clifton Eames Chairman of the Board of trustees	Eastern Maine Medical Center
Madelaine Freeman Executive Director	Eastern Area Agency on Aging
Harold Gerrish, M.D. Trustee	Mayo Regional Hospital
Judie Burke President	Maine Medical Records Assoc.
Jill Goldthwait	Private nurse
Elizabeth Whitehouse	Consumer
Grace Summner	Maine People's Alliance

Speaker	Representing
Michael Carey	Planned Approach to Community Health & Mount Desert Island Hospital
Lucy Pullman	Lives and works in shelters for the homeless
Bonnie Post	Access to Health Care Commission
Ken Schmidt	Regional Medical Center - Lubec
Craig Bean	Houlton

6249*

WRITTEN TESTIMONY IN LIEU OF VERBAL TESTIMONY

Rep. Neil Rolde	D - York
Anne Pezzullo Director of Physical Therapy	York Hospital
Barbara A. Desrochers Employee	York Hospital
Janice Fawcett	Concerned citizen
Eleanor Apgar	Concerned citizen
Laura M. Childs	Concerned citizen
Paul H. Apgar	Concerned citizen
June H. Curtis	Concerned citizen
Pauline G. Hall	Concerned citizen
Jud Knox President	York Hospital
Sally Rollins	Concerned citizen

Northern Cumberland Memorial Hospital (NCHM)

6249*

Appendix G

Summary of Public Testimony

MARTHA E. FREEMAN, DIRECTOR
WILLIAM T. GLIDDEN, PRINCIPAL ANALYST
JULIE S. JONES, PRINCIPAL ANALYST
DAVID C. ELLIOTT, PRINCIPAL ANALYST
GILBERT W. BREWER
TODD R. BURROWES
GRO FLATEBO
DEBORAH C. FRIEDMAN
JOHN B. KNOX

ANNIKA E. LANE
EDWARD POTTER
MARGARET J. REINSCH
LARS H. RYDELL
JOHN R. SELSER
HAVEN WHITESIDE
CAROLYN J. CHICK, RES. ASST.
ROBERT W. DUNN, RES. ASST.
HARTLEY PALLESCHI, JR., RES. ASST.

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TEL: (207) 289-1670

April 15, 1988

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

TO: Commission Members

FROM: Annika Lane

RE: Responses to Survey

Enclosed is a list of respondents to the February 19 survey.

Analysis of the responses provides an overall picture of how the respondents perceive various issues concerning Maine's Health Care system. **However, please note that this was not intended to be a statistically significant survey.** The survey is merely exploratory, intending to produce a range of responses. It would therefore not be appropriate or effective to associate any particular responses with any particular subgroup within the population. The responses are anecdotal at best.

However, this survey could be used as a basis for developing a random, statistically valid survey that would allow statements to be made about population subgroups. Commission members may wish to consider this option.

The survey is not statistically valid for the following reasons:

1. The sample of interested parties was developed by an ad hoc, rather than a systematic random method. It is based on names already on file, those submitted by individual Commission members and interested parties, and existing health, business, labor, insurance and community organizations around the State.

2. The questions are broad - soliciting respondents' perceptions of health care issues in their particular areas. The information collected only represents the opinion of those responding and could not be used to make statements about how the total population of parties interested in health care perceive the system.

3. The response rate is low - 200 were sent out
56 were received = 28%
51 were summarized = 25.5%

4/15/88

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES SURVEY

RESPONDENTS

HOSPITALS = 12 = 23.5%

HOSPITAL	TOWN	COUNTY	SIZE
URBAN:			
Osteo Hospital of Maine	Portland	Cumberland	Large
So. Maine Medical Center	Biddeford	York	Large
H.D. Goodall Hospital	Sanford	York	Med
York Hospital	York	York	Med
Millinocket Regional Hosp.	Millinocket	Penobscot	Small
Parkview Memorial Hosp.	Brunswick	Cumberland	Small
New England Rehab. Hosp. of Portland	Portland	Cumberland	Small
RURAL:			
Miles Memorial Hospital	Damariscotta	Lincoln	Small
Sebasticook Valley Hosp.	Pittsfield	Somerset	Small
Van Buren Community Hosp.	Van Buren	Aroostook	Small
SOLE COMMUNITY PROVIDER:			
Calais Regional Hospital	Calais	Washington	Med
Rumford Community Hospital	Rumford	Oxford	Med

