DRAFT REPORT

OF THE

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

August 5, 1988

Prepared for:

The Blue Ribbon Commission on Health Care Expenditures

by

Graham Atkinson, D.Phil.

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Preface

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

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

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

- The Commission to Study Access to Health Care

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

- The Maine Health Policy Advisory Council

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

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

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

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

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

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

Summary of Recommendations and Topics for Discussion

Hospital inpatient services

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

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

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

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

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

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

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

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

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

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

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

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

Hospital Outpatient Services

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

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

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

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

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

AIDS

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

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

Nursing homes

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

1) expansion of the supply of nursing home beds;

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

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

Physician shortages

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

Nurse and other health professionals

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

Mandated benefits

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

Regulation of hospital rates or revenues

Inpatient rates or revenues

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

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

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

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

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

Outpatient rates or revenues

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

Hospitals on the Total patient revenue system:

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

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

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

1) No regulation of outpatient rates, and

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

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

Input is solicited on the subjects of:

1) Whether hospital outpatient rates should be regulated,

2) The appropriate form of regulation of outpatient rates,

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

Components of the rate setting system.

Standard component or screens

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

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

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

Differentials and discounts

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

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

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

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

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

Appeal mechanism

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

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

Governmental shortfalls

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

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

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

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

Cross-subsidization

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

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

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

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

1 Eliminate all explicit subsidies from inpatient services

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

3 Have the level of subsidy set each year

The Commission has deferred a decision on this issue pending

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

Demonstrations

Several different types of demonstrations should be encouraged:

1) hospital payment demonstrations; and,

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

Hospital payment demonstrations:

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

Lower level facilities:

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

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

Pools for bad debts, charity care and governmental shortfalls

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

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

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

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

Rate Setting Body

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

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

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

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

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

Nursing homes

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

1) expansion of the supply of nursing home beds;

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

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

1. Expansion of the nursing home bed supply.

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

2. Providing financial incentives.

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

3. Eliminating marginal admissions.

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

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

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

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

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

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

Hospice

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

Physician Shortages

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

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

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

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

Particular programs which might be beneficial include:

1) Increase Medicaid payments for primary care physicians

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

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

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

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

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

Shortages of other health professionals

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

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

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

Mandated benefits

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

Data collection from non-hospital providers

The Commission has discussed non-hospital services, such as free standing clinics, surgi-centers, and diagnostic centers, and the shift of hospital provided services to these settings. There has been some discussion of extending some regulation to these settings, e.g., data collection. The Commission has not yet reached any conclusions on these issues.