What the Medical Profession in Maine is Doing to "Police" itself:

1. Hospital peer review:

Requirements of JCAH: Quality Assurance Committee
Tissue Committee
Credentials Committee
Utilization Review Committee

Requirements of State Law

Health Security Act: 24 M.R.S.A. Section 2503

Require each hospital to have a program for the identification and prevention of medical injury which shall include at least the following:

- One or more professional competence committees
- A grievance or complaint mechanism
- Collection of data regarding patient grievances, claims, suits, etc.
- Educational programs for the provider's staff dealing with patient safety, medical injury prevention,...and other relevant factors known to influence malpractice claims and suits

24 M.R.S.A. Section 2504

Every statwide organization of physicians must establish a professional competence committee which shall receive, investigate and determine the accuracy of any report made to the society of any member physician's acts amounting to gross or repeated medical malpractice, habitual drunkenness, addiction to the use of drugs or professional incompetence.

Requirements of State Licensure

(hospital licensure)

The state regulations for the licensure of hospitals contain a chapter on medical staffs which requires various types of review to assure high quality of medical care.

2. Conditions of Medicare participation

(federal law)

Professional Review Organizations

Review of Medicare claims for proper utilization and quality

3. Professional Societies:

- Peer Review Committees - Review care providers by members, mostly in hospitals, at request of Doctor or hospital.

- Ethics and Discipline Committees - Receives complaints against members and deliberates on them. Can issue reprimand, suspend or revoke membership. Some county medical societies and specialty societies have such committees as well. (i.e. - Maine Psychiatric Association Ethics Committee has reviewed a number of members the past 2 years)

- Maine Medical Assessment Program - A voluntary program of peer review to review variations in surgical incidence. Has been in existence for 4 years and has been nationally recognized and is funded by various Foundations and Blue Cross-Blue Shield of Maine.

- Impaired Physician Program - Program authorized by State law which provides protections to persons involved with the process of identifying, investigating and rehabilitating physicians impaired by the use of drugs, alcohol or illness. Program is funded by license fees. A Clinical Director (M.D.) directs the program on a 2-day per week basis. Maine is the smallest state in the nation with a fully funded, statewide impaired physicians program. Detailed protocols exist between the Board of Registration in Medicine and the Maine Medical Association regarding the operation of the program.

- Reporting of claims and conduct to Licensing Board. Under the provisions of the Maine Health Security Act, a professional society and individual physicians are required to report physician misconduct to the Board of Registration in Medicine. Malpractice Insurance Companies are required to report all claims, whether paid or not, to the Bureau of Insurance which then reports to the Board of Registration. Under legislation passed in 1986, any physician who has three paid claims in any 10-year period must be reviewed by the Board.

4. Review of Third-Party Payors. In addition to review by the Professional Review Organizations (PRO's) required by the federal Medicare law, nearly all third-party payors, including Medicaid, Blue Cross/Blue Shield and commercial carriers have various utilization review committees which conduct claims review.

5. Health Care Quality Improvement Act of 1986 (Federal). The federal Health Care Quality Improvement Act of 1986 authorizes the establishment of a national clearinghouse for the reporting of physician disciplinary actions by health care providers. Every hospital must check with the clearinghouse prior to credentialing a physician.

6. Malpractices Insurance Company Risk Management. Both St. Paul and Medical Mutual Insurance Company of Maine conduct extensive risk management activities in Maine. St. Paul provides risk management advice to its insured, both hospitals and individual physicians. It also publishes a periodical entitled Malpractice Digest which contains advice on how to avoid suits, based on closed claims that the Company has reviewed. Medical Mutual has a Risk Manager Director and a Risk Management Committee. The Committee recently composed three major risk management protocols in the areas of anesthesia, obstetrics and breast cancer. In addition, the Company's Risk Management Director, a registered nurse, conducts risk management reviews at the request of an insured. The Company's underwriting committee also periodically reviews physicians with a given number of claims.

APPENDIX A

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

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- 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

§ 119. Distribution of appropriations

The Commissioner of Educational and Cultural Services, with the advice of the Maine Library Commission, is authorized to apportion funds appropriated by the Legislature for the support of regional library systems.

Sec. 16. P&SL 1973, c. 11, § 1, Sect. 3 is amended. Section 3 of said charter, as amended by chapter 264 of the Acts of the Commonwealth of Massachusetts of 1973, and chapter 11 of the private and special laws of Maine of 1973 is hereby further amended to read as follows:

Sect. 3. And be it further enacted by the authority aforesaid, that for the more orderly conducting the business of the said corporation, the president and trustees shall have full power and authority, from time to time, to elect a vice president and secretary of the said corporation, and to declare the tenures and duties of their respective offices; and to elect trustees of said corporation, for such terms and upon such conditions as they may from time to time determine, and also to remove any trustee from the same corporation, when, in their judgment, he shall be incapable or shall neglect or refuse to perform the duties of his office. Provided nevertheless, that the number of the said trustees, including the president ~~and treasurer~~ of said college, for the time being, shall never be greater than 13, nor less than 7.

Sec. 17. **Effective date.** Section 16 shall take effect when approved for the purpose of its submission to the General Court of Massachusetts for its concurrence. It shall take effect for all purposes when a certificate is filed with the Secretary of State certifying that the General Court of Massachusetts has granted its concurrence.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect immediately, except that sections 7, 9, 11-D and 14 shall take effect on July 1, 1978; and exceptthat section 16 shall take effect in accordance with section 17.

Effective March 30, 1978 Unless otherwise indicated

CHAPTER 691

AN ACT to Establish the Health Facilities Information Disclosure Act.

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. 22 MRSA c. 105 is enacted to read:

CHAPTER 105

HEALTH FACILITIES INFORMATION DISCLOSURE ACT

§ 351. Findings and declaration of purpose

The Legislature finds that the rising costs of health care and services provided by health care facilities are matters of vital concern to the people of this State and have a direct relationship to the ability of the people to obtain necessary health care.

The Legislature further finds that the informed development of public policy relating to health care requires that the State regularly assemble and analyze information pertaining to health care costs.

It is the intent of the Legislature that uniform systems of reporting health care information shall be established and public disclosure of that information shall not violate the privacy rights of patients and health care practitioners, and that all health care facilities shall, subject to this chapter, be required to file reports in a manner consistent with these systems.

It is further the intent of the Legislature to provide for the review of and comment on the proposed budgets of any hospital by either the Health Facilities Cost Review Board or an approved voluntary budget review organization and for the monitoring of any voluntary budget review organization by the Health Facilities Cost Review Board.

It is further the intent of the Legislature that the Health Facilities Cost Review Board report to the Legislature and the Governor annually on the status of the costs of services rendered by the health facilities and recommend, if appropriate, mechanisms to control those costs.

§ 352. Definitions

As used in this chapter, unless the context otherwise indicates, the following words and terms shall have the following meanings.

1. Board. "Board" means the Health Facilities Cost Review Board established by this chapter.

2. Department. "Department" means the Department of Human Services.

3. Direct provider of health care. "Direct provider of health care" means an individual whose primary current activity is the provision of health care to other individuals or the administrator of a facility in which that care is provided.

4. Health facility. "Health facility" means any health care facility required to be licensed under chapter 405 or its successor, with the exception of the Cutler Health Center and the Dudley Coe Infirmary.

5. Hospital. "Hospital" means any acute care institution licensed pursuant to chapter 405 or its successor, with the exception of the Cutler Health Center and the Dudley Coe Infirmary.

6. Independent data organization. "Independent data organization" means an organization of data users, a majority of whose members are not direct providers of health care services and whose purposes are the cooperative collection, storage and retrieval of health care information.

7. Uniform system of reporting. "Uniform system of reporting" means the external reporting of health care facility activities through the preparation of financial and service data reports which in no way supersedes the responsibility reporting requirements of individual institutions.

8. Voluntary budget review organization. "Voluntary budget review organization" means a nonprofit organization established to conduct reviews of budgets of hospitals to determine that prospectively determined rates and charges are reasonably just and are reasonably related to financial requirements, and that these prospective rates and charges are allocated equitably among all purchasers of health services without undue discrimination, except as required by federal and state statutes or regulations.

9. Performance standards. "Performance standards" means the numerical measures of the costs of health care services rendered, as calculated according to methods used by the board to define these measures.

§ 353. Health Facilities Cost Review Board; membership; terms; vacancies

A Health Facilities Cost Review Board shall be established as follows.

1. Health Facilities Cost Review Board; established. There is established a Health Facilities Cost Review Board which shall function as an independent board. The board shall be composed of 10 members. Eight members shall be appointed by the Governor, subject to review by the Joint Standing Committee on Health and Institutional Services and confirmation by the Legislature. The Commissioner of Human Services or his designee shall serve as an ex officio voting member of the board; the Superintendent of Insurance or his designee shall serve as an ex officio nonvoting member of the board. The 8 members appointed by the Governor shall be selected in accordance with the following requirements:

A. One member shall be appointed from a list of 3 names submitted by the Maine Hospital Association;

B. One member shall be appointed from a list of 3 names submitted by the Maine Health Care Association;

C. One member shall have had at least 5-years' experience in the field of health insurance or in the administration of a health care service plan within the 10 years preceding the initital appointment; and

D. Five public members shall be appointed as consumers of health care. Neither the public members nor their spouses or children shall, within the preceding 12 months, have been affiliated with, employed by, or have had any professional affiliation with any health care facility or institution, health product manufacturer or corporation or insurer providing coverage for hospital or medical care.

2. Term of appointed members. Appointed members of the board shall serve for a term of 4 years. Members shall hold office until the appointment and confirmation of their successors. Of the members first appointed by the Governor, the member from the Maine Hospital Association and 2 public members shall hold office for 4 years, the member from the Maine Health Care Association and one public member shall hold office for 3 years, the member from the insurance field and one public member shall hold office for 2 years and one public member shall hold office for one year.

3. Vacancies. Vacancies among appointed members shall be filled by appointment by the Governor for the unexpired term. The Governor may remove any appointed member who becomes disqualified by virtue of the requirements of subsection 1, or for neglect of any duty required by law, or for incompetency or dishonorable conduct.

§ 354. Meetings; chairman; compensation

The board shall meet and receive compensation as follows.

1. Meetings; chairman and vice-chairman. The board shall hold one regular meeting annually in Augusta. Additionally, the board may meet from time to time as required to fulfill its responsibilities. The Governor shall appoint a chairman and vice-chairman from the public members, who shall serve in this capacity at his pleasure.

2. Compensation. Each appointed member of the board shall receive a per diem allowance of $25 for each day that he is actively engaged in performing the work of the board and each member shall be reimbursed for the actual and necessary traveling and other expenses incurred in the discharge of his duties.

3. Quorum; voting and official action. Six members of the board constitute a quorum. Actions of the board shall be by majority vote. No action the board shall be official unless a majority of the appointed public members present.

§ 355. Executive director

The board may appoint an executive director, who shall perform the duties delegated to him by the board and be responsible to it for the accomplishment of these duties. The executive director shall serve at the pleasure of the board and his salary shall be set by the board.

§ 356. Staff

The board is authorized to employ, subject to the personnel laws, such staff as it deems necessary. The department may provide staff, facilities and other appropriate assistance to the board. Any staff provided by the department shall carry out duties assigned by the board.

§ 357. Powers and duties

The board shall:

1. Data reporting systems. Establish uniform systems for reporting financial and other health service data as provided in section 358;

2. Review of budgets and revenues. Have the power to review the reasonableness of the budget of any hospital, as provided in section 359;

3. Studies and analyses. Have the power to conduct studies and analyses relating to health care costs and other related matters as provided in section 360;

4. Annual report. Prepare an annual report for transmission to the Legislature and the Governor as provided in section 361;

5. Receipt of grants, gifts and payments. Have the power to apply for and receive grants, gifts and other payments from any governmental agency, private entity or other person as provided in section 362;

6. Contract for services. Have the power to contract with 3rd parties for services necessary to carry out the activities of the board as provided in section 363;

7. Approval of budget review organizations. Approve voluntary budget review organizations for the purposes of section 359 as provided in section 364; and

8. Performance standards. Have the power to develop performance standards, after a public hearing pursuant to section 366, sub-section 1, in order to

evaluate the effects of any approved voluntary budget review organization on the costs of health care services rendered by hospitals participating in the organization.

§ 358. Uniform systems of reporting

Uniform systems of reporting health care information shall be established as follows.

1. Establishment. The board shall establish, after consultation with appropriate agencies and organizations and after holding public hearings in several areas of the State, uniform systems of reporting health care information.

2. Compliance with systems. Each health facility shall comply with the required systems for its fiscal year period to be effective at such time as the board shall direct. The board shall allow any health facility, which does not maintain its records and data in a manner consistent with the requirements of the board, a period of up to 18 months from the date which the requirements become effective to conform to these requirements. Any facility for which these requirements are temporarily waived by the board shall during the period of the waiver provide information required by the board in the manner in which the facility does assemble this information.

3. Filing. Unless the board grants in writing an extension of time, each health facility shall file with the board, as applicable, not later than 120 days after the end of its fiscal year, information as provided under subsection 4.

4. Information required. Pursuant to rules adopted by the board for form and content, each health facility shall file reports containing the following information:

A. Financial information including costs of operation, revenues, assets, liabilities, fund balances, other income, rate, charges, units of services and such other financial information as the board deems necessary for the performance of its duties; and

B. Scope of service information, including bed capacity, by service provided, special services, ancillary services, physician profiles in the aggregate by clinical specialties, and such other scope of service information as the board deems necessary for the performance of its duties.

5. Discharge data. Each health facility shall file with an independent data organization a completed Uniform Hospital Discharge Data Set, or comparable information, for each patient discharged from the facility. The board shall have access to data through the independent data organization, provided that individual patients or health care practitioners are not directly identified. Publicly released data shall not identify individual patients or health care practitioners directly. The board shall adopt its own policies pursuant to section 366 and after a public

hearing for publicly released information which may indirectly identify individual patients or health care practitioners. The affected health facility shall be provided copies of any requests by the board for data sets or analyses and have an opportunity to comment on the data or analyses before they are released by the board.

6. Modification of reporting systems. The board may allow and provide for modifications in the reporting system in order to better carry out its functions or to reflect differences in the scope or type of services, size and other differences among health facilities subject to the requirements of this chapter.

7. Compatibility with other systems. To the extent feasible, the board in establishing uniform systems shall take into account the data requirements of relevant reimbursement programs and reporting requirements of a voluntary budget review organization as approved under section 364. Existing systems of accounting and reporting used by health facilities and a model system, such as the American Hospital Association chart of accounts, shall be examined and given due consideration by the board in developing uniform systems of reporting required by this section. The reporting requirements established under this chapter, insofar as feasible and consistent with the requirements of this chapter, shall be compatible with the reporting requirements established by the Secretary of Health, Education and Welfare, under the provisions of Section 1121 of the Federal Social Security Act.

8. More than one licensed health facility operated. Where more than one licensed health facility is operated by the reporting organization, the information required by this section shall be reported for each health facility separately.

9. Certification required. The board may require certification of such financial reports as it may specify and may require attestation as to these statements from responsible officials of the facility that these reports have to the best of their knowledge and belief been prepared in accordance with the requirements of the board.

§ 359. Review of budgets

The board is authorized to review the budget of any hospital as follows.

1. Review authority. Effective with fiscal years beginning on or after July 1, 1979, the board shall have the authority to review and comment upon the reasonableness of the budget of any hospital which does not participate in a voluntary budget review program approved by the board, pursuant to section 364.

2. Submission of budget. Commencing with fiscal years beginning on or after July 1, 1979, hospital subject to review under subsection 1 shall submit to the board its budget for its next fiscal year, together with such other relevant supplemental reports and information as the board may require, within a reasonable time period as determined by the board, pursuant to rules adopted under section 366.

3. Review and findings. In accordance with subsection 1, the board is authorized to conduct review of hospital budgets to determine that prospectively determined rates and charges are reasonably just and reasonably related to financial requirements, and that these prospective rates and charges are allocated equitably among all purchasers of health services without undue discrimination, except as required by federal and state statutes or regulations. Upon completion of its review, the board shall make a written report of its findings, a copy of which shall be sent to the hospital whose budget has been reviewed. The board shall provide this copy of its findings to the hospital at least 10 days prior to public disclosure of the findings.

§ 360. Studies and analyses

1. Studies and analyses. The board is authorized to conduct or cause to be conducted studies and analyses relating to costs of health care services rendered, to the financial status of any facility subject to this chapter or to any other related matters which it deems appropriate. The board shall coordinate its activities with any public or private agency in carrying out these studies and analyses when this coordination will promote economy, avoid duplication of effort and make the best use of available personnel and other resources. In addition, and at the request of planning agencies, the board may perform appropriate duties consistent with this chapter that may be required by the planning agencies under the National Health Planning and Development Act of 1974 or its successors.

2. Public disclosure. The board may publish or make any other type of public disclosure of studies and analyses it has conducted or caused to be conducted. If the studies or analyses specify a health facility by name or by geographic location, the health facility shall be afforded an opportunity, before public release, to review and comment upon the studies or analyses.

§ 361. Annual report

Annually, prior to January 1st, the board shall present a report to the Legislature and the Governor. This report shall include, but not be limited to, a description of its activities and the activities of any voluntary budget review organization during the previous year, a summary of the costs of services rendered by health facilities and any findings and recommendations which the board deems necessary, including recommendations for controlling health facilities' costs and for containing the costs of obtaining services from health facilities.

§ 362. Receipt of grants, gifts and other payments

The board is authorized to apply for and receive grants, gifts and other payments, including property and service, from any public or private entity or person, except from a direct provider of health care, and may make arrangements for the use of these receipts, including the undertaking of studies and other projects relating to health care costs.

§ 363. Contracts

The board shall contract with 3rd parties for services necessary to carry out its activities, when this contract will promote economy, avoid duplication of effort and make the best use of available personnel and other resources. Any 3rd party shall be prohibited from releasing, publishing or otherwise using any information made available to it under its contracted responsibility without the specific written authorization of the board.

§ 364. Approval of a voluntary budget review organization

1. Submission of hospital budget. For purposes of section 359, a hospital may agree to submit its budget, together with such other relevant information as may be required, to a voluntary budget review organization which has been approved by the board in accordance with this section.

2. Approval of voluntary budget review organization. The board shall approve a voluntary budget review organization which meets each of the following criteria.

A. The budget review procedures are likely to permit the voluntary budget review organization to determine whether prospectively determined overall rates and charges are reasonably just, are reasonably related to financial requirements and are allocated equitably among all purchasers of health services.

B. The structure of the organization provides for the reviews to be made and the actions to be taken with respect to the reviews by a body of the organization which includes equal representation from members approved by the Maine Hospital Association, major 3rd-party payers and consumers of health care. Neither the consumers nor their spouses, children or parents shall, within the preceding 12 months, have been affiliated with, employed by or have had any professional affiliation with any health care facility or institution, health product manufacturer or corporation or insurer providing coverage for hospital or medical care.

C. The procedures of the organization with respect to the filing of appropriate financial information and the analysis and verification of that information are sufficient to permit the organization to determine whether prospectively determined overall rates and charges are reasonably just, are reasonably related to financial requirements and are allocated equitably among all purchasers of health services.

D. The procedures of the organization provide for the public disclosure of its findings and comments prior to the effective date of the budget.

3. Time for approval. The board shall, upon receipt of a request for approval by a voluntary budget review organization, make a determination within a

reasonable period of time. For any request for approval received prior to March 15, 1979, the board shall make a determination on or before April 15, 1979.

4. Withdrawal of approval. The board may withdraw approval from a voluntary budget review organization after a public hearing, conducted in conformance with rules and regulations adopted under section 366, for either or both of the following reasons:

A. The actions of the voluntary budget review organization no longer satisfy the criteria contained in subsection 2; or

B. The performance standards established by the board have not been met by hospitals participating in the organization.

5. Filing of findings and comments. An approved voluntary budget review organization which conducts a review of a hospital budget shall file a copy of its findings and comments with the board within 30 days of completion of the review process. In addition, the voluntary budget review organization shall upon request make available to the board, the original and the accepted budget of the affected hospital and any other financial information acquired by the organization during the course of its review.

6. Notification of intent to become approved organization. Prior to approval, any voluntary budget review organization duly incorporated under the laws of Maine shall notify the board in writing of its intention to become an approved voluntary budget review organization as defined in this section. Upon receipt of this notice, the board shall direct the organization to develop procedures and other criteria for approval as defined in subsection 2 and to conduct any pilot budget reviews of hospital budgets which it deems necessary. The board shall review and comment on the application prior to its determination of approval if the organization so requests.

7. Temporary approval criteria. The board shall grant temporary approval to any voluntary budget review organization that meets the following criteria.

A. The structure of the organization provides for the reviews to be made and the actions to be taken with respect to these reviews by a body of that organization which includes equal representation from members approved by the Maine Hospital Association, major 3rd-party payers and consumers of health care. Neither the consumers nor their spouses, children or parents shall, within the preceding 12 months, have been affiliated with, employed by or have had any professional affiliation with any health care facility or institution, health product manufacturer or corporation or insurer providing coverage for hospital or medical care.

B. The procedures of the organization provide, at a minimum, that the findings and recommendations with respect to its reviews be made public information.

C. The procedures of the organization shall be submitted to the board for its review and comment.

D. The organization intends to contract with an independent data organization for the purpose of fulfilling its responsibilities if such a contract would avoid duplication of effort.

No temporary approval granted by the board shall extend beyond April 15, 1979.

8. State anti-trust exemption. Any voluntary budget review organization approved by the board and any hospital submitting information to such an organization shall be exempt from Title 10, section 1101, et seq. and Title 5, section 207, et seq. for its reporting and budget review activities conducted pursuant to this section and section 352, subsection 8.