OTHER HEALTH CARE FACILITIES = 3 = 5.9%

Dixfield Health Care Center
100 Weld Street
Dixfield, ME 04224

Viking ICF
126 Scott Dyer Road
Cape Elizabeth, ME 04107

Jerry S. Koontz
President,
Northeast Health
108 Elm Street
Camden, ME 04843

BUSINESSES/INSURANCE = 3 = 5.9%

Maine Merchants Association

Chamber of Commerce and Industry

Blue Cross and Blue Shield of Maine

AGING = 15 = 29.4%

Advisory Council
So. Maine Area Agency on Aging
237 Oxford Street
Portland, Maine 04101

Jean Gardner, RN, BSPA
North Berwick Nursing Home
P.O. Box 6730
N. Berwick, Maine 03906

Aroostook Area Agency on Aging
P.O. Box 1288
Presque Isle, ME 04769

Paul A. Cyr
Presque Isle Nursing Home
162 Academy St.
Presque Isle, ME 04769

Caribou Nursing Home
10 Bernadette Street
Caribou, ME 04736

Margaret P. Brown, Admin.
Oceanview Nursing Home
Lubec, ME 04652

Jane G. Morrison, Director LTC
Western Area Agency on Aging
465 Main Street
Lewiston, ME 04243-0659

d'Youville Pavilion N.H.
102 Campus Avenue
Lewiston, ME 04240

Ellen E. Dutton
Southern Maine Senior Citizens Inc.
6 Margaret Circle
Saco, Maine 04072

R.H. Newton
Southern Maine Senior Citizens Inc.
Kennebunk, Maine 04043

Beatrice Wehmeyer
Southern Maine Senior Citizens Inc.
R.R. 2, Box 126
Kezar Falls, ME 04047

Arlene Cooper
Gorham Manor N. H.
30 New Portland Rd.
Gorham, ME 04038

Wendell Dennison
Penobscot Nursing Home
Penobscot, ME 04476

St. Joseph Nursing Home, Inc
Upper Frenchville, ME 04784

Aroostook Home Care Agency, Inc
18 Birdseye Avenue
P.O. Box 488
Caribou, ME 04736

HEALTH CARE ORGANIZATIONS = 8 = 15.7%

Maine State Nurse's Association

Special Select Commission on Access to Health Care

Western Maine Health Care Corp.

Maine Chapter Multiple Sclerosis Society

Health Policy Advisory Council

Northern Maine Rural Health Program

American Lung Association

Katahdin Area Health Education Center

SOCIAL SERVICE AGENCIES = 1 = 2%

York County Community Action

OTHER = 9 = 17.7%

Hester Bemis
Cornish, Maine

David L. Hall, M.D.
Family Medicine
P.O. Box 95, Rte. 1
Glen Cove, ME 04846

Madeline Freeman
P.O. Box 70
Brewer, ME 04412

Robert Hoffman, M.D.
1 Evergreen Woods
Bangor, ME 04401

Walter W. Hichens
424 State Road
Eliot, Maine 03903

4 Unidentified Responses

OTHER RESPONSES, NOT SUMMARIZED

Maine Hospital Association

American Lung Association of Maine

DHS Bureau of Medical Services

Maine Health Care Association

New England Rehabilitation Hospital of Portland

Maine Medical Association

5027m

HELEN T. GINDER, Director
HAVEN WHITESIDE, Dep. Director
GILBERT W. BREWER
DAVID C. ELLIOTT
GRO FLATEBO
MARTHA E. FREEMAN, Sr. Atty.
JERI B. GAUTSCHI
CHRISTOS GIANOPOULOS
WILLIAM T. GLIDDEN, Jr.

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JOHN R. SELSER
CAROLYN J. CHICK, Paralegal
ROBERT W. DUNN, Res. Asst.
HARTLEY PALLESCHI, Jr., Res. Asst.
KATHRYN VAN NOTE, Res. Asst.

April 11, 1988

To: Annika Lane, Legislative Analyst

From: Robert W. Dunn, Research Assistant

Re: Survey Summary: Blue Ribbon Commission On Health Care Expenditures

As you requested, I have examined and summarized the health care survey that was administered by the Blue Ribbon Commission on Health Care Expenditures. With the exception of question 8, you will find a very brief summary to each of the questions below. Question 8 is more or less a summary in its own right. In addition, I have attached a tabular summary of each of the questions, including question 8.

According to the results of the survey, it appears that the shortage of health care professionals (question 3) and shortage of nursing home beds (question 5) are major problems currently confronting Maine's health care industry.

Please keep in mind that this was not a scientific survey and therefore any statistical inferences that would be drawn from the results of this survey would be questionable.

Question 1

Is there a problem in your area with regard to the availability of affordable health insurance? If so, please describe.

