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George E. McLean
President

February 18, 1982

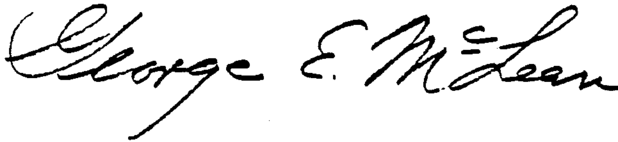
The Honorable Joseph E. Brennan
Governor of the State of Maine
State House
Augusta, ME 04333

Dear Governor Brennan:

As I mentioned to you in my letter of December 16, 1981, I have attached the Blue Cross and Blue Shield of Maine staff review of the Health Facilities Cost Review Board Report, Hospital Cost Containment in Maine.

If I or members of my staff can be of any further assistance to you, please let me know.

Sincerely,



GEM/jli

cc: David P. Cluchey, Chairman, Health Facilities Cost Review Board
Senator Barbara A. Gill, Co-Chairman, Health and Institutional Services Committee
Representative Merle R. Nelson, Co-Chairman, Health and Institutional Services Committee

BLUE CROSS AND BLUE SHIELD OF MAINE'S

REVIEW OF

THE HEALTH FACILITIES COST REVIEW BOARD REPORT

HOSPITAL COST CONTAINMENT IN MAINE

STUDY AND RECOMMENDATIONS

FEBRUARY 1982

EXECUTIVE COMMENT

Blue Cross and Blue Shield of Maine commends the Health Facilities Cost Review Board for their work in conducting such a timely and much needed study on the important and extremely complex subject of the present system for financing hospital service in Maine, for their efforts in evaluating the current efforts of Maine hospitals to voluntarily control costs, and for their assessment of the need for a mandatory hospital rate setting system.

We are aware of the considerable time and effort dedicated by the Board in examining some of the many important issues relative to the existing system for financing hospital care and some of the available alternatives to the existing financing system. Blue Cross agrees with the overall thrust of the Board's report that the present financing system should be changed. We strongly believe, however, that change needs to be brought about very carefully and deliberately and after considerably more examination of the issues. The Board has done a creditable job in highlighting some of the changes that we believe will have to be addressed. The Board report refers to several matters that interest Maine Blue Cross such as prospective reimbursement, a strengthened and mandatory budget review process, linkage between budgeting and Certificate of Need, development of a utilization review program, and a statewide maximum revenue authorization. However, we have a number of grave concerns about the report.

We feel that the report is incomplete and that it uses questionable data to reach conclusions that are not supported. We are concerned that the recommendations are entirely too broad and lacking sufficient detail. We cannot consider endorsing the report, nor do we think the Legislature should use it as the basis for making sweeping changes to the health care financing system in this state.

Additionally, we are concerned that presently there is no physician representation on the Board. The physician community is the most essential part of the health care delivery system and will be directly affected by changes to the hospital reimbursement mechanism.

We are particularly concerned that the new system would be implemented by administrative rule. This would deny the legislature its appropriate role of final review and approval of a plan for financing what is now an approximately $400 million per year hospital care delivery system, upon which the entire population of the state depends.

We are disturbed by assertions that Maine's hospital system is in financial danger and by the suggestions that Blue Cross is somehow at fault because allegedly we do not pay equitably. We do not believe this to be the case.

We are bothered by the notion, which is apparently commonly held, that the Board can get the Federal Government (Medicare) to participate in a prospective reimbursement system and thereby bring more federal dollars into the health care system in Maine. We also feel quite certain that the federal government will participate only where it can be demonstrated that overall Medicare payments to hospitals will be no greater than the amount that would have been paid under the existing system. We do believe, however, that full participation by government payors is essential to the success of any hospital reimbursement system.

Our most serious concern with the Board's recommendations is that there would be repercussions to the Blue Cross system for financing the delivery of health care. The Blue Cross method is to provide coverage for health care on a non-profit basis to the widest possible segment of the population at the lowest possible cost. This coverage is extended to those who would otherwise have difficulty obtaining affordable coverage. Coverage is not cancelled because of poor health experience by the subscriber, and it includes broad conversion privileges for those who change or lose their jobs. Other unique features of the Blue Cross method are the support of statewide health planning and utilization review programs, health promotion programs, and direct financial support of such programs as the Poison Control Center.