§ 365. Public information; availability of data

Any information, except privileged medical information, which is filed with the board under this chapter shall be made available to any public or private agencies or other persons upon request, provided that individual patients or health care practitioners are not directly identified. The board shall adopt its own policies, pursuant to section 366 and after a public hearing for information made available which may indirectly identify a particular patient or health care practitioner.

§ 366. Rules and regulations; public hearings; audit

1. Rules and regulations. The board shall adopt, amend and repeal such rules and regulations as are necessary for the proper administration and enforcement of this chapter. The board shall provide for public notice and hearing on all proposed rules and regulations pursuant to Title 5, c. 375.

2. Public hearings. The board is authorized to conduct public hearings when they are deemed necessary to carry out its responsibilities, but are not required by law.

3. Audit. The board is authorized, during normal business hours and upon reasonable notification, to audit, examine and inspect the financial accounting records of any health care facility to the extent that the activities are necessary to carry out its responsibilities.

§ 367. Enforcement

The Attorney General, upon the request of the board, shall institute and prosecute actions for the enforcement of this chapter and for any rules and regulations adopted pursuant to section 366.

§ 368. Penalty

Any person or health care fa
valid order, rule or regulation
be deemed to have committed
than $100 a day may be adjud

§ 369. Partial invalidity

If any provision of this cha
circumstance shall be held inv
application of this chapter whi
or application, and to this en
severable.

§ 370. Repeal

This chapter shall be repea

Sec. 2. Appropriation. Th
General Fund to carry out t

HEALTH FACILITIES COS
Personal Services
All Other

It is the intent of th
unexpended money
Legislature under the
shall not lapse, but
following year to be
for the purposes of t

AN ACT to Make Necessa
Budget, the Errors and
Act.

Emergency preamb
Legislature do not bec
enacted as emergencies

Any person or health care facility violating any provision of this chapter or any valid order, rule or regulation made or promulgated pursuant to this chapter shall be deemed to have committed a civil violation for which forfeiture of not more than $100 a day may be adjudged.

§ 369. Partial invalidity

If any provision of this chapter or the application thereof to any person or circumstance shall be held invalid, that invalidity shall not affect any provision or application of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

§ 370. Repeal

This chapter shall be repealed on July 1, 1982.

Sec. 2. Appropriation. The following funds shall be appropriated from the General Fund to carry out the purposes of this Act:

	1978-79
HEALTH FACILITIES COST REVIEW BOARD	
Personal Services	$ 40,000
All Other	60,000
	$100,000

It is the intent of the Legislature that any unexpended money appropriated by the Legislature under the category "All Other" shall not lapse, but shall be carried to the following year to be expended by the board for the purposes of this Act.

Effective July 6, 1978

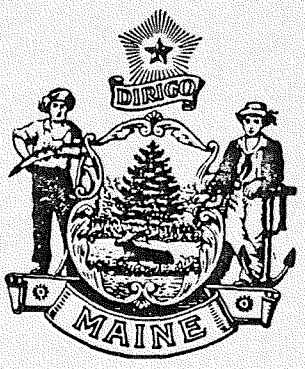
CHAPTER 692

AN ACT to Make Necessary Corrections in the Knox County and Lincoln County Budget, the Errors and Inconsistencies Act and the Administrative Procedure Act.

Emergency preamble. Whereas, Acts and resolves passed by the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Hospital Cost Containment in Maine

Study and Recommendations



Health Facilities Cost Review Board

State of Maine
December 1981

HOSPITAL COST CONTAINMENT

IN MAINE

A STUDY

and

RECOMMENDATIONS

Health Facilities
Cost Review Board

State of Maine
December 1981

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I. Introduction

In May, 1981 Governor Brennan requested that the Health Facilities Cost Review Board carry out a study consisting of three major tasks.* He asked first that we examine the present system of financing hospital services in Maine. Second, he asked for an evaluation of the current efforts of Maine hospitals to control costs on a voluntary basis. Finally, he asked the Board to examine alternatives to the present system and, specifically, to assess the need for a mandatory hospital rate setting program.

Since early June, the Board has held eight public hearings and numerous other meetings devoted exclusively to the study. The public hearings featured presentations which described several cost containment programs in other states as well as the present voluntary program in Maine. The Board encouraged the participation of individuals and groups broadly representative of Maine citizens and communicated regularly with all members of the Legislature on the progress of the study. A more detailed description of the study process is included as Appendix B.

The request for this study was timely in two ways. First, the present voluntary budget review program authorized under the provisions of the Health Facilities Information Disclosure Act, as enacted in 1978 and amended in 1980, will terminate on July 1, 1982. Second, the rapid rate of increase in hospital expenditures, which in part prompted the passage of the law, has not abated. The following table shows the rates of increases in total operating revenue and

*All references to the "Board" throughout this report will indicate the Health Facilities Cost Review Board.

total expenses for Maine hospitals for the most recent two year period for which data is available.

Measure	1978-79	1979-80
Total operating revenue	13.3%	15.5%
Total expenses	14.2%	15.0%

In addition, rates of increases in Maine are higher than national rates for the same period. The following table presents the rates of increase in expenses per admission for 1978-79 and 1979-80.

	Expense per Adjusted Admission	
	1978-79	1979-80
Maine	13.76%	15.33%
U.S.	11.35%	12.76%

Finally, data for the period between 1972 and 1980 comparing Maine with other rural states (none of which have mandatory cost containment programs) and with three states having mandatory budget or rate review programs (regulated states) indicates that Maine hospital expenditures have, generally, increased more rapidly.

	Maine	Rural*	Regulated States**
% Increase in Expenses per Capita	221.9	189.7	152.6
% Increase in Expense per Admission	207.5	220.5	149.1
% Increase in Full Time Equivalent Employees (FTE)/Day	26.3	16.5	19.6
% Increase in Payroll/FTE	114.3	114.4	84.3

In this report we address each of the questions posed by Governor Brennan. In section 2 we examine the rates of increase in the major components of hospital

*New Hampshire, Vermont, Montana, South Dakota, North Dakota and Wyoming.

**Maryland, Massachusetts and Connecticut.

expenditures and describe some of the causes which may be associated with these rates of increase. This analysis is intended to assess the nature and extent of the problems underlying these increases.

In section 3 we discuss the current financing system for hospital services in Maine and describe its weaknesses as a vehicle for addressing cost containment problems. The present voluntary budget review program has been implemented without altering the current financing system. In section 4 we assess the efforts of the existing program to moderate hospital expenditure increases within the framework of the current payment system.

The principal alternative to the current payment system for hospital services is an approach called "prospective payment." In section 5 we outline the characteristics of several prospective payment programs and describe their performance in restraining expenditure increases.

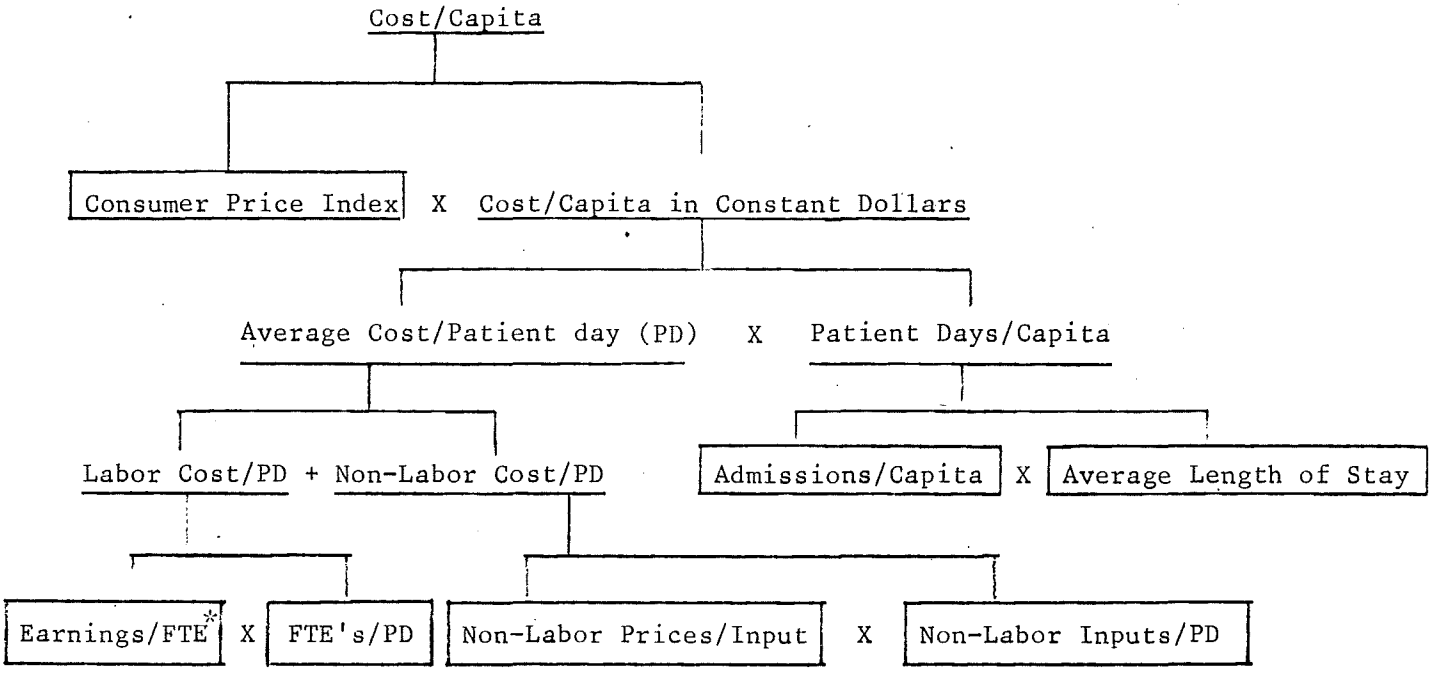
Finally, in section 6, we present recommendations for significant changes in the payment system and for formal coordination among the several hospital cost containment programs.

II. Components and Causes of Hospital Expenditure Increases

A. Components

In the first part of this section we examine the expenditure increases of Maine community hospitals between 1955 and 1979.[1] By identifying some of the components of the expenditure increases, we may be in a better position to determine whether, to what extent and how they may be restrained. In addition, we may be better able to assess the efforts of the present cost containment program and to make recommendations for changes in it.

The increases are analyzed as shown below in order to identify the relative contributions of their major components.[2]



1. Hospital costs per capita

The average cost per capita of hospital care in Maine increased from $14.96 in 1955 to $283.07 in 1979, a total rise of 1,792 percent.[3] As shown in Table 1 (the last line of column 1), this increase is equivalent to an average compound annual rate of 13.0 percent.[4]

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*Full-time equivalent employee

Among other factors, this increase in the average cost per capita reflects changes in the general level of prices. For the 1955-79 period, the general price level as measured by the Consumer Price Index,[5] rose a total of 177 percent. As shown in Table 1, column 2 (last line), this increase is equivalent to an annual compound average rate of 4.3 percent.*

Adjusting the average cost per capita for the change in general prices converts current dollar values into constant dollars. The cost per capita in constant dollars increased from $19.53 in 1955 to $133.27 in 1979. Expressed in another way, the change in the average cost per capita exceeded the increase in general prices by a total of 682 percent for the entire period. Column 3 (last line) of Table 1 shows that the change in the average cost per capita exceeded the increase in general prices by 8.3 percent annually between 1955 and 1979.

As shown in column 3, the increases in the average cost per capita have consistently and significantly exceeded those of general prices throughout the period. The two periods which show the smallest increases above the price rises in the general economy are 1972-73 and 1978-79. Without suggesting a causal relationship, it is worth noting that the 1972-73 period coincided with a substantial portion of the federal price and wage control program and the 1977-78 period paralleled the time of congressional consideration of President Carter's hospital cost containment legislation. Price and wage controls were lifted in 1974 and the Carter Administration's proposal failed to be enacted in 1979.

The rise in general prices, represented here by the Consumer Price Index, accounts for roughly one-third of the 13.0 percent annual increase in the average cost per capita between 1955 and 1979. Identifying the components or the causes of the increases in the general price level of the economy is beyond the scope of

*Table 1 is on page 11.

this study. Therefore, the analysis in this section will continue by focusing exclusively on the increase in the average cost per capita in constant dollars (1967).

The remaining columns in Table 1 present the annual rates of change in the six components of the cost per capita. Table 2 shows the relative contribution of each of these components to the annual increase in the average cost per capita. Table 3 expresses these relative contributions as percentages of the annual rate of increase.*

2. Average length of stay and non-labor prices

The smallest increases are shown in average length of stay and non-labor prices per input. The average length of stay has ranged from a low of 7.2 days to a high of 8.3 days during the period. The annual increase for the whole period as shown in column 9, Table 1, is 0.2 percent. The changes in the prices of non-labor inputs expressed in constant dollars (Table 1, column 6) have fluctuated, actually decreasing during several years, and they have increased at a rate of only 0.3 percent for the entire period. (1967 dollars)

The changes in these two components have not contributed significantly to the overall increase in the average cost per capita. As shown in Table 2, columns 3 and 6, increases in non-labor prices contribute 0.1 percent and changes in the average length of stay add 0.2 percent to the 8.3 percent increase in the average cost per capita between 1955 and 1979. As shown in Table 3, these contributions amount to a one percent and three percent share, respectively, where the total increase is expressed as 100 percent.

3. Labor prices

Annual earnings per full time equivalent (FTE) hospital employee increased at the rate of 2.4 percent annually during the entire period (Table 1, column 4).** Table 2 shows that this increase contributed 1.4 percent to the 8.3 percent rise in the average cost per capita for the period. As presented in Table 3, this

*Tables 2 and 3 are on page 12.

**In constant dollars.

contribution amounted to 18 percent of the total increase in the average cost per capita. The share of the increase in the average cost per capita attributable to annual earnings per FTE varied from zero between 1970-75 to 34 percent for the 1960-65 period (Table 3, column 2).

Table 4 shows that the rate of increase in the annual earnings per FTE has exceeded those of production workers between 1955-79.* Columns 1 and 2 present the annual earnings for hospital FTE's and production workers. As shown in column 3, the wages of hospital employees increased from roughly 70 percent of production worker wages in 1955 to 95 percent in 1979. Since 1970, however, the wage levels of the two groups have been nearly equivalent. Expressed as percentages, the wages of hospital employees increased about 78 percent while production worker earnings rose about 33 percent between 1955 and 1979. In the absence of an analysis of any changes in the education levels, training, experience and occupations in the two categories of workers, the significance of the more rapid increase of hospital employee earnings cannot be evaluated. It is worth noting, however, that the five year period (1965-70) showing the highest rate of increase in annual earnings per FTE, coincided with the first several years of the Medicare and Medicaid programs and the first application of the minimum wage laws to hospital employees. (Table 2, column 1)

The greater increase in the average earnings of hospital employees, however, may be suggested as a major cause of the rapid rise in the average cost per capita. This suggestion can be evaluated by considering the following question: What would the increase in the average cost per capita in constant dollars have been if hospital employee earnings had increased at the same rate as those of production workers? Table 5 presents an answer to this question.

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*Table 4 is on page 13

Column 1 presents the increases in the average cost per capita for selected periods. Column 2 shows what the increases in the average cost per capita would have been if hospital employee earnings had increased at the same rate as production worker earnings.

Table 5 shows that the higher rate of earnings for hospital employees made a substantial contribution to the overall increases in the average cost per capita only between 1965 and 1970. For this period if hospital employee earnings had increased at the same rate as production worker earnings, the cost per capita would have increased 9.2 percent instead of the actual rate of 11.5. The more rapid wage increases for hospital employees accounted for about 20 percent of the increase in cost per capita in excess of the CPI for this period. For the entire period between 1955 and 1979, however, differences in wage rate increases accounted for about 8 percent of the increase in the cost per capita. Since 1970 the differences shown in the wage rates of the two groups are so small that they have virtually no effect on the increase in the average cost per capita.

Table 5. Comparison of the Effect of Wage Rate Differences on the Increase in the Average Cost Per Capita

	Increase in the Average Cost Per Capita: Maine 1967 Dollars	Increase in the Average Cost Per Capita If Hospital Employee Earnings Increased Like All Production Worker Earnings:1967 $
1955-65	6.9	6.1
1965-70	11.5	9.2
1970-75	9.1	9.0
1975-79	7.1	7.0
1955-79	8.3	7.6

4. Hospital admission rate

The next component requiring consideration is the change in hospital admissions per 1000 population. The number of admissions per 1000 population increased from 97 to 157, a rise of about 62 percent between 1955 and 1970. As shown in Table 1, column 8, the admission rate increased at an annual rate of 2.0 percent. This 2.0 percent increase constituted roughly 25 percent of the annual increase in the average cost per capita for the period, as shown in Table 3, column 6.

Changes in the admission rate, then, exerted a strong upward influence on the average cost per capita throughout most of the period. This influence was not completely uniform, however, as shown in Table 3, column 6. For example, during the most recent period between 1975 and 1979, changes in the admission rate show a 9 percent downward pressure on the average cost per capita.

5. Number of employees

The number of full-time equivalent hospital employees per patient day increased a total of 294 percent or an annual rate of 2.8 percent between 1955 and 1979 (Table 1, column 5).[6] This annual increase contributed 1.7 percent to the 8.3 percent rise in the average cost per capita for the period (Table 2, column 2).[7] A substantial share of the increase in the average cost per capita, then, can be attributed to increased numbers of employees. As shown in Table 3, column 3, the share due to this increase in labor inputs was an average of 21 percent between 1955 and 1979.

The rapid increase in the number of employees over the period can also be illustrated by comparing the increases in labor inputs per capita to the increases in patient days per capita and hospital beds per capita, as shown below.

	Increase in Full-time Equivalent Hospital Employees Per Capita (%)	Increase in Patient Days Per Capita (%)	Increase in Beds Per Capita (%)
1955-79	4.7	2.2	2.5

The annual increase in labor inputs per capita was approximately double the increase in patient days and beds per capita for the entire period.

As shown below, this increase in the number of FTE's per capita represents a threefold expansion between 1955 and 1979.

	FTE Hospital Employees per Capita: Maine
1955	4.13
1979	12.48

6. Non-Labor inputs

Non-labor inputs per patient day make the largest contribution to the increase in the average cost per capita between 1955 and 1979.[8] As shown in Table 1, column 7, non-labor inputs increased at more than twice the rate of any other component, 6.5 percent per year. This increase contributed 2.6 percent to the 8.3 percent increase displayed in Table 2, column 4. For the 1955-79 period, then, the increase in non-labor inputs contributed 32 percent of the rise in the average cost per capita (Table 3, column 5). Between 1975 and 1979 the share attributable to non-labor inputs was 41 percent.

TABLE 1 - AVERAGE ANNUAL RATES OF INCREASE IN COST PER CAPITA AND ITS COMPONENTS

	(1) Average Cost per Capita: Maine Current Dollars	(2) Consumer Price Index*	(3) Average Cost per Capita: Maine (1967 Dollars)	(4) Annual Earnings per FTE (1967 Dollars)	(5) FTE's per Patient Day	(6) Non-Labor Price per Input (1967 Dollars)	(7) Non-Labor Input per Patient Day	(8) Admissions per 1,000 Population	(9) Average Length of Stay
1955-60	10.3%	2.5%	7.6	2.5%	2.3%	0.0%	4.1%	4.0%	-1.1%
1960-65	7.9	1.8	6.0	3.4	1.7	0.0	2.7	-1.0	2.9
1965-70	16.3	4.3	11.5	4.2	3.2	-0.3	8.8	4.6	-1.0
1970-71	17.7	5.1	11.9	2.8	7.2	-1.2	15.3	2.9	-2.5
1971-72	8.9	3.6	5.1	0.8	1.6	-0.7	16.6	1.4	-3.9
1972-73	12.7	6.0	6.3	-2.3	3.8	0.3	8.7	1.4	0.0
1973-74	22.9	10.4	11.4	-6.3	3.0	4.0	3.8	10.1	0.0
1974-75	21.0	9.0	11.0	5.4	4.7	3.1	10.6	-1.2	0.0
1975-76	16.3	7.6	8.1	-0.2	5.1	-0.9	9.4	0.6	1.4
1976-77	16.9	5.1	11.2	1.7	6.2	1.8	15.4	-1.2	0.0
1977-78	11.9	5.1	6.5	3.6	0.8	3.3	-1.0	0.0	4.1
1978-79	13.5	10.2	2.9	3.1	0.3	-0.9	1.5	-1.9	2.6
1955-65	9.1	2.1	6.9	2.9	2.0	0.0	3.4	1.4	0.9
1965-70	16.3	4.3	11.5	4.2	3.2	-0.3	8.8	4.6	-1.0
1970-75	16.5	6.8	9.1	0.0	4.1	1.1	10.9	2.8	-1.3
1975-79	14.6	7.0	7.1	2.1	3.0	0.8	6.1	-0.6	1.6
1955-79	13.0	4.3	8.3	2.4	2.8	0.3	6.5	2.0	0.2

*CPI; Boston; Urban Wage Earners and Clerical Workers

TABLE 2 - CONTRIBUTION OF EACH COMPONENT TO TOTAL INCREASE IN COST PER CAPITA

	(1)	(2)	(3)	(4)	(5)	(6)
	Contribution to Increase in Cost per Capita of:					
	Annual Earnings per FTE (Constant $)	FTE's per Patient Day	Non-Labor Price per Input (Constant $)	Non-Labor Inputs per Patient Day	Admissions per 1,000	Average Length of Stay
1955-60	1.5%	1.4%	0.0%	1.6%	4.0%	-1.1%
1960-65	2.1	1.0	0.0	1.1	-1.0	2.9
1965-70	2.7	2.0	-0.1	3.2	4.6	-1.0
1970-75	0.0	2.6	0.4	4.1	2.8	-1.3
1975-79	1.1	1.6	0.4	2.8	-0.6	1.6
1955-79	1.4	1.7	0.1	2.6	2.0	0.2

TABLE 3 - CONTRIBUTION TO INCREASE IN COST PER CAPITA AS A PERCENTAGE OF TOTAL

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Average Cost per Capita (Constant $)	Annual Earnings per FTE (Constant $)	FTE per Patient Day	Non-Labor Price per Input (Constant $)	Non-Labor Input per Patient Day	Admissions per 1,000	Average Length of Stay
1955-60	100%	20%	19%	0%	22%	54%	-15%
1960-65	100	34	16	0	18	-16	48
1965-70	100	24	17	-1	28	40	-8
1970-75	100	0	30	5	48	32	-15
1975-79	100	16	23	6	41	-9	23
1955-79	100	18	21	1	32	25	3

Table 4. Earnings and Labor Costs

	Average Annual Earnings per FTE Hospital Employee: Maine 1967 Dollars (1)	Average Annual Earnings Production Workers in Manufacturing Industries: Maine 1967 Dollars (2)	Ratio of Column (1) to Column (2) (3)
1955	2834	4004	70.8
1960	3205	4243	75.6
1965	3785	4681	80.9
1970	4640	4842	95.8
1971	4772	4824	98.9
1972	4812	5046	95.4
1973	4702	5088	92.4
1974	4408	4946	89.1
1975	4648	4877	95.3
1976	4638	4945	93.6
1977	4719	5100	92.5
1978	4889	5325	91.9
1979	5042	5320	94.7

B. Causes

The extraordinary increases in the average cost per capita of hospital services described in the previous section did not occur in a vacuum. They represent the accumulated results of public and private sector policies relating to the organization, delivery and payment for hospital care, changes in the composition and expectations of the population served and general movements of the economy. Without attempting to determine their respective contributions to the overall increase in hospital expenditures, we can review some of the major causes and attempt to relate them to the components of hospital expenditures which we would expect them to affect. This discussion is not intended to provide an exhaustive review of the many causes of hospital expenditure increases.[9]

1. Inflation

As we noted in the first part of this section, general inflation, as reflected by changes in the Consumer Price Index (CPI) can account for roughly one-third of the increase in the average cost per capita of hospital services. After adjusting for changes in the CPI, we found that non-labor prices had increased at a negligible rate (0.2%). Inflation in non-labor prices in excess of the CPI accounted for only one percent of the total increase in the average cost per capita.