62,7% of the respondents indicated that such a problem exists in their area. 21.6% of the respondents indicated that no such problem exists in their area. 15.7% of the respondents did not answer this question. The group listed most often as having been affected by this problem is individuals. The cost

of health insurance was listed most commonly as the reason for this problem. None of the respondents suggested a solution to this problem.

Question 2

Is there a shortage of physicians in your area? If so, describe the extent of the shortage, and whether it is confined to particular specialists.

58.8% of the respondents indicated that such a problem exists in their area. 29.4% of the respondents indicated that no such problem exists in their area. 11.8% of the respondents did not answer this question. Respondents indicated that virtually all types of physicians are in short supply. General practitioners, obstetricians, and orthopedic surgeons were the types of physicians listed most commonly as being in short supply. None of the respondents suggested a solution to this problem.

Question 3

Is there a shortage of other health care professionals in your area? If so, please describe the extent of the shortage.

84.3% of the respondents indicated that such a problem exists in their area. 9.8% of the respondents indicated that no such problem exists in their area. 5.9% of the respondents did not answer this question. Respondents indicated that a wide variety of health care professionals are in short supply. Certified Nurses Aides, Licensed Practical Nurses and Registered Nurses were listed most commonly as the types of health care professionals in short supply. One respondent suggested implementing a 2 year curriculum for a Registered Nurse Degree as a solution to the RN shortage.

Question 4

Is there a problem in your area with the unavailability of particular health care services, e.g. hospice care, home health care, mental health care, or even acute care? If so, please describe.

64.7% of the respondents indicated that such a problem exists in their area. 19.6% of the respondents indicated that no such problem exists. 15.7% of the respondents did not answer this question. A wide variety of health care services were indicated to be in short supply. Home health care, hospice care, and mental health care were the types of health care listed most commonly as being in short supply. Geographic access, a lack of funds, and staffing inadequacy are some of the reasons listed for this shortage. Geographic access was the most commonly listed reason for the shortage. None of the respondents suggested a solution to this problem.

Question 5

Is there a problem with access to or cost of nursing home care in your area? If so, please describe.

82.4% of the respondents indicated that such a problem exists in their area. 7.8% of the respondents indicated that no such problem exists in their area. 9.8% of the respondents did not answer this question. Bed shortages, a building moratorium, cost, and the reimbursement system were all listed as reasons for this problem. Bed shortage was the reason listed most commonly. None of the respondents suggested a solution to this problem.

Question 6

Do you have an insufficient volume of patients in your local hospital for the hospital to be financially viable?

A) Is your community willing to subsidize the hospital?

B) What particular services is it important to preserve in the hospital?

37.3% of the respondents indicated that there was a sufficient volume of patients in the local hospital to make it financially viable. 27.5% of the respondents indicated that there was not a sufficient volume of patients in the local hospital to make it financially viable. 35.3% of the respondents did not answer this question.

42.9% of the respondents that indicated that their local hospital had an insufficient volume of patients also indicated that their community would be willing to subsidize the local hospital. 37.5% of the respondents indicated that their local hospital had an insufficient volume of patients also indicated that their community would not be willing to subsidize the local hospital. 21.4% of the respondents that indicated that their local hospital had an insufficient volume of patients did not answer this question. Respondents indicated that virtually all services should be preserved in the hospital. Emergency services was the service that should be preserved that was listed the most commonly. None of the respondents suggested solutions to this problem.

Question 7A

If Maine health care insurance costs are likely to increase by 25% a year, do you believe:

Health services should be decreased?

Which kind of services should be cut?

To whom should the services be cut?

23.5% of the respondents indicated that given the situation depicted in this question, 7A, services should be cut. 66.7% of the respondents indicated that given the situation depicted in question 7A, services should not be cut. 9.8% of the respondents did not answer this question. Respondents indicated that acute care beds, home health care, life supported services, mental health care, and repetitive tests are services which should be cut. Respondents indicated that services should be cut to those receiving the services listed previously.

Question 7B

If Maine health care insurance costs are likely to increase by 25% a year, do you believe:

Health care revenues should be raised to pay for these cost increases. If yes, where should money come from?

A) Increased premiums for privately purchased health insurance?

B) Through a payroll tax?

C) Through general revenues? (Personal income and sales taxes)

D) Other?

84.3%of the respondents indicated that given the situation depicted in question 7B, health care revenues should be raised. 3.9% of the respondents indicated that given the situation depicted in question 7B, health care revenues should not be raised. 11.8% of the respondents did not answer this question.