In contrast, after adjusting for the changes in the CPI, labor prices increased at an average rate of two percent throughout the period. This increase constituted 18 percent of the increase in the average cost per capita. These increases in labor and non-labor prices are consistent with the higher skill levels which may be required by the advancements in technology which we discuss next as one aspect of changes in "intensity."

2. Intensity

The increase in labor and non-labor resources is the largest contributor (53%) to the increase in the average cost per capita. These increases in "intensity" or "service intensity" include both the number and skill levels of employees and the number of services used per admission or per day. The increase is consistent with the effects of a number of the major forces affecting hospital care over the last 25 years.

First, since the 1950's the Federal Government has made substantial investments in research and in hospital construction programs. The results have been a flood of technological advancements and a significant increase in the number of beds. For example, the number of beds in Maine increased 83 percent between 1955 and 1980, while the population increased about 22 percent.

New technology can improve the quality of hospital services. To the extent that new technology is purchased by hospitals, however, it can also contribute to increased hospital expenditures. The retrospective reimbursement system, adopted as the payment approach by Medicare, Medicaid and many Blue Cross plans, provided the money and the incentives to purchase this new technology.[10] Under this approach hospitals were reimbursed for the allowable costs of the services which they provided. The costs of the new technology and the increased number of employees which might be associated with it were accepted as allowable costs.

In an industry with price competition, the rate of acquisition of new equipment and the growth in the number of employees would be moderated by normal market pressures. Price competition, however, is not a notable feature of the hospital industry. The industry is not wholly without competition. Hospitals sometimes compete for physicians or for a market share of services through the purchase of equipment. This kind of competition may or may not contribute to the most efficient provision of services.

Second, during the last 25 years the case mix of hospitals has changed significantly. For example, we are aging as a society and we may be subject to more episodes requiring hospitalization than earlier generations. It is no longer uncommon for a person to survive several near fatal episodes and each of these will involve a substantial amount of the labor and non-labor resources of a hospital.

Third, decisions to increase intensity may not always reflect the most efficient approach to providing hospital services. As described earlier, the rapid and sustained expansion of labor and non-labor resources was encouraged by a payment system which assured the hospital of reimbursement. The industry does not exhibit market forces which would act as incentives to efficient growth. Given these two features, it is unlikely that all increases in intensity are justified by corresponding increases in efficiency.

3. Volume

The expansion of beds described earlier has been accompanied by a major increase in the volume of services provided. As noted in the previous section, the growth in admissions contributed about 25 percent of the increase in the average cost per patient day between 1955 and 1979. This increase in admissions is consistent with other changes which occurred during the period.

First, the Medicare and Medicaid programs have improved access to hospital services since their inception in 1966 and the aging of the population has compounded the impact of the increased access due to Medicare. Similarly, access has also expanded with increased participation in Blue Cross plans and the growth in coverage by commercial insurance. In 1950 public and private insurance programs paid roughly 50 percent of all hospital costs. By 1979, their share had increased to more than 90 percent.

Federal and state tax laws have provided a strong incentive for the purchase of medical care insurance as a fringe benefit. To the extent that increased insurance contributes to growth in the demand for hospital services, the tax law subsidy can be considered as a factor in the increased volume of services provided.

Second, medical schools have expanded significantly in the past twenty years. Greater numbers of doctors are available to deal with increases in the demand for hospital services associated with expanded insurance coverage and bed access.

Third, some of the ways people choose to live and the environments in which they live also contribute to the increased volume of hospital services. Behaviors or conditions with clearly associated health risks such as smoking, alcohol or drug abuse, poor nutrition, and obesity bear directly on the overall rise in the demand for hospital services.

4. Summary

The average cost per capita of hospital care in Maine between 1955 and 1979 has increased significantly faster than the general price level of the economy as expressed by the Consumer Price Index. The average annual rate of increase in the cost per capita exceeded the average annual rate of increase in the CPI by an average of 8.3 percentage points in each year during the entire period. (Table 1, columns 1, 2 and 3)

Fifty-three percent (53%) of this 8.3 percent excess over the increase in the CPI is attributable to increases in labor and non-labor inputs per patient day. (Table 3, columns 3 and 5) Another 25 percent is attributable to an increase in the number of hospital admissions per capita. (Table 3, column 6)

Increases in hospital employee earnings contribute on the average an additional 18 percent to the overall increase in the average cost per capita. (Table 3, column 2)

Throughout most of the period, hospital employee earnings have increased faster than both the general price level and the earnings of production workers. The difference between hospital employee wage increases and those of production workers, however, is responsible for a small and diminishing portion of the overall increase in the average cost per capita.

Public and private policies to expand the availability of hospital resources, lower financial barriers to receiving hospital services and improve the quality of these services have been major factors contributing to the rapid rise in hospital expenditures. Other important factors have been the changes in the age composition and the expectations of the population, trends in the general level of prices and individual behavior which has clearly associated health risks.

Some of these factors contributing to the increase in hospital expenditures are structural in nature. We examine one of these, the current financing system, in the next section.

FOOTNOTES

1. The data on Maine hospitals is derived from the American Hospital Association's annual publication "Hospital Statistics." Population data is from the Maine State Planning Office and the Division of Research and Vital Records of the Department of Human Services. The wage data for production workers is from the Division of Manpower Research of the Department of Manpower Affairs. The components which are boxed are those which are not broken down further.

2. The derivation of data displayed in this section is provided in Appendix C of this report.

3. Total Hospital expenditures increased from $13.867 million in 1955 to $312.857 million in 1979, a total increase of 2156% or an average compound annual rate of 13.9%.

4. Unless otherwise indicated, all rates in this paper will be average compound annual rates.

5. The use of the Consumer Price Index (CPI) in this section is not prescriptive; i.e., there is no implication about what relationship (whether equal to, less or greater than) the increases in hospital costs should bear to increases in the CPI. The CPI is used simply as an indicator of the changes in the general price level of the economy. No CPI is computed exclusively for either Maine or northern New England. Therefore, the Boston CPI has been used throughout this section.

6. "Patient days," have been used throughout this section. Since some costs are incurred to provide outpatient services, dividing any costs by inpatient days necessarily overstates the actual cost of inpatient care. The American Hospital Association has developed another unit, the adjusted inpatient day or the inpatient day equivalent, which is an attempt to reflect both the number of inpatient days and the volume of outpatient services. Dividing costs by adjusted patient days (inpatient day equivalents) has the effect of removing the costs of outpatient services and providing a measure of inpatient services only. This section focuses on rates of changes in total expenditures. Since the rates of change in adjusted patient days are similar to those of patient days (roughly 0.6% difference for the 1972-80 period) and since patient day data is available for the entire period (adjusted patient day data is available only after 1970), we have used patient days throughout.

7. Since 1955, total FTE's have increased about fourfold from 3,824 to 15,087.

8. The term "non-labor inputs" refers to all those resources other than labor which are used in the provision of hospital services. These include supplies, equipment, drugs, buildings and numerous others.

9. Other causes include the shift from internal funds to borrowing as the source of money for equipment and buildings, the increased costs of malpractice, changing public expections about the quality and availability of hospital services and laws or regulations (e.g., the minimum wage law).

10. A discussion of some of the weaknesses of the retrospective reimbursement system is included in section 3.

III. Current Financing System

Hospitals are usually viewed almost exclusively as basic providers of health services. They are also, however, businesses. The community[1] provides funds to hospitals in payment for services and, in turn, hospitals make payments to their suppliers.[2] The community includes the following payment sources:

1. Patients
   - A. Self pay
   - B. Third-parties[3]
     1. Medicare
     2. Medicaid
     3. Blue Cross (BCBS)
   - C. Commercial insurance
   - D. Other (including other insurance programs)

II. Other
   - A. Contributions (and income from contributions)
   - B. Grants
   - C. Investment and interest income
   - D. Miscellaneous; including such sources as hospital enterprises (e.g., coffee shops) and the sale of items by hospitals (e.g. silver).

1. Sources of revenue

The largest source of revenue for Maine hospitals is payments for services provided to patients. Payments from third-parties account for roughly 75 percent of this patient revenue and most of the remaining 25 percent is derived from the payments from patients with commercial insurance and self-pay patients.

In addition to patient revenue, Maine hospitals receive funds from individuals, foundations and corporations in the form of contributions and earn interest income on these contributions. Although in many cases the sum of contributions and interest may be small relative to the total amount of patient revenue, these funds can nevertheless be significant. For some hospitals, contributions and income earned on them may represent the difference between net income and net loss.

Finally, some Maine hospitals receive funds in the form of grants for patient care, education and research purposes. These grants may be received from individuals, government, foundations or private corporations.

In the long run, a hospital must receive dollar payments from all its revenue sources in an amount at least equal to the dollar payments that it makes to its suppliers. In other words, a hospital must receive total payments that meet its financial requirements.[4] Receiving payments in this amount is a condition of the hospital's continuing financial viability.

2. Sources of patient revenue

Since it is by far the largest source of total hospital revenue, patient revenue and the payment systems through which it is provided will be the focus of the balance of this section. On the average, revenue from services to patients is 90 percent or more of total revenue for Maine hospitals. The proportion of patient revenue from each payment source, the payment system used by each of these sources and the interaction of these payment systems have a substantial effect on the financial viability of Maine hospitals and any efforts to restrain increases in hospital costs.

Presently, Maine hospitals receive patient revenue through several different payment systems. Patients insured with commercial insurance companies and self-pay patients are expected to pay hospital charges, the prices which a hospital sets for its services.[5] The Medicare and Medicaid programs pay hospitals on the basis of the costs which hospitals incur in providing care to the beneficiaries of these programs. Each program defines in regulation which costs may be reimbursed as allowable costs. BCBS, the other major source of patient revenue for Maine hospitals, also pays for patient services on the basis of costs. The payment principles for this method are established in a contract between hospitals and BCBS. Under this contract BCBS payments cover some items which are not included by the Medicare and Medicaid payment systems and provide additional amounts to

hospitals for achieving certain goals which BCBS has identified as contributing to restraining cost increases.

The Medicare and Medicaid programs provide roughly fifty percent (50%) and BCBS pays roughly twenty-five percent (25%) of patient revenue. The remaining twenty-five percent (25%) is derived mainly from commercial insurance, self-pay patients and other small non-commercial insurance programs.

3. Retrospective payment systems

The current payment systems which have a cost or cost-plus basis are also referred to as retrospective cost reimbursement. Under a retrospective cost reimbursement approach, a hospital can expect to receive total payments which reflect the allowable costs which it has incurred in providing care. During the payment period, a hospital receives payments at an interim rate. At the end of the period, the hospital's allowable costs of providing care are computed and an adjustment is made to ensure that the total payments received are consistent with the total costs incurred. The methods of determining allowable costs, the rates of payment and the final adjustments are specified in detailed regulations in the case of Medicare and Medicaid and in contract provisions in the case of BCBS.

Retrospective cost reimbursement was developed as a response to two problems. A growing number of patients faced financial hardship in trying to pay for their hospital care and, as a result, many hospitals were experiencing an increase in the amount of money owed to them. The retrospective cost reimbursement systems offered hospitals the assurance that they would receive payment for their costs in providing care and guaranteed patients access to services as well as a way of paying their bills.

When the Medicare and Medicaid programs were initiated in 1966, their payment systems were based on the retrospective cost reimbursement approach. The dramatic increase in access to hospital services associated with the establishment of these two programs was fueled by substantial increases in funds provided

through retrospective cost reimbursement. If measured exclusively against the goal of increased access to hospital care, these cost-based systems can be seen as successful. Due to the way they have been implemented, however, these cost-based systems have been less successful in addressing the goal of improving the financial stability of hospitals. We describe this shortcoming later in this section.

When measured against a wholly different set of goals, the current cost-based payment systems seem even less desirable. For example, retrospective cost reimbursement implied that hospitals should provide whatever care was reasonable and expect to be paid for it. As such, the system contained unmistakable incentives to spend and lacked incentives to control costs. Increased expenditures were rewarded by increased reimbursements while increased efficiency was not rewarded at all. As the costs of hospital care have increased at rates far exceeding the rise in general prices,[6] retrospective cost reimbursement has been generally accepted as a significant contributing cause of this inflation. If one goal of any payment system should be the encouragement of appropriate and responsible levels of spending for hospital services, the absence of any financial incentive to control costs can be considered as a major defect of retrospective cost reimbursement.

The current retrospective cost reimbursement systems can be faulted not only for their inherent lack of incentives to restrain expenditure increases but also for the way the systems have been implemented. A brief description of each payment system will illustrate this second serious flaw.

4. Medicare and Medicaid

The Medicare program provides payments to hospitals on the basis of the reasonable costs of those services which satisfy two conditions. The services must be covered by the program and they must be related to the patient care of Medicare beneficiaries. The term "reasonable cost" is defined as the costs actually incurred by the hospital, excluding any amount found by Medicare to be unnecessary

to the efficient delivery of needed health services. Two other qualifications are necessary. First, since 1974 the Medicare program has included a limit on the payment for the costs of routine services. Second, Medicare payments are limited to the lesser of the hospital's total charges or its allowable costs in the aggregate.

In Maine, payments under the Medicaid program are based on the costs actually incurred by hospitals. With a few exceptions, related primarily to the different populations served by the two programs, Medicare principles of reimbursement are also used by the Medicaid program.

5. Blue Cross Blue Shield of Maine (BCBS)

The BCBS payment system is also based on the Medicare definitions of allowable costs. The BCBS system, however, adds to Medicare's allowable costs several other payment categories. The system provides an additional four percent of BCBS costs in recognition of a hospital's capital requirements and roughly another 1.5 percent as a contribution to the hospital's bad debts. Another feature of the system is the provision of a payment floor for inpatient services. Presently, payments for inpatient services are the lesser of costs or charges but payments may not be less than 84 percent of the charges for covered services.

In addition to these payments in excess of Medicare's allowable costs, the BCBS system includes four other features which may result in further payments. These additional payments are made as rewards when a hospital achieves the objectives tied to each of them. First, hospitals can qualify for an additional one percent by voluntarily limiting the increase in their per day costs to an average of roughly 12 percent per year for a three year period. Second, hospitals can receive one percent of Blue Cross costs by voluntarily reducing the number of licensed beds. Third, maintaining the same ratio of full-time employees per adjusted average patient day as in the previous fiscal year is worth an additional

one-half percent. Finally, if a hospital funds depreciation it may receive an added one-half percent through the BCBS system.

6. Cost shifting

For most Maine hospitals the sum of reasonable costs as defined in the Medicare principles of reimbursement does not equal the hospital's financial requirements. For example, uninsured patients are the primary source of bad debts for hospitals and Medicare does not include the cost of bad debts attributable to non-Medicare beneficiaries as an allowable cost. Similarly, the Medicare payment system does not provide funds for initial capital expenditures or for increases in working capital which may be needed in order to avoid short term borrowing.

Hospitals compensate for shortfalls from one payment source by increasing the payment share from other sources. For example, since the costs of the bad debts of non-Medicare beneficiaries are not provided under the Medicare payment system, these costs would be shifted to the Blue Cross and commercial insurance payment systems. Similarly, to the extent that the Blue Cross system may not provide for hospitals' financial requirements, these costs would be shifted primarily to commercial insurance payers.

Patients with commercial insurance are expected to pay the hospital's charges, i.e. the prices it sets for its services. Commercial insurance policies, however, often do not cover full charges, e.g. these policies usually include deductibles and may not cover all services provided. If patients do not pay the balance caused by these features of commercial insurance policies, the shortfalls are made up through increased charges for all commercially insured and self-pay patients.

The cost shifting caused by the shortfalls from one or more payment sources, then, force hospital charges to rise, independent of any change in the rate of increase in hospital costs. As the proportion of hospitals' patients covered by the

current retrospective cost-based payment systems grows larger, the gap can widen between the rate of increase in charges and in costs.

Presently, Maine hospitals in the aggregate receive roughly 75 percent of their revenue through retrospective cost-based payment systems. Since only 25 percent of revenue is derived from charge paying patients, hospitals must increase prices by four dollars in order to realize one additional dollar of revenue. If the proportion of charge paying patients declines, the burden of the price rises caused by this cost shifting only increases.

The financial viability of a hospital depends on its obtaining its financial requirements. In turn, a hospital's success in realizing its financial requirements depends on having a base of charge payers to compensate for the shortfalls attributable to other payment sources. Ironically, then, although retrospective cost reimbursement was developed in part to improve the financial viability of hosptials, the way it has been implemented can actually threaten that financial viability.

7. Retrospective payment of charges

Other than retrospective cost reimbursement, the other major type of payment system currently used in Maine is a method based on a hospital's charges. Patients with commercial insurance and self-pay patients are expected to pay the charges set by hospitals. Unfortunately, this uncontrolled charge based system contains even fewer incentives to control costs than retrospective cost reimbursement. The continued or expanded use of an uncontrolled charge based payment system will not contribute to the encouragement of appropriate and responsible levels of spending for hospital services.

8. Summary

None of the present payment methods for hospital services contain adequate incentives or other characteristics which can be expected to slow the rate of

expenditure increases. In addition, the way in which retrospective cost reimbursement has been implemented results in a lack of equity among payers and a potential threat to the long term financial viability of hospitals.[7] Substantial changes in these present payment systems are needed.

In the next section we assess the present voluntary budget review program. This program operates independently of the present payment systems for hospital services. If increases in hospital expenditures are in part associated with structural defects in these systems, the budget review program may be operating with built in limitations. We examine this issue as part of the discussion of the budget review program.

FOOTNOTES

1. As used here, the term "community" has no geographic connotations. It is used simply to indicate the overall source of hospital revenues.

2. As used here, the term "suppliers" is intended to include the following: employees, equipment, contractors, consumable supplies and lenders.

3. The term "third-party payers" refers to programs which contract with both the consumers of hospital care and with hospitals to guarantee payment for hospital services. Blue Cross plans, Medicare and Medicaid are third-party payers.

4. The concept of "full financial requirements" is the subject of continuing debate between payers and providers of hospital services. We have deliberately intended to avoid this controversy by using the non-technical phrase "financial requirements" throughout this section.

5. Medicare, Medicaid and BCBS also pay hospital charges when these charges are lower than the hospital's allowable costs for the services provided.

6. As measured by the consumer price index and other standard indicators.

7. In pointing out this potential threat to the long-term financial viability of hospitals, we are not making any judgment about the present financial viability of Maine hospitals. We have not completed an analysis of their present financial condition. One measure of financial viability, however, is the level of hospitals' operating margin. Data from the first budget review cycle shows that the level of operating margin for 34 hospitals in the aggregate improved somewhat during this period. Operating margin rose from 1 percent to 1.4 percent, an increase representing roughly $1.8 million. We recognize that the level of operating margin is not necessarily an indication of whether a hospital is meeting its financial requirements.

IV. Voluntary Budget Review Program

1. Present program

The Health Facilities Information Disclosure Act requires each Maine hospital to submit its budget annually for review and comment to either the Health Facilities Cost Review Board or a voluntary budget review organization. The program is mandatory in the sense that all hospitals are required to participate, and voluntary in the sense that no hospital is required to abide by any comments made on its budget. Under this law the Board is authorized to approve, set performance standards for and withdraw approval of any voluntary budget review organization. The law defines a voluntary budget review organization, generally, as a nonprofit organization established to conduct reviews of hospital budgets and it establishes certain requirements for the budget review panel of such an organization.