41.8% of the respondents that indicated that health care revenues should be raised indicated that they should be raised through increased premiums for privately purchased health insurance. 37.6% of the respondents that indicated that health care revenues should be raised indicated that they should be raised through a payroll tax. 72.1% of respondents that indicated that health care revenues should be raised indicated that they should be raised through general revenues. Other methods of raising revenues indicated by the respondents include cost containment federal money, and sin taxes.

Robert Dunn
Human Resources
April 4, 1988
Doc. #4854*

Question 1 - 25.5% Response Rate.

Is there a problem in your area with regard to the availability of affordable health insurance? If so, please describe.

Yes, a problem exists.	No problem exists.	No Answer
32 (62.7%)	11 (21.6%)	8 (15.7%)

Groups or Persons Affected

Employees
Indigent
Individuals
Large Employers
Private Industries
Self Employed
Single Mothers
Small Business
Unemployed

Groups Listed Most Commonly

Individuals

Most Common Reason for Problem

Cost

Suggested Solutions

None

Question 2 - 25.5% Response Rate.

Is there a shortage of physicians in your area? If so, describe the extent of the shortage, and whether it is confined to particular specialists.

Yes, a problem exists.	No problem exists.	No Answer
30 (58.8%)	15 (29.4%)	6 (11.8%)

Types of Physicians in Short Supply

Virtually All Types of Physicians

Types of Physicians Listed Most Commonly

General Practitioners
Obstetrics
Orthopedic Surgeons

Suggested Solutions

None

Question 3 - 25.5% Response Rate

Is there a shortage of other health care professionals in your area? If so, please describe the extent of the shortage.

Yes, a problem exists.	No problem exists.	No Answer
43 (84.3%)	5 (9.8%)	3 (5.9%)

Types of Health Care
Professionals in Short Supply

Certified Nurses Aides
Licensed Practical Nurses
Occupational Therapists
Pharmacists
Physical Therapists
Registered Nurses
Respiratory Therapists
Speech Therapists
X-Ray Technicians

Types of Health Care Professionals
Listed Most Commonly

Certified Nurses Aides
Licensed Practical Nurses
Registered Nurses

Suggested Solutions

Implement a 2 year curriculum for
a Registered Nurse Degree

Question 4 - 25.5% Response Rate

Is there a problem in your area with the unavailability of particular health care services, e.g. hospice care, home health care, mental health care, or even acute care? If so, please describe.

Yes, a problem exists.	No problem exists.	No Answer
33 (64.7%)	10 (19.6%)	8 (15.7%)

Types of Health Care
Services in Short Supply

Acute Care
Adult Day Care
Home Health Care
Hospice Care
Mental Health Care
Occupational Health Care
Psychiatric Care
Substance Abuse Care

Types of Health Care Services
Listed Most Commonly

Home Health Care
Hospice Care
Mental Health Care

Reasons for Shortage

Geographic Access
Lack of Funds
Staffing Inadequacies

Reasons for Shortage
Listed Most Commonly

Geographic Access

Suggested Solutions

None

Question 5 - 25.5% Response Rate

Is there a problem with access to or cost of nursing home care in your area? If so, please describe.

Yes, a problem exists.	No problem exists.	No Answer
42 (82.4%)	4 (7.8%)	5 (9.8%)

Reasons for Shortage

Bed Shortage
Building Moratorium
Cost
Reimbursement System

Reasons for Shortage Listed Most Commonly

Bed Shortage

Suggested Solutions

None

Question 6

Do you have an insufficient volume of patients in your local hospital for the hospital to be financially viable? - 25.5% Response Rate

A) Is your community willing to subsidize the hospital? - 7% Response Rate

B) What particular services is it important to preserve in the hospital? - 10.5% Response Rate

Sufficient Volume	Insufficient Volume	No Answer
19 (37.3%)	14 (27.5%)	18 (35.3%)

Will Community Subsidize Hospital?

Yes	No	No Answer
6	5	3

Services That Should Be Preserved

Virtually all Services

Services That Should Be Preserved Listed Most Commonly

Emergency Services

Suggested Solutions

None

Question 7A - 25.5% Response Rate

If Maine health care insurance costs are likely to increase by 25% a year, do you believe:

Health services should be decreased?

Which kind of services should be cut?

To whom should the services be cut?

Services should be cut.	Services should not be cut.	No Answer
12 (23.5%)	34 (66.7%)	5 (9.8%)

Which Services Should Be Cut?

Acute Care Beds
Home Health Care
Life Support Services
Mental Health Care
Repetitive Tests

To Whom Should Services Be Cut?

Those receiving services listed above.