The concept of a voluntary budget review program, as provided in the law, was strongly supported by Maine hospitals. Hospitals saw the program as an opportunity to demonstrate that self-regulation, within the framework of a review of their budgets by an external private organization, could moderate further increases in hospital expenditures.[1] If successful, it might, therefore, provide a practical alternative to greater public regulation.

The Board approved the Voluntary Budget Review Organization of Maine (VBRO) in April of 1979 and the first budget review cycle began for hospitals with fiscal years beginning on or after July 1, 1979 and before June 30, 1980. Forty-five of the forty-nine Maine hospitals submitted their budgets to the VBRO during the first budget review cycle. In the second cycle 45 out of 47 submitted budgets and in the current third cycle, all forty-six hospitals are submitting their budgets to the VBRO.[2]

2. Study approach

Maine hospitals do not operate in accordance with a uniform fiscal year and, as we discuss later, the absence of a uniform fiscal year creates problems for a budget review program. Staggered fiscal years also imposed certain limits on our study. The first budget review cycle covered fiscal years beginning between July 1, 1979 and June 30, 1980. Hospitals with fiscal years beginning in the spring of 1980, then, have actual year end data only for this first cycle. In contrast, hospitals with fiscal years beginning in July have already completed the second cycle. As a result of this disparity in fiscal years, our assessment of VBRO influence on actual outcomes must focus exclusively on the single year covered by the first budget review cycle.

Limiting the outcome assessment portion of the study to the first budget cycle raises two further issues. First, the availability of only a single year of data reflecting both budget reviews and actual outcomes restricts our ability to construct, statistically, a set of predicted outcome measures which would suggest how the data might look if the VBRO review had not occurred. Second, both intuition and empirical studies suggest that even in very stringent cost control programs, the introduction of the program may not be followed by immediate changes in hospital operating or financial performance. While mandatory programs can limit the flow of revenue immediately, the cost containment or efficiency promoting objectives require a corresponding reduction in expenditures on the part of the hospital. Unfortunately, hospital managers are not always able to reduce instantly the rate of expenditures. A lag occurs because of the need to make changes in hospital policies, staffing patterns, suppliers and other factors. The result is that the full effect of external controls or reviews on financial and operating statistics may not be apparent in the first year or two of a program. Therefore, it may be difficult in some cases to distinguish easily between an ineffective program and one that is beginning to cause desirable changes in hospital behavior.

To address these two issues, we attempted to isolate the effects of the VBRO by first identifying those areas of performance, types of hospital circumstances and the corresponding forms of VBRO scrutiny where the effects, if any, are most likely to appear. We then examined the budget review process in order to establish the nature of the incentives and the data patterns which would be expected if VBRO were being effective. Finally, we reviewed the trends in hospital performance during the first budget cycle and determined the nature of and the extent to which budgeted performance and actual year-end experience were consistent.

We acknowledge and accept the limitations created by the fact that data from only one complete budget review cycle can be examined. We believe, however, that an analysis of this data is useful and significant and that it supports our ultimate recommendations. Budgeted data is available for the complete second cycle and more than one-half of the third cycle. This data provides a sufficient base for an evaluation of the process. Similarly, the available data from the completed first cycle is sufficient as the basis for conclusions about the influence of the VBRO on hospitals' year end compliance with their budgets. We are satisfied, therefore, that the approach used in this study permits a careful and informative assessment of the VBRO.[3]

3. Process

(a) Information system

The VBRO has implemented a sound and manageable information system for presenting the prior, current and budget year data of Maine hospitals. The system generates summaries of statistical, financial and operating data from individual hospitals as well as reports featuring a variety of performance measures and target values for hospital peer groups. In contrast to programs in several other states, the VBRO has used the system, not simply as part of the annual budget review process,

but also as the basis for periodic reports to hospitals throughout the year.

This type of system is an essential building block for any hospital cost containment program. Some programs in other states have encountered major problems by attempting to carry out budget reviews or rate-setting without adequate uniform information systems.

The VBRO system seems to have been especially helpful to medium and small size hospitals which may not have sufficient staff to prepare such reports. Because of the required submission of budgets for review, the system has been used by many smaller hospitals to initiate or significantly improve their budget preparation process. A survey of hospitals indicated that many hospitals would welcome additional data from the VBRO.

(b) Review by exception

The VBRO reviews hospital budgets "by exception," i.e., hospital budgets are screened against a set of performance measures and only those failing to satisfy the screens receive a detailed budget review. If the screens select the budgets most likely to be unreasonable, this approach is an efficient way to allocate staff resources.

A review of 34 hospital budgets submitted during both the first and second budget review cycles shows that 50 of 68 received detailed reviews.[4] The majority of hospitals were reviewed in detail in both years. The detailed review appears to be thoroughly grounded in peer comparisons and conducted in an equitable way.[5]

In order to avoid a detailed review a hospital budget must pass the screens for either revenues or expenses. As a result the system selects for detailed review those hospitals which have higher costs relative to their peers. More than 76 percent of hospital expenses received detailed reviews in both cycles.

The weak compliance incentives which we describe later and the potential for the VBRO to be more influential with smaller hospitals suggests that detailed reviews may yield more economies in smaller hospitals. The data shows, however, that the budgets of smaller hospitals received a smaller share (52%) of detailed reviews than their larger counterparts (84-85%). It is not clear whether the rate of detailed reviews for the smaller hospitals may be too low or the rate for the larger hospitals may be too high.

(c) Weak compliance incentives

Under the present law, the VBRO reviews and comments on the reasonableness of hospital budgets. It has no authority to require compliance with its determinations. Hospitals are neither required to change budgets which are determined to be unreasonable nor to live within budgets which have been found to be reasonable. The payment systems for hospital services operate independently of the budget review system. In other words, payments are neither guaranteed nor jeopardized by any determinations made by the VBRO.

In the absence of mandatory compliance and a link to payment systems, the VBRO impact on costs can occur through three types of accountability:

1. Accountability to the welfare of the institution; by providing information and a kind of consulting service to managers and trustees which help them isolate inefficiencies and develop solutions.

2. Accountability to peers in other institutions; by applying peer pressure to managers and trustees which may incite them to modify behavior.

3. Accountability to the public; by risking public disclosure of noncompliance by the Health Facilities Cost Review Board.

These three mechanisms are considerably weaker than mandatory compliance through direct financial incentives and penalties. We will discuss the actual influence of these weaker compliance mechanisms later in this section.

Another aspect contributing to compliance is the set of expectations which the VBRO process creates for hospitals. Several examples will illustrate the point.

First, while the budget review method appears thorough and based uniformly on peer group comparisons, the policies on financial requirements (relative to the reimbursement policies of most cost-based third party payers and relative to most other formal review programs) and the allowance of more than all of anticipated inflation in the screening process may not impart to hospital managers a sufficient sense of urgency about cost containment. Although providing a hospital's financial requirements is essential, most of the effective cost containment programs exert pressure on either financial requirements or volumes of services in order to encourage management to eliminate inefficiencies.

Second, the VBRO method contains a strong incentive to increase or at the least maintain the current level of admissions. For example, if admissions rise 10 percent, the system permits expenses to rise 10 percent. The true cost of providing services to the 10 percent extra patients, however, is probably less than the average cost. The average cost includes both a fixed and variable component. Because it permits increases in the average cost, rather than solely the variable cost component, the VBRO method can encourage growth in admissions. Most review systems allow additional expenditures or revenue to cover only the variable expenses associated with the increased volume, not the full average cost permitted under the VBRO method.

This approach of treating all costs as variable costs favors growing hospitals over shrinking hospitals. Shrinking hospitals are required to cut costs in proportion to admissions. This approach ignores those fixed costs which a hospital may not be able to reduce in proportion to the decrease in admissions.

Another aspect of this potential incentive to increase admissions is the emphasis which the VBRO places on changes in unit revenues or expenses, rather than on changes in total revenues or expenses. Under the VBRO approach the reasonableness of a budget depends on the revenues or expenses per unit increasing at a rate which either meets the budget screens or is found to be an acceptable variance by the budget review panel. A modest increase in revenues or expenses per unit, however, could occur while total revenues or expenses were rising at an unacceptably rapid rate.

Third, the VBRO does not attempt to determine the reasonableness of the budget base, i.e., the bench mark against which the program will determine the reasonableness of increases. In the absence of this kind of review, hospitals may be permitted to increase reasonably on a very inefficient base.

Fourth, the pattern of adverse findings on budgets may not communicate a sufficiently strong concern about cost containment to induce behavioral changes. During the first budget cycle the budgets of five out of 45 hospitals were found to be unreasonable. During the second cycle four out of 45 hospitals received adverse findings. Expressed in another way, during the first budget review cycle roughly 97 percent of budgeted dollars were reviewed as reasonable. This pattern seems to be changing in the third cycle. More adverse findings are being made.

The screening process, as described earlier, seems to be identifying potential sources of unreasonableness. The budget review panel, however, has not found many hospital budgets to be unreasonable. It is not clear whether the panel is overlooking them, discounting the reasonableness of the screens or placing considerable weight on the hospital's explanation of the variance.

(d) Peer groups

The VBRO groups hospitals based on size, geographic location, a

service costliness index and average length of stay. The budget review process involves a comparison of an individual hospital's values for a set of performance measures with those of its peer group (based on an average of these factors for all hospitals in the group). Because the screens that trigger detailed budget reviews are set on the basis of percentiles for each peer group, some fraction of hospitals in each group must pass or fail the screens. A small fraction of hospital expenses will fail the screens in the smaller groups. A disproportionate amount of staff effort may be devoted to this small fraction which fails the screens in the smaller groups. Forming peer groups of roughly equal size, as measured by total expenses, can address this potential misallocation of staff resources.

A second question relates to whether the groups are truly homogeneous. Peer groups have been formed based on characteristics which were intended to approximate case mix data. Rigorous comparisons of hospitals, however, may require the use of actual case mix data. Maine has available the data base on which case mix comparisons might be made. This further refinement of the program may be necessary if the budget review program becomes the basis for payments to hospitals.

(e) Staggered fiscal years

Although the VBRO information system produces a variety of useful reports for measuring hospital performance, the lack of a common fiscal year for all hospitals may undermine somewhat the comparability of this data. This problem is of special concern because of the use of peer groups for the budget review process. The members of a peer group may have significantly different fiscal years and, as a result, calculating target values for the group becomes difficult.

4. Performance

In the first part of this section we examined the major elements of the VBRO budget process. In this part we describe the extent to which year end compliance with budgets was achieved by hospitals statewide during the first budget cycle and the level of the VBRO's influence on compliance.

(a) Overall compliance

One of the arguments for a budget review program is that it provides a degree of predictability to both payers and hospitals. If the approved budget is linked to the payment system, payers will know at the beginning of each year, with an allowance for small year end adjustments, what their payments will be. Similarly, hospitals will know roughly what financial resources will be available to them for the period. An important test of the success of a budget review program is whether hospitals comply with their budgets. If hospitals fail to live within their budgets, the benefits of predictability are quickly eroded.

As we described in the first part of this section, the present voluntary system is not linked to any payment system. In addition, the VBRO has no authority to require compliance with approved budgets or to bring about changes in budgets found to be unreasonable. The incentives for a hospital to live within its budget are based on the less formal restraints associated with accountability to the hospital, peer hospitals and the public. The extent to which hospitals statewide live within their budgets, therefore, is in part a direct measure of the effectiveness of these informal incentives.

Overall compliance during the first budget review cycle was not encouraging. Ten hospitals stayed within their budgets while twenty-four exceeded them. Overall, the hospitals budgeted an increase of $35 million in revenue and actually experienced an increase of $44 million* This $9 million represents a 3.1 percent excess of actual revenues over budgeted revenues.

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*Operating revenue

Revenue compliance is important for two reasons. First, it represents that aspect of performance which is usually controlled when budget review or rate-setting programs are linked to payment systems; e.g., by controlling revenues, incentives are given to managers to control expenditures. Second, the volatility (or lack of it) of revenues is the focal point of payers' concerns about the predictability of their reimbursement obligations. Based on the first budget cycle data, the budget review process does not seem to be providing any measure of predictability of hospital reimbursement levels.

Using the budgeted levels of operating revenue, expenses per adjusted admission and operating margin as performance measures, we obtained the following results:

1. None of the 34 hospitals were able to stay within budgeted levels for all three measures;

2. 7 hospitals representing 13 percent of all revenue, exceeded all three measures;

3. 10 hospitals, representing 48 percent of all revenue, exceeded the budgeted levels for revenues and expenses;

4. 16 hospitals, representing 63 percent of all revenue exceeded budgeted operating margins;

5. Only 6 hospitals, representing 14 percent of revenue, reached the year end exceeding just one of the measures.

This overall pattern of noncompliance may be due to a variety of factors including: inaccurate predictions of inflation, base year costs or volumes of services provided; errors in estimating labor needs; new costs (not included in the budget) associated with projects receiving Certificates of Need; unanticipated changes in the case mix of patients served by the hospitals; generally unrealistic budget projections; and ineffective management which undermined otherwise sound budgets. Hospitals can control or strongly influence some of these factors while others are clearly beyond the scope of hospital control or direct influence.

In budget review programs which are linked to payment systems, hospitals are at financial risk for failure to comply unless the factors underlying the failure are recognized by the program as justifiable variations from the budget. For example, some programs pay hospitals for the variable costs associated with volume which exceeds budgeted levels.

We examined three factors which might have contributed to the pattern of noncompliance; inaccurate predictions of base year costs, under prediction of inflation and unanticipated increases in volume. In the aggregate, hospitals under-predicted base year costs, an error which would be likely to contribute to non-compliance. The under-prediction was small, however, and was not an important factor in the overall noncompliance. Hospitals as a whole also under-predicted inflation and volume increases. The error in forecasting inflation could contribute to revenues and expenses exceeding budgeted levels. The underestimate of volume, however, should result in values for expenses per adjusted admission which were lower than budget values. Unfortunately, revenues, expenses and expenses per adjusted admission exceeded budgeted levels. Inflation and volume alone, then, cannot account for the overall pattern of noncompliance.

(b) Pattern of compliance; VBRO influence

In any budget review program some hospitals will comply and others will not. At least two critical questions need to be considered relating to compliance. The first concerns the extent of overall compliance and, as we just described, overall compliance was not encouraging. The second question deals with the VBRO influence on compliance, i.e., are there any patterns of compliance that can be related to efforts of the VBRO.

To address this second question, we grouped hospitals by characteristics which relate to VBRO activity. By comparing the patterns of compliance of these

groups with those of other groups less likely to show VBRO influence, we can establish whether patterns of compliance exist which are consistent with VBRO influence. For example, hospitals which received detailed budget reviews might be expected to be more influenced by the VBRO than hospitals which avoided a detailed review. We can compare the compliance patterns of each group in order to test for this influence.

We grouped hospitals by size, level of budget review, the issue of concern expressed at the budget review panel meeting, the type of finding on the budget and a combination of size and level of review. Patterns of compliance were based on the hospital's staying within budgeted levels for total revenue, expenses per adjusted admission and operating margin.

An examination of descriptive data based on these groupings results in the general finding that no pattern of compliance exists at all. Therefore, no pattern exists which is consistent with VBRO influence.

We expected that the budget review process might produce more compliance in smaller hospitals but we found that hospitals did not comply with revenue and expense levels regardless of size. Similarly, we expected that receiving a detailed budget review might be an indicator of compliance but hospitals did not meet their budgeted level of expenses regardless of whether they had received a detailed review. We examined the data for patterns of compliance relating to the issues identified by the budget review panel at the hearing. These included financial need, efficiency, other issues and no issue. We found no pattern of compliance relating to these issues. Finally, the type of finding on a budget did not show any compliance pattern.

The general conclusion from this data is that the budget review process is not exerting any discernible influence on compliance with budgets. This conclusion is consistent with our earlier finding that the present budget review process

has weak compliance incentives. It also suggests that self-restraint based on accountability to the hospital, to peer hospitals and to the public may have serious limits as an incentive to control increases in hospital expenditures.

5. Summary

The VBRO process is based on a sound information system and an approach to budget reviews (review by exception) which encourages an efficient use of staff time. The present law leaves the budget review process without strong compliance incentives. The process is also weak in the expectations it may create for hospitals. For instance, the system contains incentives to increase admissions; emphasis is placed on changes in the revenues or expenses per unit, not on changes in total revenues or expenses; base year budget reviews are not carried out; and the budget review panel has issued only a small number of adverse findings even though a significant number of hospitals received detailed reviews after failing to pass the budget screens. The law requires determinations of payer equity but does not provide the budget review process with a mechanism for dealing with it. Finally, a standard fiscal year would improve the comparability of data, as would a peer grouping method which is based on case mix.

During the first budget review cycle hospitals exceeded budgeted levels of total revenue by 3.1 percent or $9 million.* Based on three dimensions of compliance (revenue, cost per case and operating margin), none of the hospitals complied in all three areas and 82 percent (representing 86% of revenue) did not comply in two areas.

The budget review process did not provide any degree of predictability to levels of revenues and expenses. An attempt to study patterns of compliance (by hospital size, type of budget review, type of VBRO finding, and principal issue) did not reveal any influence of the budget review process on compliance. A major limitation on the effectiveness of the budget review process seems to be the lack of stronger incentives for compliance.

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*Operating revenue

FOOTNOTES

1. The statutory authorization for a voluntary budget review program was of interest to Maine hospitals for at least two other significant reasons. First, when the law was enacted in 1978, Congress was considering the Carter Administration's hospital cost containment bill, legislation which was strongly opposed by the hospital industry. It was assumed that any federal law would contain waivers for states with existing cost containment programs. The creation of the voluntary budget review program was expected to justify a waiver for Maine. Second, Maine hospitals also viewed the voluntary budget review program as the administrative mechanism for implementing a new payment system with BCBS.

2. Since the first budget cycle, several hospitals have either closed or merged with other hospitals.

3. The Board contracted with Abt Associates, a consulting firm located in Cambridge, Massachusetts, to carry out an independent analysis of the process and performance of the VBRO. The Board's findings in this section are based in part on this analysis. Copies of the report prepared by Abt for the Board are available upon request.

4. Thirty-four hospitals were selected which had filed year end data with the Board for the complete first budget cycle and budgeted data for the second cycle. These hospitals represented about 88.5 percent of total hospital revenue in the year prior to the first cycle.

5. For purposes of making comparative assessments, the VBRO clusters hospitals in peer groups based on size, geographic location, a service costliness index and average length of stay.

V. Alternatives

The voluntary budget review program, as described in the previous section, is one of a variety of responses by public and private agencies to the rapid increase in hospital expenditures during the past two decades. In this section we outline some of the major characteristics of these programs, describe their evolution in recent years and indicate some of the common features of the more successful programs.

1. Prospective reimbursement

The principal alternative to retrospective cost or charge based reimbursement, as described in section 3, is a prospective reimbursement or prospective payment system.[1] Prospective reimbursement is a method of paying hospitals according to pre-established rates of payment for fixed periods of time regardless of the actual costs incurred by the hospitals.

This approach addresses the central defect of the retrospective cost based payment system, the lack of any financial incentive for hospitals to attempt to control costs. Because the payment amount or rate is set in advance and because hospitals cannot change this amount or rate, prospective reimbursement shifts to the hospital some of the risks for costs incurred during the payment period. The hospital has a financial incentive to control its costs, to plan carefully all of its expenditures and to monitor closely the cost implications of the quantity, quality and scope of its services. If the hospital lives within the agreed upon payment amount or rate, it may generate a surplus. If it does not, the hospital may find itself operating at a loss.

In addition to the financial incentive to control costs, prospective reimbursement has other appealing features. First, for hospitals, the system offers

stability and the preservation of management autonomy. Since the level of payments is agreed upon in advance, the hospital will not face the possibility of a year end adjustment, common to retrospective payment programs, which may cause a denial of a portion of the payments. In this way management is encouraged to make those decisions which may result in a surplus. Second, to the extent that the program includes all payers, a measure of equity is assured. In contrast, under the present retrospective payment methods, self-pay patients and patients with commercial insurance may pay more for the same care than a patient covered by Medicare, Medicaid or Blue Cross. Third, since the amount or rate of payment is determined in advance, predictability and accountability are enhanced for the payer and the public in general.

2. Implementation of prospective reimbursement

Prospective reimbursement programs are administered through budget review (or approval) and rate review (or approval) programs. These programs vary in a number of ways including: the reasons for their establishment, general objectives, organizational structure, scope of authority, and methods or procedures.

As part of this study, we heard presentations describing the programs in Maryland, Rhode Island, Massachusetts and Rochester, New York.[2] These programs were selected because they represented the full diversity of prospective reimbursement programs.

The creation of the Maryland rate-setting program was initiated by Maryland hospitals because of the precarious financial condition of a number of urban hospitals. It is a mandatory program administered by a nine member, part time, independent commission which has the authority to establish hospital charges for all payers, including Medicare and Medicaid.

The Rhode Island program was established at a time when Rhode Island Blue Cross was facing insolvency. In Rhode Island, Blue Cross provides virtually all the non-governmental insurance coverage. The program is mandatory and it is based on negotiations among hospitals, Blue Cross and the State Budget Office, rather than on determinations by a single public or private agency. A maximum statewide revenue amount is established and individual hospitals then negotiate with Blue Cross and the Budget Office for the allocation of the statewide amount.

The Massachusetts program was initiated in response to rapid increases in the cost of the state Medicaid program. A three member full-time commission administers a mandatory program which approves the charges paid by self-pay patients and patients with commercial insurance and is also authorized to approve the Blue Cross contract with hospitals. A second program administered by the Department of Human Services covers the Medicaid program.

In contrast, the Rochester program was initiated by hospitals in the Rochester area. This program is voluntary but it is binding on the hospitals which have agreed to participate. For hospitals in the area, it is an alternative to the New York State rate-setting program. The participating hospitals agree upon a maximum percentage increase in revenue in the aggregate for the year and then allocate this amount among themselves through a board established by the area hospital group. All payers, including Medicare and Medicaid, participate in the program but, unlike Maryland, payer equity is not a feature of the program.

3. Common themes

In reviewing these four programs directly through presentations and in considering several other programs through case studies, a number of common features or general trends seemed to emerge. First as new programs have been

initiated and earlier programs have evolved over the past decade, there has been a general trend away from privately sponsored voluntary efforts and toward publicly administered mandatory programs. This trend has been in response to a desire for greater stringency and predictability in the programs. Second, the scope of payer coverage has tended to expand from one or two payers to all classes of payers. This movement is in response to the potential for cost shifting described in section 3. Third, in recent years, budget or rate review programs have established increasingly formal connections with Certificate of Need (CN) programs.[3] In several states poor coordination between these two programs undermined the efforts of both programs, as CN approved projects failed to be accepted for purposes of budget review or budget review limits were ignored by CN agencies. For similar reasons, budget review programs have become increasingly concerned about utilization restraints and the lack of coordination between utilization review and budget review programs. The response has been the development of a variety of coordination procedures. Fourth, programs have moved away from limits exclusively on unit prices or price increases to limits on total revenue. Similarly, they have evolved from annual budget reviews for individual hospitals toward formula based approaches which involve reviews only by exception. Fifth, as programs have become more sophisticated, they have attempted to improve equity to both providers and payers by recognizing case mix differences among hospitals as part of the review process.

In contrast to these common themes, no single organizational structure seems to be critical to the success of budget or rate review programs. The structure of different programs, whether it is an independent commission, state agency, or public and private combination, seems to be mainly a function of the local circumstances of their creation. The characteristics which seem to be a better

guide to the stringency and equity of the programs are features such as: complete payer coverage; mandatory compliance; broad discretion in defining, with the cooperation of all interested parties, operating procedures and key concepts such as financial requirements; authority to specify reporting and accounting procedures; and significant coordination with other regulatory activities such as the Certificate of Need and utilization review programs.

4. Performance of prospective reimbursement programs

Both mandatory and voluntary programs have demonstrated a capacity to moderate hospital expenditure increases. Mandatory programs, however, have been more successful.[4] These programs have demonstrated a capacity to exert a downward influence on annual rates of increase in hospital expenditures and to bring about a convergence of these expenditure rates and the annual rates of inflation for all consumer goods and services.

The following table indicates the comparative performance of Maine and several other states with mandatory programs between 1972 and 1980. The regulated states include Massachusetts, Maryland and Connecticut.

	Maine	Regulated States
% Increase in Expenses per/Capita	221.9	152.6
% Increase in Expenses per/Admission	207.5	149.1
% Increase in FTE's/per Day	26.3	19.6
% Increase in Payroll/FTE	114.3	84.3

5. Summary

Prospective reimbursement offers an alternative which addresses the major structural weaknesses of the current payment system for hospital services. A

prospective reimbursement system gives hospitals financial incentives to restrain expenditures. It also preserves management autonomy, rewards better hospital management, and provides a degree of predictability to both hospitals and payers.

Budget or rate review programs vary in the reasons for their establishment, scope of authority, organizational structure, general objectives and methods or procedures. The more successful programs share features such as: complete payer coverage; mandatory compliance; discretion in defining procedures with involvement by all interested parties; the authority to require uniform accounting and reporting; and significant coordination with Certificate of Need and utilization review efforts. Mandatory programs which are linked to prospective reimbursement programs have been more successful than voluntary programs in moderating expenditure increases.

FOOTNOTES

1. Several other types of programs also focus on cost containment but do not directly monitor or regulate hospital prices or costs. These include Certificate of Need programs and utilization review efforts.

2. A description of the study process is included in Appendix B.

3. Certificate of Need programs require health facilities, including hospitals, to receive a review and approval (in Maine by the Department of Human Services) prior to initiating new health services. The purposes of these programs are generally to promote effective health planning, to ensure an orderly development of health facilities and services and to avoid the costs associated with unnecessary duplication of facilities and services.

4. "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures," Abt Associates Inc., National Hospital Rate-Setting Study; Health Care Financing Administration Review, January 1981.

VI. Recommendations

During the past 25 years enormous progress has been made in the availability, access to and quality of hospital services in Maine. The data presented earlier in this report, however, shows that this progress has been achieved at a staggering cost.

The challenge for the future will be to preserve the gains and continue the progress within the context of more limited economic resources. We believe that the recommendations that follow contain the outline of a comprehensive program which can begin to meet this challenge.

This kind of program should be developed against the background of a set of general objectives. We used the following objectives as the framework for our recommendations:

1. A hospital payment system should:
   a. Encourage the most efficient use of resources in providing hospital services;
   b. Provide predictability in payment amounts for payers, providers and patients;
   c. Assure accountability to the public;
   d. Create equity among payers; and
   e. Preserve the financial viability of Maine's hospital system.
2. Programs of budget review (operating expenses), Certificate of Need (capital expansion), utilization review (volume of services) and appropriateness review (types of services) should be coordinated as a single cost containment program.

These recommendations require legislation and we are preparing a bill for submission to Governor Brennan for his consideration. We believe that the most effective way to implement these recommendations is by extending and amending the Health Facilities Information Disclosure Act. Our recommendations fall into three general categories, as follows.

1. Prospective payment system. We recommend the establishment of a prospective payment system for hospital services.

The present payment systems for hospital services do not contain incentives or other characteristics which can be expected to moderate the rate of hospital expenditure increases. The present voluntary budget review program includes only weak incentives for compliance with the findings of individual hospital budget reviews. Mandatory prospective payment systems in other states have demonstrated a capacity to restrain the rate of increase in hospital expenditures. Hospital expenditures in Maine are increasing at rates which are greater than those in several states with prospective payment programs. For all of these reasons, we believe that a prospective payment program can encourage the most efficient use of resources for the provision of hospital services in Maine.

Participation in this payment system should be mandatory for both hospitals and payers. The system should provide for the financial requirements of hospitals and, in turn, the financial resources of hospitals should be available to offset these requirements. The concepts of financial requirements and resources would be defined in the implementation of the prospective payment system.

(a) Equity

All payers should be required to pay the same amounts for the same services except when different payment amounts can be justified, based on documented quantifiable differences among the payers.

We recognize that the Medicare and Medicaid programs are required by law to pay in accordance with their own payment systems. Congress has enacted legislation which authorizes waivers from these requirements, however, and the Department of Health and Human Services has granted such waivers for participation in prospective payment programs in several other states. As part of the implementation process for the prospective payment system for hospital services, waivers

from Medicare and Medicaid requirements should be sought. We also strongly urge that the State, as the administrator of the Medicaid program, should become a full participant in this prospective reimbursement system.

(b) General governance structure

The system should be administered through a two level governance structure. A public body should establish annually a statewide maximum revenue authorization for the hospital payment system. Given the experience and involvement of the Health Facilities Cost Review Board with these issues, we recommend that the Board should be continued and charged with the responsibilities described under this recommendation.

The revenue authorization should be calculated to include, but not necessarily be limited to, the following: inflation; projects approved under the Certificate of Need program; changes in volume, intensity, and the age composition of the population and costs associated with regulatory changes. The Board would implement the maximum authorization in such a way as to provide exceptions for appropriate unforeseen circumstances. The Voluntary Budget Review Organization of Maine or a similar body should be authorized to allocate the total revenue authorization among Maine hospitals through a mandatory budget approval program.

(c) Health Facilities Cost Review Board

Under this governance structure, the Board would be authorized to carry out several other responsibilities. It would:

1. Make determinations on appeals from the budget review decisions;

2. Make determinations on any discounts to payers;

3. Continue to perform the oversight role for the Voluntary Budget Review Organization currently carried out under the present law. Specifically, it should be authorized to approve and withdraw approval of the VBRO. In the event of a withdrawal of approval, the Board should be authorized to continue the mandatory budget review program; and

4. Adopt the rules necessary for the implementation of the prospective payment system.

(d) VBRO

The VBRO should be modified to provide for the following:

1. It should be authorized to issue binding determinations on the reasonableness of budgets. These will be the basis of payments to hospitals.

2. All budget review hearings and budget determinations and all information relating to budget reviews should be public, consistent with the Freedom of Access Law and the Administrative Procedures Act.

3. The VBRO should select each public member of its budget review panel from a list of three names for each vacancy submitted by the Board.

4. The VBRO should be required to carry out studies relating to its budget review responsibilities upon request from the Board.

(e) Change in fiscal years

A standardization of hospital fiscal years should be adopted as part of the implementation of the system.

2. Coordination of budget review and Certificate of Need. We recommend that coordination between the budget review and Certificate of Need programs should be mandatory.

The lack of coordination between budget review and Certificate of Need programs in several other states has undermined the objectives of both efforts and has been disruptive for hospitals and payers. In some cases payments for approved projects to hospitals have been reduced or denied in the budget review process and in other cases overall payment limits of the budget review program have been exceeded because projects were granted Certificates of Need without consideration of their impact on the annual aggregate payments to hospitals. Both of these results are undesirable and they can be substantially eliminated through mandatory coordination of the two programs.

3. Coordination of budget review and utilization review. We recommend the establishment of a utilization review program which is coordinated statewide with the budget review efforts.

The utilization review program administered by the Pine Tree Organization for Professional Standards Review was terminated on October 1, 1981, and no program has yet been developed to replace it. Maine is in a unique position to establish a utilization review program which is closely coordinated with the budget review process.

As indicated in section 1, increases in the volume of services provided by Maine hospitals make a substantial contribution to the overall increase in the average cost per capita of hospital services. Public policy has encouraged an increased volume of services by increasing the amount of hospital resources available and easing access to those resources. Public policy will have to address the issue of what kinds of care are appropriate. A first step in this effort is to establish formally the coordination of utilization review and budget review programs.

Coordination between these two programs can assist the budget review effort in its assessment of what will be considered an acceptable increase in the volume of services. Budget review efforts in other states have found that a lack of coordination between utilization review and budget review efforts can erode the effectiveness of the budget review program. The Board should provide the necessary coordination between the budget review and the utilization review programs.

4. Health maintenance measures.

Public and private agencies, hospitals and payers can make important institutional responses to some of the factors influencing hospital expenditure

increases. Hospital cost containment, however, can also be addressed by individuals. As we indicated in section 2, disregard of the health risks clearly associated with behaviors such as smoking, alcohol abuse, and others contribute to the increasing volume of services provided by Maine hospitals. Many of these services might be eliminated if individuals made choices to avoid or reduce some of these activities. A better understanding is needed of the health benefits and health care expenditure savings that can result from health maintenance practices. It is a topic which should be explored further.

5. Conclusion.

The recommendations presented here call for significant structural changes in payment systems for hospital services and for formal coordination of the major cost containment programs. We believe that these recommendations can contribute to the building of a health care system which provides for accountability and predictability in the allocation and use of limited health care resources and for a public determination of the appropriate rate of change of these resources within Maine.

APPENDIX A

Letter from Governor Brennan

STATE OF MAINE
OFFICE OF THE GOVERNOR
AUGUSTA, MAINE
04333

JOSEPH E. BRENNAN
GOVERNOR

May 20, 1981

Mr. David P. Cluchey
Birch Knolls
Cape Elizabeth, Maine 04107

Dear David:

As you know, I am deeply concerned about the continuing significant growth in hospital expenditures. These increases present an added burden to Maine citizens at a time of substantial and unrelieved inflationary pressures from other parts of the economy.

Under the provisions of the Health Facilities Information Disclosure Act, the Board is authorized to monitor the voluntary budget review program, carry out studies to health care cost containment and compile reports based on these studies. The voluntary program is in its third and final year under its present legislative authorization. I believe it is time for a thorough evaluation of the effects of this program and for a careful examination of any available alternatives.

For these reasons I am requesting that the Board immediately initiate a study of the present system of financing hospital services in Maine. I believe that this study should evaluate the present efforts of Maine hospitals to control costs on a voluntary basis and should assess the need for the establishment of a mandatory hospital rate setting program.

The results of the study should be available for consideration during the Second Regular Session of the Legislature. I am asking, therefore, that the Board complete the study and present one with a report and any necessary recommendations by December 1 of this year. These recommendations should describe the structure of any new program or changes in the current system which the Board considers necessary.

This study could have substantial and long lasting effects on the delivery and the financing of hospital services in Maine. For this reason, I would urge you to seek out the views of business, labor, health care providers and other Maine citizens as part of your review process.

I would also encourage you to communicate regularly with the appropriate legislative committees on the progress of the study. The results of the study will be reviewed during the Second Regular Session of the current Legislature. The Legislature should be prepared to deal with any issues which may emerge from the study.

Finally, I am directing Commissioner Petit to make available appropriate resources of the Department of Human Services to assist the Board in its work.

Restraining the growth of hospital expenditures is a troubling and complex problem that is the concern of consumers and providers of care alike. Your work on this study could make a significant contribution to our efforts to address this problem in Maine.

Thank you for your continued cooperation.

Sincerely,

JOSEPH E. BRENNAN
Governor

JEB/gr

APPENDIX B

Description of the Study Process

On May 20 Governor Brennan requested that the Board carry out a study consisting of three major tasks. He asked first that we examine the present system of financing hospital services in Maine. Second, he asked for an evaluation of the current efforts of Maine hospitals to control costs on a voluntary basis. Finally, he asked the Board to examine any available alternatives to the present system and specifically, to assess the need for a mandatory hospital rate setting program. In his letter of May 20, Governor Brennan asked the Board to prepare a report of the results of its study, including any recommendations, and he specified that these recommendations should describe the structure of any new program or changes in the present program which the Board considered necessary.

The Board initiated this study in early June and has held two or three meetings each month since then. This series of meetings has included eight public hearings and several other less formal meetings. The public hearings featured presentations by invited guests as well as discussion periods for further examination of the issues raised in the presentations. The other meetings were devoted to the planning of the later phases of the study, the review of the information which had been presented and the deliberations on the full range of issues identified during the study.

In his letter requesting the study, Governor Brennan urged the Board to seek out the views of persons broadly representative of Maine citizens and to communicate regularly with the Legislature on the progress of the study. In accordance with these suggestions, the Board provided invitations for each of its public hearings to all members of the Legislature, all hospitals and their Boards of Trustees, the major payers of hospital costs, professional associations in the health care field, representatives of business and labor groups and numerous groups and individuals associated with the issues examined in the study.[1]

Although the public hearings featured formal presentations from invited speakers, the Board encouraged everyone attending the hearings to participate in the discussion and question periods which accompanied each presentation. In addition, the Board prepared verbatim transcripts of these meetings and made copies available upon request.

To examine the present system of financing hospital services in Maine, the Board received presentations from Dr. William Cleverley,[2] several representatives of Maine hospitals, Blue Cross and Blue Shield of Maine and the Department of Human Services.

Dr. Cleverley identified some of the general causes of hospital expenditure increases, described the economic environment within which hospitals operate, outlined the major financial requirements of hospitals and suggested a set of criteria for evaluating hospital payment systems. His presentation provided a general framework for the discussion which followed on the financing of hospital services in Maine.

Representatives of three Maine hospitals which were significantly different in size, services and geographic areas served discussed hospital financing in general and some of the problems which were unique to their institutions. Donald McDowell, Executive Vice-President and Treasurer of Maine Medical Center, reviewed some of the major achievements in health care during the last twenty years and pointed out that hospital expenditure increases were in large part the price of these achievements. In addition, Mr. McDowell provided the Board with a description of the budget process at Maine's largest hospital. Warren Kessler, Executive Director of Kennebec Valley Medical Center (KVMC) identified some of the major causes of hospital expenditure increases and illustrated several of these with concrete examples from his KVMC experience. John McCormack, Executive Director of Cary Memorial Hospital, identified a number of problems unique to smaller hospitals

and reminded the Board of the large proportion of hospitals with 50 or less beds in Maine.

To familiarize itself with the several payment systems for hospital services in Maine, the Board heard presentations from Blue Cross/Blue Shield of Maine, representatives of the Maine Hospital Association, and the Department of Human Services.

The Board held two public hearings to discuss the contract between Blue Cross and Blue Shield and Maine hospitals. At the first hearing, Francis Faherty and George Hanson, senior vice-presidents of Blue Cross/Blue Shield of Maine (BCBS) described the payment system which is the basis of the present contract between BCBS and Maine hospitals. Donald McDowell and Eugene Joyner from Maine Medical Center identified some of the strengths and weaknesses of the present BCBS payment system and reviewed the impact of the interaction of several different payment systems for hospital services.

The second hearing was devoted to a discussion of the negotiations on a new contract between BCBS and Maine hospitals. Edward Andrews, M.D., President of the Maine Medical Center described some of the changes in the BCBS payment system which Maine hospitals had identified as desirable. Francis Faherty of BCBS outlined the position taken by BCBS on changes in the present contract.

The Department of Human Services administers the Medicaid program in Maine. Frank McGinty, Deputy Commissioner for Health and Medical Services made a presentation which included a general description of the Medicaid program and the recent federal changes affecting it and an outline of what might be done to make the program more effective.

The Board invited representatives of the Federal Department of Health and Human Services to make a presentation describing the Medicare principles of reim-

bursement. Due to other commitments, Medicare's representative was unable to make a presentation as planned. BCBS administers the major portion of the Medicare program in Maine. The Board was grateful to Philip Harmon, Director of Audit and Reimbursement at BCBS, for agreeing to appear on very short notice to respond to questions about the Medicare payment system.

To evaluate the efforts of Maine hospitals to restrain increases in costs on a voluntary basis, the Board heard presentations by both the Voluntary Budget Review Organization of Maine (VBRO) and the Maine Hospital Association, gathered information directly from individual hospitals and completed an independent analysis of the effects of the present budget review program.

The Board devoted one public hearing exclusively to presentations by representatives of the VBRO. A member of the VBRO board, a budget review panel member, and the VBRO staff provided the Board with information on the background of the VBRO, its budget review procedures, its performance thus far and possible changes in the budget review process. In addition, a hospital chief executive officer and a chief fiscal officer offered their views on the effects of the VBRO.

To assist in the evaluation of the VBRO, the Board retained the services of Abt Associates, a consulting firm located in Cambridge, Massachusetts. Abt Associates has been the principal contractor carrying out the National Hospital Rate-Setting study for the Department of Health and Human Services. This continuing study, launched in 1978, has included individual case studies of the major voluntary and mandatory hospital cost containment programs nationwide. These case studies have traced the origin and development of these programs and have attempted to identify some of their strengths and weaknesses.

Abt has assisted the Board in carrying out three tasks. First, the budget review methods of the VBRO have been examined in order to assess such features as

the incentives for efficiency, the potential for cost containment and the degree of inter-hospital equity inherent in the methods used to review budgets. Second, the actual effect of the VBRO on individual hospital budgets has been analyzed by determining the pattern of variation between budgeted amounts and actual performance for the VBRO members during the first complete budget review cycle. Third, the performance of VBRO hospitals has been compared to hospitals in a number of other states representing the full range of cost containment efforts, including states without programs.

In addition to these efforts to identify the VBRO's contribution to short-term cost containment, the Board has attempted to measure those VBRO effects which may have a less direct but longer term impact on costs. With the assistance of the Social Science Research Institute of the University of Maine at Orono, the board has collected information about the VBRO's effects on the individual hospital's budgeting process, staffing patterns and other areas of hospital management.

The third part of Governor Brennan's request to the Board called for an evaluation of the other cost containment programs. The Board has addressed this task through a series of presentations on programs in other states and through a review of the completed portions of the National Hospital Rate-Setting Study.

The Board scheduled presentations on programs which reflected the full range of characteristics common to cost containment efforts. The programs described included one of the earliest and most well established as well as one of the newest; both voluntary and mandatory efforts; programs which originated for significantly different reasons; programs known for the high degree of cooperation between hospitals and the regulating body as well as those using more of an adversary approach; and programs based on a traditional public utility model and those which featured self-imposed spending ceilings.

Specifically, the Board held full public hearings on the programs in Maryland, Rhode Island, and Massachusetts. In addition, the Board heard a shorter presentation on the program in Rochester, New York. For the Maryland, Rhode Island, and Massachusetts sessions, the Board heard presentations from a representative of the principal agency responsible for the administration of the program and from a representative of the hospitals included in the program. In addition, in the case of Maryland, the Board heard a presentation from an individual who had studied the program as part of the National Hospital Rate-Setting Study. In the cases of Rhode Island and Massachusetts, the Board heard from representatives of the Blue Cross plan affected by the program. The Rochester program was described by its principal designer and its features were compared to the approaches in several other states.

The monographs in the National Hospital Rate-Setting Study were a helpful source of information in both programs which we heard about directly as well as those which were not included in our public hearing schedule. Although programs have been established for very different reasons in various states, some strong common themes run through the development and evolution of many of these programs. Their successful innovations as well as their mistakes have been useful guides as we have reviewed the efforts in Maine.

Programs which monitor or directly regulate hospital prices or costs are not the only kind of hospital cost containment efforts which the Board examined. Certificate of Need programs and utilization review efforts are also directed at restraining the rates of increase in hospital expenditures.

In Maine the Certificate of Need program is administered by the Department of Human Services with the advice of the Maine Health Systems Agency. Gordon Browne, Director of the Bureau of Health Planning and Development within the Department,

described the C/N process, the present scope of the program and the major changes in the federal C/N law.