Question 7B - 25.5% Response Rate

If Maine health care insurance costs are likely to increase by 25% a year, do you believe:

Health care revenues should be raised to pay for these cost increases. If yes, where should money come from?

A) Increased premiums for privately purchased health insurance?

B) Through a payroll tax?

C) Through general revenues? (Personal income and sales taxes)

D) Other?

Health Care Revenues Should be Raised	Health Care Revenues Should Not Be Raised	No Answer
43 (84.3%)	2 (3.9%)	6 (11.8%)

Increased Premiums	Payroll Tax	General Revenues
18 (41.8%)	14 (32.6%)	31 (72.1%)

Other Methods of Raising Revenue

Cost Containment
Federal Money
Sin Taxes

Question 8 - 11.5% Response Rate.

If you have any other comments or information which you feel would be useful to the Commission in completing its work, please indicate below or on a seperate sheet.

- State mandated health care benefits are in part to blame for the increases in health care costs.
- State officials must create an environment which is conducive to providing primary and secondary health services at the local level.
- The current tax system can be utilized to pay for health care. The state must change the areas in which it spends tax revenues.
- Part of the cost increases are due to the increased paperwork required of health care providers by both the federal and state government.
- Incentives for primary care physicians should be established thus encouraging individuals to practice in those specialties.
- User fees or taxes need to be imposed on all programs in order to eliminate those persons who live off the system yet do not contribute to the system.
- Hospitals need to operate in more of an unregulated environment and must be able to recoup their financial investments made for equipment and services.
- Regulations mandating that physicians visit nursing home patients every 60 days, regardless of the need to be seen, create an unneccessary financial burden on the patient.
- Nursing shortage can be addressed by recruiting nurses from overseas.
- The state should institutionalize associate degree nursing programs at the VTI's throughout the state.
- The assumption that the current system of hospital revenue regulation guarantees solvency for effective hospitals must be questioned.
- Maine Health Care Finance Commission regulations fail to recognize the added cost of providing more services to a growing community
- Spending should be shifted from remedial programs to preventive programs.

MARTHA E. FREEMAN, DIRECTOR
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December 2, 1988

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

TO: Subcommittee on the structure of the RSB

FROM: Annika Lane

RE: December 1 meeting

I have enclosed my interpretation of your discussion regarding the structure of the RSB. I hope it will be useful to you in preparing for the next Commission meeting.

I have not distributed this to the rest of the Commission, assuming that you would prefer to make your case verbally at the next meeting, rather than through a memo. Please let me know if you would like me to do otherwise.

I have forwarded a copy of this to Paul Gauvreau and Graham Atkinson, however.

Please call me if you have any questions or need any more information.

7259m

12/2/88

Blue Ribbon Commission on Health Care Expenditures
Subcommittee to Develop a Proposal for the Structure of the Rate Setting Body

December 2, 1988
Meeting Notes

Some issues/concerns raised at the beginning of the discussion:

1. RSB will have to deal with complicated transition issues - moving towards new regulatory system. Key changes such as:
   - Appeal Mechanism
   - Demonstration Projects
   - Pooling
   - Outpatient Regulation
   - Different Regulatory Options

2. If too many people on Commission, too complex, cumbersome.

3. No Commissioners should be involved with hospital management while serving on the Commission

4. Support of hospital community imperative to sucessful RSB (makes it too controversial to simply continue current MHCFC to administer regulatory system.)

5. What role do Commission members play - should they be adjudicators or investigators, or both? Very relevant to full time versus part-time debate as being both requires a lot of time and energy.

6. Hospitals and other interested parties should be able to have more voice during proceedings - dialogue with Commissioners.

Recommendation:

A three-member, full-time Commission, nominated by the Governor, approved by the Committee on Human Resources.
- Consumer
- Provider
- Payor

Staggered terms - minimum 4 years, maybe 6 (needs to be decided)

The Chair shall act as executive director, other staff left to the discretion of the Commission.

Three advisory committees shall be established to represent:
- Payors
- Hospitals
- Other health care professionals

NOTE: Who would appoint committee members? Need to decide on composition and structure.

The Chairs of these three committees can take an active part in Commission proceedings but have no formal vote.

Some reasons for recommendation:

1. Full-time Commission provides for more accountability

2. Better regulation - not necessarily more regulation

3. Transition to a different system will be difficult and complicated. Full-time commissioners will be able to devote more energy, more time to the issues, and have more committment to working towards a better health care environment.

4. Advisory committees with participating chairs allows for regular interaction with interested parties - involves them

5. Flexibility provided by changed system assisted by full-time, hands-on commission.

7260m