Peter Leadley, M.D., Executive Director of the Pine Tree Organization for Professional Standards Review (PSRO), made a presentation which included a description of the origin and development of the PSRO in Maine and an outline of how the PSRO carried out its responsibilities. The PSRO in Maine was supported by Federal Government funds. With the withdrawal of that support, the PSRO terminated its activities as of October 1, 1981.

In addition to these specific presentations, the Board also discussed these programs at the public hearings on the payment programs in other states. Among other topics addressed in these discussions, the Board examined the issue of coordination among all cost containment programs.

The series of public hearings ended in October. The Board then held another series of meetings to discuss the presentations made at the hearings, to review and evaluate the analysis of the VBRO and to reach final conclusions and recommendations on the study. As it did for the public hearings, the Board encouraged the attendance and participation of all interested parties in this second set of meetings. The Board completed its work on December 21.

FOOTNOTES

1. These included the following: Maine Hospital Association, Maine Osteopathic Association, Maine Medical Association, Maine Nurses Association, Blue Cross Blue Shield of Maine, Union Mutual Life Insurance, Pine Tree Organization for Professional Standards Review, Maine Health Information Center, Medical Care Development Inc., New England College of Osteopathy, University of Maine School of Nursing and Human Services Development Institute, Maine Health Systems Agency, Human Services Council, Maine Health Care Association, Maine Chamber of Commerce, Associated Industries of Maine, Maine Merchants Association, Maine AFL-CIO, Maine State Employees Association, and Maine Teachers Association.

2. Dr. Cleverley is a professor in the graduate program in Hospital and Health Services Administration and in the Department of Accounting at the Ohio State University. He is also the director of the Hospital Financial Analysis Service and the author or editor of a number of books and other publications.

APPENDIX C

Additional Data

The data in Tables 1 and 2 of Section 2
was derived from the data in the following tables.

TABLE 1 - DECOMPOSITION OF AVERAGE COST PER CAPITA

	(1) Average Cost per Capita-Maine Current Dollars	(2) Consumer Price Index* (1967=100)	(3) Average Cost per Capita-Maine 1967 Dollars	(4) Average Cost per Patient Day (1967 Dollars)	(5) Patient Days per Capita	(6) Admissions per 1,000 Population	(7) Average Length of Stay (Days)
1955	14.96	76.6	19.53	26.57	.735	97	7.6
1960	24.46	86.5	28.28	33.13	.853	118	7.2
1965	35.85	94.5	37.93	40.78	.930	112	8.3
1970	76.35	116.7	65.42	59.33	1.103	140	7.9
1971	89.84	122.7	73.22	66.22	1.106	144	7.7
1972	97.82	127.1	76.96	71.28	1.080	146	7.4
1973	110.21	134.7	81.82	74.51	1.098	148	7.4
1974	135.48	148.7	91.11	75.60	1.205	163	7.4
1975	163.96	162.1	101.15	84.75	1.193	161	7.4
1976	190.72	174.5	109.30	90.17	1.212	162	7.5
1977	222.95	183.4	121.56	101.58	1.197	160	7.5
1978	249.51	192.7	129.48	105.11	1.232	160	7.7
1979	283.07	212.4	133.27	107.09	1.244	157	7.9

*CPI; Boston; Urban Wage Earners and Clerical Workers

TABLE 2 - DECOMPOSITION OF AVERAGE COST PER PATIENT DAY

	(1) Average Cost per Patient Day (1967 Dollars)	(2) Average Labor Cost per Patient Day (1967 Dollars)	(3) Annual Earnings per FTE (1967 Dollars)	(4) FTE's per Patient Day (Days)	(5) Average Non-Labor Cost per Patient Day (1967 Dollars)	(6) Non-Labor Price per Input (1967 Dollars)	(7) Non-Labor Inputs per Patient Day
1955	26.57	15.91	2834	2.04	10.67	.999	10.68
1960	33.13	20.09	3205	2.29	13.05	.999	13.06
1965	40.78	25.89	3785	2.47	14.89	.999	14.90
1970	59.33	37.01	4640	2.91	22.32	.984	22.68
1971	66.22	40.80	4772	3.12	25.43	.972	26.16
1972	71.28	41.86	4812	3.17	29.43	.965	30.50
1973	74.51	42.41	4702	3.29	32.09	.968	33.15
1974	75.60	40.93	4408	3.39	34.65	1.007	34.41
1975	84.75	45.27	4648	3.55	39.51	1.038	38.06
1976	90.17	47.31	4638	3.73	42.85	1.029	41.64
1977	101.58	51.21	4719	3.96	50.36	1.048	48.05
1978	105.11	53.60	4889	3.99	51.52	1.083	47.57
1979	107.09	55.31	5042	4.00	51.78	1.073	48.26

The data in this Appendix and in Section 2 were derived as follows:

A. Appendix: Table 1

Columns

1. Average cost per capita: Total expenses ÷ total population.
2. CPI: U. S. Department of Labor, Boston; Urban wage earners and clerical workers.
3. Average cost per capita (1967 dollars): Average cost per capita ÷ (CPI ÷ 100).
4. Average cost per patient day (1967 dollars): Average cost per capita (1967 dollars) ÷ patient days per capita.
5. Patient days per capita: Total patient days ÷ total population.
6. Admissions per 1000 population: Total admissions ÷ (total population ÷ 1000).
7. Average length of stay: Total patient days ÷ total admissions.

6. Average length of stay: Average compound annual rate of change of column 7, Table 2 of Appendix C.

D. Table 3 of Section 2

The contribution of each of the components was computed on the basis of the sum of the rates of change presented for each period in Table 2 of Section 2. We recognize that several of the rates of change shown in Section 2 are not additive and that using their sum ignores the interaction effect of multiplying them. This effect, however, is small and results in only a slight change in the computed percent contributions.

E. Table 5 of Section 2

Column 1 of this table is taken from Table 1 of Section 2 (column 4). Column 2 is derived as follows:

(1) Percent of labor expenses X percent change of labor earnings (1967 dollars).

(2) Percent of labor expenses X percent change of production worker earnings (1967 dollars).

(3) Subtract the difference between (1) and (2) from the percent change in the average cost per capita (1967 dollars) as given in column 1.

DRAFT-FOR COMMENT

November 16, 1988

MAINE HEALTH POLICY ADVISORY COUNCIL

SECOND ANNUAL REPORT

ANNUAL REPORT -- DRAFT NOVEMBER 16, 1988
HEALTH POLICY ADVISORY COUNCIL

EXECUTIVE SUMMARY

The Maine Health Policy Advisory Council was created under chapter 498, Public Laws of Maine, 1987, to "advise and be available for consultation to the Governor, Commissioner of Human Services, Commissioner of Mental Health and Mental Retardation, other executive branch agencies, the Legislature, and the Maine Congressional Delegation on health policy issues relating to health status, health prevention, and health care delivery on health policy issues related to health status, health promotion, and health care delivery that the Council believes to be significant and that it has the resources to address." (sec. 19101)

The problems Maine faces are generally neither new nor unique to Maine. Although Maine's hospital regulatory system is unique, hospitals and insurers across the country are facing similar financial problems and rapidly rising premiums; these are being blamed on Federal Medicare reimbursement policies as well as rising medical costs. Maine shares problems faced by other states with large rural populations, which are often relatively poor and disproportionately elderly. Despite its limited economic base, Maine has often been on the national forefront in its approach to health policy issues, and has a national reputation for developing compassionate and pragmatic programs for its population.

CONTENTS OF THE ANNUAL REPORT

The report contains four sections. These are:

1) a statement of fundamental goals and principles;
2) a forecast of emerging issues, including description of relevant trends;
3) a health policy agenda for the upcoming year, including description of interested actors; and
4) a review of the Council's activities in the previous year.

The Council selected four broad issue areas to focus on for the upcoming year:

(1) health planning;
(2) health personnel;
(3) access, quality and financing; and
(3) the implications of the Institute of Medicine Report on the Future of Public Health

CURRENT ISSUES

Access, quality and finance were included together because the issues are so profoundly intertwined the Council determined they could not be addressed separately. The Council began to study the personnel issue in 1988, with a media analysis of the nursing shortage produced by a summer intern. It has also recently begun to look at two different issues within public health: the findings of the Institute of Medicine report on the Future of Public Health, particularly as they pertain to the organization of the State's departments concerned with health; and the purpose and process of state health planning.

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- Roughly 67,000 children in Maine live in poverty. Children living in poverty die at three times the rate of other children.
- Drugs, including alcohol and tobacco, are used by children as well as adults, yet little is known about what methods are most effective in preventing or curing these addictions.
- A terrible new disease, AIDS, challenges not only our medical knowledge but the structure of our financing and delivery systems.
- The tie between what care is provided and how it is financed is often tenuous.
- The system for evaluating and choosing between competing priorities is in disarray.
- Key leadership positions in the Department of Human Services have been vacant for extended periods.
- The health system is made up of a collection of players with disparate agendas, and no apparent shared vision of the future of health in Maine.
- There are increasingly urgent calls for State government to develop and maintain comprehensive health planning.

The problems Maine faces are generally neither new nor unique to Maine. Although Maine's regulatory system is unique, hospitals and insurers across the country are facing similar financial problems and rapidly rising premiums. The financial problems are being blamed on Federal Medicare reimbursement policies as well as rising medical costs. Maine shares problems faced by other states with large rural populations, which are often relatively poor and disproportionately elderly.

The sense of crisis has led to a flurry of activity by government, consumer groups, insurers, business, and provider groups. At least five State commissions are studying different aspects of the problem, including access, financial regulation, the nursing shortage, and mandated benefits. The Maine Health Policy Advisory Council was formed to provide continuity, and can encourage cohesive planning among the different efforts. Despite its limited economic base, Maine has often been on the national forefront in its approach to health policy issues, and has a national reputation for developing compassionate and pragmatic programs for its population.

The Council has identified four broad issue areas as particularly important in the upcoming year. These are:

- The health planning process in Maine
- Access, quality and financing
- Health personnel
- The Institute of Medicine report on the Future of Public Health, and its implications for Maine

C. CONTENTS OF THE ANNUAL REPORT

The report contains four sections. These are:

1) a statement of fundamental goals and principles;
2) a forecast of emerging issues, including description of relevant trends;
3) a health policy agenda for the upcoming year, including description of interested players; and
4) a review of the Council's activities in the previous year.

The following principles should be kept in mind during deliberations:

1) **CONTINUUM OF HEALTH** -- Health policy is concerned with the entire continuum of health and illness. The continuum includes prevention, early detection, and treatment. It is at least as important to prevent illness and accidents as to treat them.
2) **MIXTURE OF ROLES AND RESPONSIBILITIES** -- Both individuals and society benefit from the good health of citizens. Government, the private sector, and individuals all have different roles and responsibilities in ensuring health and financing care.
3) **ETHICAL DECISION-MAKING** -- Health affects the quality and length of life. There is a profoundly ethical dimension to decisions about health, which cannot be set aside during deliberations.
4) **CONFLICTING GOALS** -- Basic goals, such as quality, access, and affordability, often conflict. We need to understand how competing goals interact to avoid sacrificing one goal in pursuit of another.
5) **PLANNING AND INVESTMENT** -- Many health policy decisions have an important time dimension. Investment should be based on strategic and long-range planning that addresses real problems and trends, with a time span similar to the time span of the investment. Health education, prevention, appropriate human resources development, and research and development are all health investments, and are at least as important as "bricks and mortar" investment.

C. FUNDAMENTAL ISSUES

Health policy issues are complex and closely interrelated. The Council found that there were many different ways of grouping identified problems together into general issues. The following list is only one approach. The Council used this list of issue areas to identify emerging problems.

1) **CONTINUUM OF HEALTH AND CARE** -- How can we stay well? What can we do to preserve and improve individual, workplace, and environmental health? How can we encourage individuals to seek care early on the continuum of health care? How do we acquire and allocate resources for primary care and prevention? How can we prevent premature illness, disability and death? How can we reduce the risk of accidents and hazards to health and life?

2) **ACCESS** -- Is health a fundamental right? Is health care? If so, what level and kinds of care? Who should decide? How should it be provided?

3) **FINANCING AND COST** -- How much are we willing to spend, individually and collectively? What is the most equitable way to finance care? How do we trade-off between individual preferences, quality, and cost?

4) **QUALITY** -- What is good care? How can we tell if it is being provided? Is more always better? When should we use new technologies?

5) **LIFE AND DEATH** -- How do we balance quality of life against length of existence? How should we treat the process of dying?

Strategies which address these fundamental issues raise questions about the structure of the health and medical care delivery system. Three separate issue areas related to how health care is produced are outlined below.

III. FIVE YEAR FORECAST OF EMERGING ISSUES

A. OVERVIEW

The crises in health facing the state today have developed gradually over a period of time. The most important policy needs over the next five years will be to develop long-range approaches to problems which are evident today. This section is an **overview of trends** which have implications for health policy and a **forecast of emerging issues** that are likely to confront the state over the next five years. Section IV focuses more closely on three broad policy areas and describes the immediate agenda in these areas.

A number of issues were identified by the members of the Council. Organizations and individuals concerned with health issues were contacted and national health care agendas or issue lists were examined to complete the issues list. These problems were grouped into the eight issue areas described in the previous section. Projections of likely changes in the environment were examined. These include **DEMOGRAPHIC, ECONOMIC, SOCIAL, TECHNOLOGICAL, ENVIRONMENTAL, and POLICY CHANGES.** The Council identified problems likely to arise in the various issue areas as a result of these trends.

B. ASSUMPTIONS ABOUT THE FUTURE

Forecasts are based on assumptions which can be more or less certain. Many trends with health policy implications, such as the aging of the baby boom and the shift to a service economy, are relatively easy to predict. On the other hand, few could have predicted the importance of AIDS a decade ago. Many predictions about changes in the environment are controversial. This section describes current and emerging trends with implications for health policy.

1. DEMOGRAPHIC CHANGES

There will be continued **growth in the elderly population**, with the old-old (over 85) being the fastest growing component of the elderly population. This trend will continue well into the next century as the "baby boom" ages.

- Increased demand for long term care, care for chronic conditions of aging, and for acute and terminal care. Problems of access and financing for protracted and chronic illness.
- Demand for personnel, facilities, services, outreach, and prevention/health education programs to meet needs of an older population.
- Growing interest in innovative approaches, a continuum of services and changes from current structure of providing care.
- Challenges to individual and societal values about old age ("ageism"), quality of life, and death and dying.
- Increasing demand for non-institutional services and creative alternatives for retirees such as continuing care retirement communities.
- Higher disposable income in control of the new elderly may lead to new opportunities for public/private partnerships in funding care.
- Employer funding of retiree health benefits may be withdrawn or limited (particularly in light of accounting requirements that they be carried as liabilities), leading to greater demands on public sources of funding for medical care for the elderly.

A larger proportion of the **elderly live alone** than ever before.

- Increased demand for congregate housing and other models.
- More demand for paid care-givers, need for personal care as well as medical care. Personnel shortages.

- Employers and business groups will become activated consumers, encouraging health care marketplace competition, and calling for more information on prices and services.
- Managed care and alternative delivery systems such as preferred provider organizations (PPOs) and Health Maintenance Organizations (HMOs) will continue to grow in popularity and will become increasingly stringent.
- Pre-employment and placement screening may increase, with legal, personal and civil-rights problems and implications. The ability to screen for genetic predisposition as well as for active conditions will raise serious legal and ethical problems.

Geographic and socioeconomic differences will persist.

- Population density will continue to be a limiting factor in ensuring access in some rural areas.
- To the extent that small businesses in rural areas are marginal, the impact of rising health care premiums can affect an entire community's access to goods and services.
- The "two Maines" is a socioeconomic as well as a geographic reality. Access is an issue in every community for at least part of the population.

3. SOCIAL CHANGES

The **structure of the household** has changed a great deal in the last two decades, and may continue to change. The ratio of divorces to marriages doubled from 1960 to 1980, with more than one divorce for every two marriages annually. New social structures have not yet formed to take the place of the extended family and the nuclear family. More adults are living alone, and more children and adults are having children without conventional marriages.

- The "feminization of poverty" is likely to continue. Nationally, households headed by a single mother doubled from 1970 to 1980, but tripled in Maine. Children in female-headed households are the group most at risk for being uninsured. Most of these families have working mothers, and are not covered by any public program.
- Maine has found that the death rate for children in poverty is more than triple the rate for all other children.
- Disrupted families are under stress and may be at risk for mental health problems, drug and alcohol abuse, and physical abuse.
- It is not clear whether the trend to smaller and later families will continue. Parents with only one child may demand "perfect babies", and have unrealistic expectations of the medical system. Reproductive technology will continue to raise ethical and legal questions.
- While births to adolescents have decreased slightly, births to teens under 16 have risen. Pregnant teens are particularly likely to receive inadequate prenatal care, greatly increasing the likelihood of bad birth outcomes such as low birth weight infants. Outreach to this group will continue to be critical, but difficult.
- Out of wedlock births rose 44% from 1979 - 1985; 45% to teens under 18.

The **relationship of individuals to society** is changing. The result is a paradoxical combination of increased individualism and distrust of institutions, combined with a sense of individual helplessness and loss of control. Conflicts over the locus of responsibility slow the development of public policy in many values-related areas.

- o Systems have potential for improving efficiency and continuity of care. Confidentiality and appropriate use of data may become a problem.
- o Information and telecommunication technologies can improve continuing medical education and decrease professional isolation in rural areas.

The continued "**industrialization of medicine**" will lead to changed relationships between physicians and purchasers of care. The corporate model (physician as medical expert in a firm, patient as customer) will increasingly replace the model of physicians as solo entrepreneurs, particularly in urban areas.

- o Growth of competitive health plans such as Health Maintenance Organizations (HMOs), preferred provider organizations (PPOs), and other managed care systems will increase demand for methods of monitoring quality and appropriateness of care.
- o Legal and antitrust implications of vertical integration (e.g., hospitals with primary care providers and long term care providers) and negotiations between groups of providers and payors will continue to be complicated.

5. ENVIRONMENT

Past and current practices will continue to effect the environment. Acid rain, the ozone hole, toxic wastes, and industrial pollution create problems and leave an **environmental debt** that needs to be repaired.

- o New abatement and clean-up technologies continue to be developed. Policies to encourage the use of these technologies through incentives and penalties need to be developed as well.
- o The link between environment and personal health will become clearer as new diagnostic and monitoring techniques are developed.

Maine currently has the highest **occupational injury** rate in the nation, even after adjusting for the mix of occupations. Occupational illness rates are unknown.

- o Techniques for identifying occupational illness will continue to develop, leading to increased pressure for workplace safety.

6. GOVERNMENT AND POLICY

Health care will continue to be a prominent public issue because the cost has become such a dominant part of public budgets. Federal budget deficits will mean continued **constraint on Medicare funding**.

- o Physicians, laboratories, and other non-hospital providers are likely to receive new Federal regulation designed to contain costs, while hospital reimbursement rates will continue at low levels.
- o Efforts to monitor quality may lead to greater reporting requirements.
- o Problems of rural hospitals may be exacerbated, unless recent Federal research initiatives directed at rural hospitals lead to policy changes.

Will there be some kind of **National Health Insurance**?

- o States are experimenting with public subsidy of coverage for the uninsured. The Massachusetts experiment is the broadest, but Wisconsin, Washington, and other states also have some level of support.
- o The Robert Wood Johnson (RWJ) demonstration projects (including one in Maine) also address coverage for the uninsured. Results of these experiments will be watched, and successful experiments are likely to be adopted by other states or nationally.

FIVE-YEAR FORECAST: FUNDAMENTAL ISSUES AND EMERGING PROBLEMS

	FUNDAMENTAL ISSUE		EMERGING PROBLEM AND SPECIAL NEEDS AREAS
1)	Continuum of Care - health promotion, prevention, and health protection. Needs for increased emphasis, funding, organization of systems to encourage prevention.	A)	**Health promotion** and **health education** -- need better funding, trained staff, and ability to measure results. Includes substance abuse and reproductive health education.
		B)	**Primary care and prevention**, including behavioral changes such as smoking cessation and seat belt use.
		C)	**Environmental protection.**
		D)	**Occupational health and safety.**
		E)	Care related to **pregnancy, children and adolescent** health should emphasize prevention, health promotion and primary care.
		F)	Early diagnosis, treatment, and prevention of disability, particularly techniques for the **older population.**
2)	Access Need to improve availability and physical and economic access to care	A)	**Maldistribution** of personnel and services -- **geographical**, by type of specialty, technology, beds.
		B)	Economic access -- insurance and the cost of care limit access to the poor and **uninsured.**
		C)	Availability of special services: e.g., needs of the **elderly; addiction treatment** programs; prenatal and **obstetric** care; **rehabilitation.**
3)	Quality Need to maintain quality during efforts to increase access and lower costs.	A)	Definition and assurance of quality in all medical and health professions. **Peer review**, regulation and standards of practice.
		B)	Definition of **basic level of care**, case management.
		C)	**Malpractice** -- liability, impaired providers, defensive medicine, tort reform, and patients' rights.
4)	Cost and Funding Major decisions need to be made on the State's role in regulating, financing, and planning the provision of health care services.	A)	Capital funding and other hospital **shortfalls**, and the role of Federal and State reimbursement and regulation policies.
		B)	Potential conflicts between **cost containment**, quality, and access -- need to assure quality in cost containment.
		C)	Criteria for comparing **costs and benefits** of different technologies and services, both for choosing whether to provide and for location decisions.
		D)	Impact of **cost shifting** on third party payors. Broaden base for funding indigent and uncompensated care.
		E)	Information on costs and services -- for third party payors and for **consumer education.**
		F)	**Mandated benefits** and their impacts on cost and quality.

IV. 1989 AGENDA

A. OVERVIEW

The Council selected four broad issue areas to focus on for the upcoming year:

- o State health planning
- o Health personnel
- o Access, quality and financing
- o The Institute of Medicine report on the Future of Public Health

The Council is particularly interested in how the public and private sectors interact in each of these areas, and is concerned to define and develop the State's role in a way that encourages and supports private and local initiatives.

- o The purpose and process of health planning, both by the State and for the state, is currently under study by the Council.
- o The Council began to study the personnel issue in 1988, with a media analysis of the nursing shortage produced by a summer intern.
- o Access, quality and finance were included together as a single issue area because the issues are so profoundly intertwined the Council determined they could not be addressed separately.
- o The Council has begun to look at the findings of the Institute of Medicine report on the Future of Public Health, particularly as they pertain to the organization of the State's departments concerned with health, and plans to work with the Maine Public Health Association in presenting the report to the public.

Three public meetings were held in different parts of the state to solicit public input into defining the issues and suggesting potential roles for the State in each of these areas. The meetings were well attended, with over seventy people in total taking part in discussions. At each meeting, the public was invited to divide into three discussion groups, led by council members. Each group defined the issue and proposed possible policy approaches to the problem in one of the three areas.

The following sections look at the issue areas in more depth. Each section has four parts:

1) Definition of the issue and problems
2) Report of concerns raised at the public meetings
3) Overview of the players and their policy agendas -- interest groups, commissions, task forces, departments
4) Proposed Council activity for the upcoming year.

B. HEALTH PLANNING

1. Problem Definition

A number of groups both within and outside State government have called for improved State health planning and policy development. National standards and public health objectives have been developed, and can provide a framework from which to measure the State's efforts.

HEALTH PLANNING

The State plays an important role in orchestrating and coordinating the components of the health care system, both public and private. The private sector looks to it for help to plan and implement strategies that address shared goals. A key role is collecting and disseminating information to be used in decision-making.

STATE ADMINISTRATIVE GROUPS: The **Maine Health Care Finance Commission** has called for a revised State Health Plan. The **Department of Environmental Protection** regulates and monitors the quality of water and air, and the disposal of wastes, important local issues in many counties and towns. The **Department of Human Services**, the **Department of Mental Health and Retardation** and other executive branch agencies each carry out planning activities related to their internal objectives and mandates.

THIRD PARTY PAYORS: Blue Cross and Blue Shield believes health planning is critically important, but that it should not be done by the Department of Human Services.

There is a large consensus among these different groups for the need of a cohesive health plan to guide the creation of public health policy and programs in a thoughtful way, with priorities based on health outcomes. Planning is needed to help stabilize the health care system while maintaining affordability of services.

4. Proposed Council Activity

a) Continue to monitor the activities of the commissions and groups listed in the above text.
b) Advise the Legislature, Governor, and Commissioners about National standards and Maine's performance as measured in this framework
c) Carry out a special study, conference or other action in the following area:
i) Delphi and panels on State health planning process and needs

C. ACCESS, QUALITY, AND FINANCING OF HEALTH CARE

1. Problem Definition

Access, quality and financing are in the forefront of the Legislative agenda this year. Employer groups are urgently concerned over rising insurance costs. Hospitals are distressed at current regulations and reimbursement, both State and Federal, and are calling for relief and funding. Consumer advocates are pointing out the connection between the large numbers of Maine citizens without insurance and the problems that the hospitals and insurers are facing: uninsured individuals receive care at hospitals, and run up bills that are ultimately paid by others, including the State and Federal governments.

ACCESS

Access is a problem when there are not enough providers, where there are physical or cultural barriers to obtaining care, and when cost affects an individual's ability to obtain care. There has been considerable activity in the past year designed to avoid the erosion of insurance benefits and extend coverage to the uninsured. Access to preventive and primary care is an equally important problem, particularly for the poor.

Financial access is not only an issue for the poor. The gaps in the patchwork system of public and private insurance are growing, with more of the population uninsured than ever, and even the insured find themselves with inadequate coverage or unable to buy coverage when they need it most. While hospitals and insurers complain about the cost of treating the uninsured, the uninsured continue to bear the greatest share of the cost in the form of ill health and shortened lives.

particularly with who should be the payer of last resort. Broad-based taxation is gaining support among payers who blame cost-shifting for rising expenditures.

Overall questions about the structure of the system includes: the appropriate mix of public and private roles in different areas; the use of different financing mechanisms; location and provider of care; and, above all, how to balance the goals of the health care system an other societal goals.

2. Concerns Raised at Public Meetings

A series of public meetings were held by the Council in October 1988, at Orono, Caribou, and Portland to identify policy issues and possible State roles in the solutions. Here are some common concerns and possible solutions concerning access, quality and financing of health care voiced by at least two of the three sites polled:

1) The government has some responsibility for the uninsured and low income. Methods include: State-sponsored universal health coverage for individuals living below 150% of poverty; government responsibility for the medically indigent; and focus on the working uninsured.

2) The State should play a role in assuring coverage for others. Strategies include expanding the high risk insurance pool, expanding the Robert Wood Johnson (RWJ) program to cover small businesses, assuring affordable insurance for consumers with a sliding-scale copay and deductible based on income, or mandating employers to provide medical insurance for their workers.

3) A larger percentage of funds should be used for prevention and primary care, with expanded access to primary care and prenatal care.

4) Current regulation of reimbursement should be revised to allow adequate funding and growth of the health care industry. Cost shifting and the Medicare shortfall must be addressed, and government should continue to review cost, access, and quality of care.

5) The size of liability claims should be regulated (i.e. tort reform), to reduce costs and slow the practice of defensive medicine.

6) Managed care, peer review, and utilization review should be encouraged.

7) Consumer demand should be reduced by consumer education on costs.

8) Incentives are needed to place physicians in rural areas.

9) State health planning should be a part of the approach to this problem.

3. Interest Groups and Their Policy Agendas

There has been much activity on the issue of access, quality, and financing of health care in the past year. Players include advisory councils and legislatively-mandated groups, State administrative and Governor's groups,

CONSUMER GROUPS: **Consumers for Affordable Health Care** is a newly organized consumer group particularly concerned with maintaining access. It is working closely with both the Blue ribbon Commission and the Commission on Access, and watching the Hospital Development Account and its effect on financial access.

CONSUMER GROUPS REPRESENTING SPECIFIC POPULATIONS: Groups representing the elderly are concerned about the lack of adequate insurance for the elderly. They point out that copayments, large deductibles, a lack of long term care coverage, and a lack of coverage for prescriptions are causing hardships for many elderly. They are concerned with a lack of certain available health care services such as home care, adult day care, and transportation to health services. **The Maine Head Injured Foundation** is concerned with the lack of rehabilitative services and the funds available to pay for such services.

BUSINESS AND LABOR: **The Maine Labor Group on Health** is concerned with workplace safety, worker advocacy, and health care costs. They are interested in creating worker-run occupational health clinics to encourage employees to report and be treated for work-related injuries. Another new development has been the formation of a business group called the **Coalition for Responsible Health Care**, whose concerns include cost-shifting, and the need for a broadened tax base to cover the shortfall, bad debt, and charity care, along with a need for tort reform.

PROVIDER GROUPS such as the **Maine Medical Association** and the **Maine Osteopathic Association** are concerned with access and quality. The physician organizations have instituted programs such as the **Impaired Physician's Program**, the **Maine Medical Assessment Program**, stronger peer review programs, and utilization review programs extending beyond the hospital environment to protect the public and ensure quality among their members. They also are concerned with malpractice and see a need for tort reform. The **Maine Hospital Association** is particularly concerned with the financing problems of hospitals. The Association supports financing and regulatory changes that would allow growth and new technology, and provide a larger base for funding uncompensated care. The **Maine Health Care Association** is concerned by the lack of incentives to encourage the development of non-institutional community-based care, a lack of a continuum of care for the elderly, and a need for alternatives to Medicaid for funding long term care.

THIRD PARTY PAYORS such as **Blue Cross and Blue Shield** are concerned with cost shifting, particularly the lack of federal accountability for the Medicare shortfall. They support regulating outpatient services, educating consumers of the impact of mandated benefits, and introducing new technologies carefully. Blue Cross is concerned about the development of a two-tiered system of medical care, and maintains that there is a need to preserve the community hospital network, perhaps with modifications in the services offered by the rural hospitals.

There is a large consensus among the different groups on the need for cohesive health planning to help stabilize the health care system while maintaining affordability of health services.

4. Proposed Council Activity

a) Continue to monitor the activities of these commissions and groups listed in the above text.
b) Advise the Governor, Commissioners, and Legislators on specific topics. In particular, the Council will :

1) Maldistribution of Personnel - Shortages in specific professions (primary care physicians, OT, and PT); shortages in rural areas; and a lack of personnel with specific levels of training.

2) Recruitment and Training - Poor access to training for specific professions, such as PA/NP; dwindling pool of new high school graduates and the need to recruit non-traditional students; lack of awareness of health career opportunities, and the high cost of training relative to salaries for nurses.

3) Compensation and Conditions of Work - Need for appropriate compensation for all kinds of health personnel; child care and flextime; financial (rather than service) orientation of new personnel; competition between long term care and hospital providers; and the impact of malpractice rates on access.

4) Demand - Sicker patients require a higher level of care; need for more efficient use of nurses; problem of patients discharged early with lack of community-based care; role of prevention in reducing demand.

5) Planning - Lack of survey data on nursing.

Suggested Solutions:

1) The State should fund training programs, including loan forgiveness, low interest loans, and employer help with loan payback.

2) Regulatory flexibility, including creating incentive through adjustment of cap for hospitals to deal with personnel issues, financing Medicare and Medicaid shortfall, and removing caps on nursing home pay scales, should be shown.

3) Attract professionals to medically underserved areas, especially rural areas, through financial incentives such as loan forgiveness and equalized Medicaid reimbursement for rural areas.

4) Develop and pay for a data base on health professions.

5) Recruit secondary students into health professions by improving guidance counselor systems, providing health care options information, and developing media campaigns.

6) Make more information available on opportunities, salaries and benefits, particularly for allied health professions.

3. Interest Groups and Their Policy Agendas

Many groups have voiced their concern about health personnel shortages experienced in Maine. The basic concerns are: a maldistribution of all kinds of health personnel, need for recruitment and retention to increase supply, an increase in the demand, a need to maintain professional standards to ensure quality care, malpractice, and a lack of data necessary to study the problem.

ADVISORY COUNCILS AND LEGISLATIVELY-MANDATED GROUPS: The Maine Commission on Nursing Supply and Educational Accessibility is studying the nursing supply and working to ensure career mobility for nurses through educational means. The

THIRD PARTY PAYORS such as **Blue Cross and Blue Shield** is concerned about the lack of health care professionals in rural areas, and the need to provide innovative training to recruit nontraditional students to these professions. BC/BS states that quality of care cannot exist unless there is an adequate number of providers, and that maldistribution is an important factor in the creation of a two-tiered system of health care.

4. Proposed Council Activity

a) Continue to monitor the activities of these commissions and groups listed in the above text.
b) Advise on proposals before committees and the Legislature.
c) Carry out a special study in the following areas:
i) Demand, supply, and training opportunities for other health professions.
ii) Geographic factors in demand and supply

E. INSTITUTE OF MEDICINE REPORT ON THE FUTURE OF PUBLIC HEALTH

1. Problem Definition

The Institute of Medicine report on the Future of Public Health has focussed national attention on the structure and function of state health departments. In Maine the **Department of Human Services** has responsibilities which include epidemiology, public health nursing, dental health, health engineering, state health planning, and financing and providing for Medicaid eligible populations. Other executive departments with roles in public health and health include: the **Department of Mental Health and Retardation**; the **Department of Professional and Financial Regulation** -- health insurance, malpractice insurance, workman's compensation, HMOs, and some licensing of professions; the **Department of Labor** -- health manpower, occupational safety, Health Occupations Training (HOT); the **Department of Education and Cultural Services** -- school health education, training of ancillary workers; the **Department of Environmental Protection**; and the **Department of Agriculture** -- food safety. In addition, the **State Planning Office** has taken the lead in the **Governor's Cabinet Task Force to Address Health Care Cost Containment**. There is no mechanism in place at this time to coordinate public health functions of the different departments.

Public health as a current issue has several components: health promotion; health protection; public health services; and planning and administrative organization. Health promotion and preventive services should be considered as part of any comprehensive health package. Health protection issues such as occupational safety and environmental protection have been urgent issues before the Legislature for some time. It may be useful to consider approaches to these problems in the context of the health care system.

PUBLIC HEALTH SERVICES

The role and responsibility of the State in health is changing rapidly. In addition to traditional public health functions, such as disease control, sanitation, environmental health and epidemiology, the State carries out research and planning finances Medicaid, regulates professional licensing, trains health professionals, and provides funds for patient care for certain groups such as the physically and mentally handicapped. It regulates environmental and occupational health and safety. It also regulates nursing homes and hospitals closely, and places limits on capital expenditures and revenues. There are vary few local

4) State health system planning is an essential part of the public health functions. It should include the planning of prevention and health education.

5) The State should have a single Department of Health responsible for all major aspects of health policy (public health, Medicare, maternal health, environmental health, occupational health, etc.)

3. Interest Groups and Their Policy Agendas

There is growing concern over the lack of State health planning, and interest in the implications of the Institute of Medicine report which recommends a cabinet-level State health department. In general, interest in public health focuses on health promotion, health protection, public health services, and health planning. Health promotion includes health education as a means of reducing risk, and screening services for early detection. Both of these hinge on funding, such as reimbursement for preventive care. This investment could be money saved in time if it lessens the need for acute care services. Health protection includes environmental health and worksite health, both currently outside DHS and therefore not well coordinated with other public health activities.

ADVISORY COUNCILS AND LEGISLATIVELY-MANDATED GROUPS: The **Maine Coalition on Smoking or Health** perceives a need for better enforcement of laws for the sale of cigarettes to minors.

STATE ADMINISTRATIVE GROUPS: The **Bureau of Health** will present new initiatives for DHS in the following public health areas: teen and young adult health, healthy Maine, health care industry, AIDS, low income and disabled persons, and the State Health Plan. The **Maine Health Care Finance Commission** has called for a revised State Health Plan. The **Department of Environmental Protection** regulates and monitors the quality of water and air, and the disposal of wastes, important local issues in many counties and towns.

ADVOCATES FOR SPECIAL POPULATIONS: The **Bureau of Maine's Elderly** and the **Maine Committee on Aging** are interested in targeting certain programs such as smoking cessation, blood pressure and cholesterol screening to elderly widowed females living alone who are at great risk. The **Maine Labor Group on Health** is concerned with work place safety and worker advocacy.

PROVIDER ORGANIZATIONS: The **Maine Hospital Association** feels that public health efforts will ease the pressure on acute care costs. The **Maine Hospital Association** is interested in seeing the state assist the private sector with planning. The **Maine Health Care Association** would like to see policy to develop the Hospice concept in nursing homes, especially for patients with AIDS. The **Maine Medical Association** strongly supports efforts to require seat belts for motorists and helmets for motorcyclists, and efforts to reduce smoking. The **Maine Osteopathic Association** is concerned about the need to establish regulation and procedures for the disposal of infectious wastes from hospitals and private facilities.

PUBLIC HEALTH GROUPS: The **Maine Public Health Association (MPHA)** is greatly interested in the Institute of Medicine report which suggests a reorganization of State public health systems to a cabinet-level department. The Maine Public Health Association believes that a director of the Bureau of Health must have public health training. The MPHA is also focusing on the availability of

V. PREVIOUS YEAR'S ACTIVITIES

The Council was created in the last session of the Legislature. The Council held its first meeting on October 14, 1987, and staff was hired and an office opened in August, 1988. The Council met seven times during the rest of the fiscal year, organizing itself and its staff and beginning exploration of the health policy issues to be addressed in its December, 1988 annual report. It has met 4 times between July 1, 1988 and November 10, in addition to the three public meetings held around the state. While staff activities to date have been primarily organizational, active liaison has been established with major public and private health policy interest groups.

The Council's health policy issue discussions have covered access to care, cost and financing of health care services, supply and demand for health care professionals, AIDS, the future of public health services and programs, and health care planning. The Council has invited prominent speakers from both the public and private sector to address the council. These include Bailus Walker, president, American Public Health Association; Richard Silkman, director, Maine State Planning Office; members of the Maine Department of Human Services, Maine Committee on Aging, and Maine Department of Labor; Francis McGinty, executive director, Maine Health Care Finance Commission; James Castle, president, Maine Hospital Association; Steven Michaud, director, Informational Services, Maine Hospital Association; John Dexter, president, Maine Chamber of Commerce and Industry; Christopher St. John representing Pine Tree Legal; Andrew Coburn, director, and Elizabeth Kilbreth, research associate, from Human Services Development Institute, University of Southern Maine; and William Johnson, president, Blue Cross and Blue Shield. Three meetings were held -- in Orono, Portland and Caribou -- in order to invite public discussion of the issue agenda for the upcoming year.

The Council commissioned one discussion paper in 1988. Jeanne Lambrew, a summer student intern for the Council, carried out a media survey of the nursing supply-demand problem. The Council is in the process of reviewing and discussing the implications of her findings, which emphasized the role of increased demand in the crisis. Reactions and responses to the paper have been requested from the Maine State Nursing Association and The Organization of Maine Nursing Executives. The study was presented to Senator George Mitchell at a hearing on the nursing shortage held in Portland on August 31. The study has generated considerable interest. Once comments have been received, they will be added to the study before its final publication.

The Council has begun an active review of the State health planning process. The Chair participated in a DHS session on the State Health Plan. Members of DHS and the State Planning Office have described their health planning activities to the Council, and it has solicited written descriptions of the planning process from other departments with health concerns as well. It is in the process of reaching consensus on the purpose of a State Health Plan and criteria for developing a plan. In this activity it is actively engaged with the appropriate public bodies. It is also actively soliciting the opinion of private sector groups such as the Maine Hospital Association which have expressed concern over the lack of a State health plan.

Tel: 289-2814

STATE OF MAINE
HEALTH FACILITIES COST REVIEW BOARD
Station 102
235 State Street
Augusta, Maine 04333

February 24, 1982

The Honorable Joseph E. Brennan
Governor of Maine
State House
Augusta, Maine 04333

Dear Governor Brennan:

I am enclosing a copy of the draft legislation which reflects the Board's recommendations as presented in its report Hospital Cost Containment in Maine. Like the Board's report, this draft legislation was approved without a dissenting vote.

I would be pleased to discuss the draft legislation with you or your staff at your convenience.

Sincerely,

David P. Cluchey

David P. Cluchey
Chairman

DPC:wb
enc.

Draft submitted by the
Health Facilities Cost
Review Board

AN ACT to Amend the Health Facilities Information Disclosure Act

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, major changes in the payment systems for hospital services will encourage the most efficient use of resources; provide predictability in payment amounts for payers, providers and patients; assure accountability to the public; ensure equity among payers and preserve the financial viability of Maine's hospital system; and

Whereas, the beneficial effects of these changes will be enhanced by the coordination of programs of budget review, Certificate of Need, hospital utilization review and appropriateness review; and

Whereas, a new payment method for hospital services and the coordination of the major programs overseeing hospital activities can contribute significantly to the building of a strengthened system for the delivery of high quality hospital services in Maine; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. 22 MRSA §351, as enacted by P.L. 1977, c. 691, §1, is amended by adding after the third paragraph the following:

It is further the intent of the Legislature to establish a hospital payment system which:

1. Efficiency. Encourages the most efficient use of resources in providing hospital services;

2. Predictability. Provides predictability in payment amounts for payers, providers and patients;

3. Accountability. Assures accountability to the public;

4. Equity. Ensures equity among payers; and

5. Financial viability. Preserves the financial viability of Maine's hospital system.

It is further the intent of the Legislature to provide for coordination among programs of hospital budget review, Certificate of Need, hospital utilization review, and appropriateness review.

Sec. 2. 22 MRSA §351, next to last paragraph, as enacted by P.L. 1977, c. 691, §1, is repealed.

Sec. 3. 22 MRSA §352, sub-§§8, 9 and 10, as enacted by P.L. 1977, c. 691, §1, are repealed.

Sec. 4. 22 MRSA §352, as enacted by P.L. 1977, c. 691, §1, is amended by adding the following and renumbering the subsections 1-10 accordingly:

11. Appropriateness review. "Appropriateness review" means a process by which an authorized public body makes prospective determinations as to whether and under what circumstances specific types of medically necessary services are to be provided in hospitals.

12. Appropriate service. "Appropriate service" means any type of service which, in the absence of an appropriateness review determination to the contrary, a hospital may provide under federal or state statutes or regulations.

13. Designated budget review organization. "Designated budget review organization" means a nonprofit organization approved by the Board, as provided under section 364-A, established to conduct reviews of hospital budgets for fiscal years beginning on or after July 1, 1983 and to carry out the other duties provided under this Chapter.

14. Statewide maximum revenue authorization. "Statewide maximum revenue authorization" is the amount of aggregate statewide hospital revenues established by the Board as provided under section 361-A.

Sec. 5. 22 MRSA §353, sub-§1, first paragraph, as enacted by P.L. 1977, c. 691, §1, is amended to read:

1. Health Facilities Cost Review Board: established. There is established a Health Facilities Cost Review Board which shall function as an independent board. The Board shall be composed of ~~10~~ 12 members. ~~Eight~~ Ten members shall be appointed by the Governor, subject to review by the Joint Standing Committee on Health and Institutional Services and confirmation by the Legislature. The Commissioner of Human Services or his designee shall serve as an ex officio voting member of the Board; the Superintendent of Insurance or his designee shall serve as an ex officio nonvoting member of the Board. The 8 10 members appointed by the Governor shall be selected in accordance with the following requirements:

Sec. 6. 22 MRSA §353, sub-§1, paragraph D, as enacted by P.L. 1977, c. 691, §1, is repealed and the following enacted in its place:

D. One member shall be a physician licensed under state law to practice medicine or osteopathy and shall be appointed from a list of four names submitted jointly by the Maine Medical Association and the Maine Osteopathic Association.

E. Six public members shall be appointed as consumers of health care. Neither the public members nor their spouses or children shall, within the 12 months preceding appointment, have been affiliated with, employed by, or have had any professional affiliation with any health care facility or institution, health product manufacturer or corporation or insurer providing coverage for hospital or medical care; provided that neither membership in nor subscription to a service plan maintained by a nonprofit hospital and medical service organization, nor enrollment in a health maintenance organization, nor membership as a policyholder in a mutual insurer or coverage under such a policy, nor the purchase of or coverage under a policy issued by a stock insurer shall disqualify a person from serving as a public member.

Sec. 7. 22 MRSA §353, sub-§2, last sentence, as enacted by P.L. 1977, c. 691, §1 is repealed.

Sec. 8. 22 MRSA §356, as enacted by P.L. 1977, c. 691, §1, is amended to read:

The Board is authorized to employ, subject to the personnel laws, such staff as it deems necessary. ~~The department may provide staff, facilities and other appropriate assistance to the Board. Any staff provided by the department shall carry out duties assigned by the Board.~~ Upon request from the Board, the department may provide the Board with appropriate administrative and technical services and the use of facilities and equipment.

Sec. 9. 22 MRSA §357, sub-§3, as enacted by P.L. 1977, c. 691, §1, is amended to read:

3. Studies and analyses. Have the power to conduct or cause to be conducted by the designated budget review organization studies and analyses relating to health care costs and other related matters as provided in section 360;

Sec. 10. 22 MRSA §357, as enacted by P.L. 1977, c. 691, §1, is amended by adding the following at the end:

9. Statewide maximum revenue authorization. Establish the statewide maximum revenue authorization as provided in section 361-A.

10. Determinations of equity among purchasers. Make determinations of equity among purchasers as provided in section 361-B.

11. Approval or withdrawal of approval of designated budget review organization. Approve or withdraw approval of a designated budget review organization for the purposes of section 359-A, as provided in section 364-A.

12. Review and approval of budgets. Review and approve individual hospital budgets, as provided in section 359-A.

13. Appeals and reconsideration. Hear and make decisions on appeals from determinations of the designated budget review organization and act on requests for reconsideration of actions taken by the Board.

14. Coordination with Certificate of Need program. Provide for coordination between programs of budget review and Certificate of Need, as provided under section 361-E.

15. Coordination with hospital utilization review. Provide coordination between programs of budget review and hospital utilization review, as provided under section 361-F.

16. Coordination with appropriateness review. Provide coordination between the budget review program and an appropriateness review process, as defined in section 352, sub-§11, and as provided under section 361-G.

17. Rules. Adopt rules, in accordance with section 366, necessary for the administration and enforcement of this chapter.

18. Selection of public members of budget review panel. Submit names for appointments as public members of the budget review panel of the designated budget review organization, as provided in section 361-H.

19. Standard fiscal years. Provide for the standardization of hospital fiscal years as may be necessary in order to carry out this chapter.

20. Fees. Charge and retain fees as provided in sections 359-A and 361-I.

Sec. 11. 22 MRSA §357, sub-§§7-8, as enacted by P.L. 1977, c. 691, §1, are repealed.

Sec. 12. 22 MRSA §359, as enacted by P.L. 1977, c. 691, §1, is repealed.

Sec. 13. 22 MRSA §359-A, is enacted to read:

§359-A. Review and approval of budgets.

1. Review authority. Effective with fiscal years beginning on or after July 1, 1983, the designated budget review organization shall have the authority to review and approve individual hospital budgets, as provided in subsection 3 of this section. In the absence of a designated budget review organization, the Board shall carry out the responsibilities assigned to the designated budget review organization in this section.

2. Submission of budget. Effective with fiscal years beginning on or after July 1, 1983, each hospital shall submit to the designated budget review

organization the budget for its next fiscal year, together with any other relevant supplemental reports and information which the designated budget review organization may require, within a reasonable period as prescribed by the designated budget review organization in its budget review procedures.

3. Review and approval of budgets. The designated budget review organization shall review and approve individual hospital budgets in accordance with the following:

A. The statewide total of all budgets reviewed and approved by the designated budget review organization shall not exceed that portion of the statewide maximum revenue authorization provided by the Board for allocation by the designated budget review organization.

B. In approving an individual hospital's budget, the designated budget review organization shall consider all available financial resources of the hospital.

C. The review and approval of any budget shall include but not be limited to determinations on the following:

(1) The prospectively determined financial requirements of each hospital are reasonable for the total services to be provided by the hospital;

(2) The financial resources provided for in the budget of each hospital are sufficient to meet the hospital's financial requirements but are not excessive; and

(3) The prospectively determined revenues are allocated equitably among all purchasers of hospital services, as provided under section 361-B.

4. Budget review findings. Upon completion of its review the designated budget review organization shall make a written report of its findings to the hospital whose budget has been reviewed and to the Board.

5. Basis of payment. The aggregate revenues approved by the designated budget review organization shall be the basis of payments to hospitals for the fiscal year reviewed unless this determination is amended through an appeal or a reconsideration as provided in section 361-C.

6. Fees. The designated budget review organization or, in the absence of a designated budget review organization, the Board is authorized to charge each hospital submitting its budget a fee sufficient to provide for the cost of the budget review. The Board shall establish by rule, in accordance with section 366, any fees which it is authorized to charge under this section. The Board is authorized to retain any fees collected for the purpose of carrying out budget reviews.

Sec. 14. 22 MRSA §360, as enacted by P.L. 1977, c. 691, §1, is amended to read:

§360. Studies and analyses

1. Studies and analyses. The Board is authorized to conduct or cause to be conducted by the designated budget review organization studies and analyses relating to costs of health care services rendered, to the financial status of any facility subject to this chapter or to any other related matters which it deems appropriate. The designated budget review organization may charge the Board a fee to recover the reasonable costs incurred in carrying out any study requested. The Board shall coordinate its activities with any public or private agency in carrying out these studies and analyses when this coordination will promote economy, avoid duplication of effort and make the best use of available personnel and other resources.

Sec. 15. 22 MRSA §361-A-§361-H are enacted to read:

§361-A. Statewide maximum revenue authorization

1. Establishment. The Board shall establish in a timely manner prior to the beginning of each fiscal year a statewide maximum revenue authorization.

2. Calculation. The statewide maximum revenue authorization shall be calculated to include, but not be limited to, the following factors: inflation, the costs associated with projects which have been approved under the Certificate of Need program, changes in the volume and intensity of hospital services, changes in the total population and the age composition of the population, the costs associated with regulatory requirements and the effect of any determinations as to the appropriateness of services offered.

3. Rules. The Board shall adopt rules for the establishment of this authorization.

A. These rules shall provide for implementation of the authorization in such a way as to permit exceptions due to unforeseen circumstances and the retention by the Board of a portion of the authorization for purposes of financing appeals, reconsiderations and other determinations by the Board as provided under this chapter.

B. These rules shall include provisions for public hearings prior to the establishment of the authorization.

C. No authorization shall be established prior to the adoption of these rules.

§361-B. Determinations of equity among purchasers

1. Payments of approved revenues. All purchasers of hospital services shall pay in accordance with the approved aggregate revenues of each hospital for its services, except as provided in this section.

2. Determinations. The Board is authorized to make determinations of equity in order to assure that the approved aggregate revenues statewide are allocated equitably among all purchasers of hospital services.

A. The Board may conduct any studies or investigations necessary to make these determinations of equity.

B. In making these determinations of equity the Board is authorized to provide for different payment rates for different purchasers if, in the judgment of the Board, such differences are justified by demonstrated and quantified differences among purchasers in the services which they provide to hospitals.

C. The budget review and approval program provided under this chapter shall not be effective until the Board has made any determinations of equity which will be applicable under the program.

3. Rules. The Board shall adopt rules for making determinations of equity. No determinations shall be made prior to the adoption of these rules.

§361-C. Appeals

Any purchaser of hospital services or any hospital may file an appeal with the Board within 30 days following any review and approval of the hospital's budget by the designated budget review organization.

A. The Board may affirm the determination of the designated budget review organization, may remand the budget to the designated budget review organization for reconsideration or may amend the determination of the designated budget review organization.

B. The Board shall adopt rules which provide for the procedures to be used in hearing appeals.

§361-D. Participation in payment system

The Board shall seek agreements for participation in the payment system required under the budget review and approval program provided in this chapter from the department and from the United States Department of Health and Human Services.

The payment system provided under this chapter shall not be effective until the Board has obtained these agreements for participation.

§361-E. Coordination with Certificate of Need program

1. Budget review determinations shall be consistent with the decisions made under the Certificate of Need law, as follows:

A. In the review and approval of individual hospital budgets, the designated budget review organization shall include the lesser of the maximum capital expenditures approved by the department in issuing the Certificate of Need or the actual capital expenditures made by the hospital.

B. In the review and approval of individual budgets, the designated budget review organization shall include the lesser of the annual revenues and operating costs in the application submitted for a proposal for which the department has issued a Certificate of Need or the financial requirements determined by the designated budget review organization.

(1) Any determinations by the designated budget review organization shall be consistent with rules adopted by the Board for carrying out the provisions of this paragraph.

(2) These rules shall assure that adequate financial resources are provided to meet the fixed operating costs associated with a proposal for which the department has issued a Certificate of Need, while permitting the Board or the designated budget review organization to

review and make determinations on those financial resources which are deemed necessary to meet the variable operating costs associated with such a proposal.

2. The Board and the designated budget review organization may provide consultation, reports and testimony on any application or on the cumulative effects of applications filed under the Certificate of Need law.

§361-F. Coordination of hospital utilization review

1. In recognition of the need for individual hospitals to maintain effective utilization review programs and for the statewide coordination of these programs, the Board is authorized as follows:

A. In consultation with hospitals, physicians, the major purchasers of hospital services and the department, the Board shall encourage the development of a statewide program of hospital utilization review coordinated by a single agency or organization;

B. The Board may require each hospital to establish and file a utilization review plan with the statewide coordinating agency for utilization review. The plan shall apply to the care rendered to all patients on a sampling basis and shall provide for review by the hospital's medical staff of factors including but not limited to the necessity of admission and length of stay and for concurrent monitoring focused on identified problem areas;

C. The Board may require the filing of utilization review information and the provision of this information in a standard form with the statewide coordinating agency or organization;

D. The Board may provide for public access to the information filed with the statewide coordinating agency or organization, provided that individual patients or health care practitioners are not directly identified.

E. In the absence of a statewide coordinating agency or organization, the Board may, after January 1, 1983, establish and coordinate a statewide utilization review program.

2. The Board shall provide for coordination between the statewide utilization review program and the budget review program required under this chapter.

3. The Board shall adopt rules to carry out any duties provided by this section.

§361-G. Coordination with appropriateness review

1. The Board and the designated budget review organization shall ensure coordination between the budget review program and the determinations made under an appropriateness review process, as follows:

A. Statewide maximum revenue authorization. In its calculation of the statewide maximum revenue authorization, the Board shall include only appropriate services;

B. Budget review and approval. In the review and approval of individual hospital budgets, the designated budget review organization shall include only appropriate services.

2. Program. In consultation with hospitals, physicians, major purchasers of hospital services and the department, the Board shall encourage the development and implementation of a program of appropriateness review, as defined in section 352, subsection 11.

§361-H. Appointments to budget review panel

The designated budget review organization shall select each public member of its budget review panel from a list of three names submitted by the Board for each vacancy.

§361-I. Fees

The Board is authorized to charge and retain fees to recover the reasonable costs incurred both in reproducing and distributing reports, studies and other publications and in responding to requests for information filed with the Board.

Sec. 16. 22 MRSA §362, as enacted by P.L. 1977, c. 691, §1, is amended by adding the following sentence at the end:

This section shall not be construed as limiting the authority of the Board to charge fees as provided under section 359-A.

Sec. 17. 22 MRSA §364, as enacted by P.L. 1977, c. 691, §1, is repealed.

Sec. 18. 22 MRSA §364-A is enacted to read:

§364-A. Approval of a designated budget review organization

1. The Board shall approve a designated budget review organization which meets each of the following criteria.

A. The budget review and approval procedures are likely to permit the designated budget review organization to make determinations which include but are not limited to the following:

(1) The prospectively determined financial requirements of each hospital are reasonable for the total services to be provided by the hospital;

(2) The financial resources provided for in the budget of each hospital are sufficient to meet the hospital's financial requirements but are not excessive;

(3) The prospectively determined revenues are allocated equitably among all purchasers of hospital services, as provided under section 361-B; and

(4) The statewide total of all budgets reviewed and approved by the designated budget review organization shall not exceed that portion of the statewide maximum revenue authorization provided by the Board for allocation by the designated budget review organization.

B. The structure of the designated budget review organization provides for the reviews to be made and the actions to be taken with respect to the reviews by a body of the designated budget review organization which includes equal representation from members approved by the Maine Hospital Association, major 3rd party payers and consumers of health care.

(1) Neither the consumers nor their spouses, children or parents shall, within the 12 months preceding appointment, have been affiliated with, employed by or have had any professional affiliation with any health care facility or institution, health product manufacturer or corporation or insurer providing coverage for hospital or medical care; provided that neither membership in a nonprofit hospital and medical organization, coverage for hospital care under an insurance policy, nor service as a corporator or member of an honorary board of a health care facility or institution shall operate to disqualify a person from serving as a public member.

C. The procedures of the designated budget review organization with respect to the filing of appropriate financial information and the analysis and verification of that information are sufficient to permit the designated budget review organization to make determinations which include but are not limited to the following:

(1) The prospectively determined financial requirements of each hospital are reasonable for the total services to be provided by the hospital;

(2) The financial resources provided for in the budget of each hospital are sufficient to meet the hospital's financial requirements but are not excessive;

(3) The prospectively determined revenues are allocated equitably among all purchasers of hospital services, as provided under section 361-B; and

(4) The statewide total of all budgets reviewed and approved by the designated budget review organization shall not exceed that portion of the statewide maximum revenue authorization provided by the Board for allocation by the designated budget review organization.

D. All budget reviews and determinations and all information relating to budget review activities of the designated budget review organization shall be subject to the provisions of the Freedom of Access law.

2. Time for approval. The Board shall, upon receipt of a request for approval by a designated budget review organization, make a determination within a reasonable period of time.

3. Limit on approval of organizations. The Board may approve no more than one designated budget review organization for any single year of budget reviews.

4. Withdrawal of approval. The Board may withdraw approval from a designated budget review organization after a public hearing, conducted in conformance with rules and regulations adopted under section 366, for either or both of the following reasons:

A. The designated budget review organization no longer satisfies the criteria contained in subsection 1; or

B. The procedures of the organization have not been applied in such a way as to satisfy the criteria contained in subsection 1.

5. Filing of findings and comments. An approved designated budget review organization which conducts a review of a hospital budget shall file a copy of its findings and comments with the Board upon completion of its review, as provided in section 359-A, subsection 4. In addition, the designated budget review organization shall upon request make available to the Board, the original and the accepted budget of the affected hospital and any other financial information acquired by the organization during the course of its review.

6. Notification of intent to become approved organization. Prior to approval, any designated budget review organization duly incorporated under the laws of Maine shall notify the Board in writing of its intention to become a designated budget review organization as defined in this section.

A. Upon receipt of this notice, the Board shall direct the organization to develop procedures and other criteria for approval as defined in subsection 1.

B. The Board shall review and comment on the application prior to its determination of approval of the organization.

7. State anti-trust exemption. Any parties required to participate under the budget review and approval or the payment system provisions of this chapter shall be exempt from Title 10, section 1101, et seq. and Title 5, section 207, et seq. for their conduct required pursuant to these provisions.

Sec. 19. 22 MRSA §368, as enacted by P.L. 1977, c. 691, §1, is repealed and and the following enacted in its place:

§368. Penalty

1. In the event of a violation of any provision of this chapter or of any regulations adopted by the Board, the Attorney General may institute injunctive proceedings to enjoin any further violation thereof.

2. Any person or health care facility violating any provision of this chapter or any valid order, rule or regulation made or promulgated pursuant to this chapter shall be deemed to have committed a civil violation for which forfieture of not more than $100 a day may be adjudged.

Sec. 20. 22 MRSA §370, as enacted by P.L. 1977, c. 691, §1, is repealed.

Sec. 21. Appropriation. There is appropriated from the General Fund the sum of $200,000 to carry out the purposes of this Act.

Health Facilities Cost Review Board	1982-83
Positions	(1)
Personal Services	$ 80,000
All Other	120,000
Capital	--
Total	$200,000

Sec. 22. Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved, except that sections 2, 3, 11, 12, 17, shall be effective on July 1, 1983.

HELEN T. GINDER, DIRECTOR
HAVEN WHITESIDE, DEP. DIRECTOR
GILBERT W. BREWER
DAVID C. ELLIOTT
GRO FLATEBO
MARTHA E. FREEMAN, SR. ATTY.
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10/18/88
6741m

TO: BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

FROM: Annika Lane

SUMMARY OF LEGISLATION PROPOSED BY THE HEALTH FACILITIES COST REVIEW BOARD. FEBRUARY, 1982

In February of 1982, the Health Facilities Cost Review Board proposed legislation to Governor Brennan that would result in major changes to Maine's Health Care regulatory system.

The legislation proposes to amend the Health Facilities Information Disclosure Act (22 MRSA §357 as enacted by P.L. 1977, c. 691) to implement its recommendation that a mandatory prospective payment system be established.

The Governor accepted the general principles of the legislation, but requested further revision to include more detail on components of the rate setting system. The Board was instructed to work with the Department of Human Services on a revised version, which resulted in the current statute establishing the Maine Health Care Finance Commission in 1983 (22 MRSA c 107 § 381).

I have summarized the key provisions, to spare you the trouble of flipping back and forth between the original legislation and proposed amendments.

Enclosures:

1. Draft legislation submitted to Governor Brennan by the Health Facilities Cost Review Board, February, 1982,

2. Health Facilities Information Disclosure Act, P.L. 1977, c 691.

3. 22 MRSA, Chapter 107, Maine Health Care Finance Commission.

HEALTH FACILITIES COST REVIEW BOARD
PROPOSED LEGISLATION, FEBRUARY 1982.
SUMMARY OF KEY PROVISIONS

1. Establishing a hospital payment system which focuses on:

a) Efficient use of resources
b) Predictability in payment
c) Accountability
d) Equity among payors
e) Preserving the financial viability of Maine's hospitals

2. Provides for coordination among programs of:

a) Hospital Budget Review
b) Certificate of Need
c) Hospital Utilization Review
d) Appropriateness Review

3. Establishes an independent Health Facilities Cost Review Board, consisting of 12 members, with a term of four years. The Board's duties (22 MRSA §357, as enacted by P.L. 1977, c691, §1) are expanded by the proposed legislation (Page 5, Sec 10). Total duties including the proposed amendment would be:

The Board shall:

a) Establish uniform systems for reporting financial and other health service data.
b) Review hospital budgets and revenues.
c) Conduct studies and analyses
d) Prepare an annual report to the Legislature and Governor
e) Have the power to apply for grants etc
f) Contract for services
g) Approve voluntary budget review organizations
h) Develop performance standards
i) Establish a statewide maximum revenue authorization
j) Make determinations of equity among purchasers
k) Approve or withdraw approval of a designated budget review organization
l) Hear and make decisions on appeals from determinations of the designated budget review organization and act on requests for reconsideration of actions taken by the Board
m) Provide coordination between programs of budget review and hospital utilization review
n) Provide coordination between the budget review program and an appropriateness review process
o) Adopt rules
p) Submit names for appointments as public members of the budget review panel
r) Provide for the standardization of hospital fiscal years
s) Charge and retain fees

4. Some of the above powers/duties expanded by the proposed legislation, that may be of interest to Commission members are:

g) That the Board approves a nonprofit budget review organization that is established to conduct reviews of individual hospital budgets for each fiscal year (§364-A, page 14).

i) That the Board shall establish a statewide maximum revenue authorization (the amount of aggregate statewide hospital revenues established under §161-A, page 9), which shall be calculated to include, but not be limited to:

- Inflation
- Costs associated with projects which have been approved under the CoN program
- Changes in the volume and intensity of hospital services
- Changes in the total population and age composition of the population
- Costs associated with regulatory requirements
- The effect of any determinations as to the appropriateness of services offered.

j) Make determination of equity among payors (Sec 361-B, page 9)

All purchasers of hospital services shall pay in accordance with the approved aggregate revenues of each hospital for its services.

The Board makes determinations of equity to ensure that the approved aggregate revenues statewide are allocated equitably among all purchasers of hospital services

m) Provide coordination between programs of budget review and hospital utilization review (§361-F, page 12).

Development of a statewide program of hospital utilization review coordinated by a single agency or organization. The Board may require each hospital to establish a utilization review plan with the statewide coordinating agency for utilization review.

Standardized filing of utilization review information.

n) Provide coordination between the budget review program and an "appropriateness review process".(§361-G, page 13).

Appropriateness review is defined as a process by which an authorized public body makes prospective determinations as to whether and under what circumstances specific types of medically necessary services are to be provided in hospitals.

The legislation proposes that the Board only include appropriate services in its calculation of the statewide maximum revenue authorization.

The designated budget review organization shall include only appropriate services in the review and approval of individual hospital services.

Appropriate services are defined as any service a hospital may provide under federal or state regulations or statutes - unless appropriateness review deems otherwise (Sec 4, sub-§12, page 3).

Further note: - The proposed legislation also states that budget review determinations shall be consistent with decisions made under the Certificate of Need Law (§356-E, page 11).