We are concerned that the changes envisioned by the Board could result in a higher and unfair payment to hospitals, and that this in turn would result in both higher subscription rates for our members and a reduction in the unique services noted above.

Because of the complexity of the hospital financing system, the danger of a misstep in overhauling the system in the manner that has been recommended, is real and can be catastrophic and have a far reaching impact on the health care system in the State of Maine. Blue Cross and Blue Shield of Maine urges an extension of the existing Health Facilities Information Disclosure Act beyond its expiration on June 30, 1982 and further that physician representation be added to the Health Facilities Cost Review Board. We recommend that the Board be charged with the responsibility for developing the details of a proposed system which would be sent to the legislature for review and approval in 1983.

Comments - Introduction

In the introduction of the report, Maine is compared to other rural states. However, it is not clearly established that these states are comparable to Maine.

In our view, and as Dr. James R. Diggins, President of Hospcost Forecast Associates, suggested to the Board in his August 7, 1981 testimony, making comparisons among various states is a highly complicated undertaking and one that can be done only after thorough research. Many things must be considered for such a comparison, such as, the patient mix in the state's hospitals, the population density (i.e., distance to hospitals), the number and size of the hospitals, the number of physicians, the number of physicians among the various specialties, and the changes that may be occurring in total population.

Several questions can be raised about the validity of the comparisons presented in the table on page 2 and the conclusions drawn from the figures presented. When comparing Maine to rural states in the area of expense per capita, Maine is higher. However, when comparing the increase in expense per admission, Maine is lower than the rural state figures.

It could be that Maine's higher expense per admission figure can be substantiated. In the expense per capita computation, a possible explanation could be that the population in the rural states used in the comparison is growing faster than the population in Maine, resulting in the lower per capita figure for the rural states compared to Maine. In other words, the numerator of the comparisons (expenses) may not be the problem, but the denominator (population) may be. Furthermore, what was the change in absolute numbers for the expense per admission comparison, the overall change in the base year expense per admission?

We feel that Maine's hospital system has changed dramatically over the last eight or ten years due to new services and to hospital expansions. Perhaps it has undergone more dramatic changes than the states used in the comparison. The increase of Full Time Equivalents (FTE) might represent such a change because perhaps Maine's hospitals were understaffed prior to that time. These are areas that must be examined in order to draw any valid conclusions from these comparisons.

In the same table, Maine is compared to regulated states that in many ways are dissimiliar from Maine. To make any valid comparison, a more complete collection of regulated states must be provided. For example, are the regulated states used in the comparison the states which have experienced the lowest rate of increase in hospital costs among both regulated and unregulated states? What percentage of the total number of regulated states do they represent?

Comments - Components and Causes of Hospital Expenditure Increase

In the Introduction to the report, Maine was compared to rural states in terms of increase in expenditures per capita, expenditures per admission, full time equivalents/day, and payroll/FTE. In the Components section, there is no discussion of comparable states and no attempt to determine if Maine's experience is reasonable or unreasonable. It would be meaningful to again look at Maine's experience in, for example, FTES/day, or payroll per FTE compared to other states.

This section of the report goes on to address the causes of hopsital cost increases and lists many of them ranging from public and private policy to individual behavior and its associated health risks. We certainly agree that the increased use of hospital services and the increased availability of new services have caused an increase in hospital costs. We suspect that for the most part the increased availability and use of new services are appropriate and that they have improved quality of care substantially.

The report does a good job of looking at some of the causes of the cost increase, but it does not address the upgrading of quality of patient care that is provided in Maine hospitals. It is possible that the present level of cost of hospital care in Maine is warranted. It may be that the system for providing hospital care in Maine is of appropriately high quality and that the cost may be the price we have to pay for that quality of care. We believe the Board should have included in their study an evaluation of this cost vs. quality issue. Another matter of importance that we think is related to the causes of hospital cost increase is the increasing average age of Maine's elderly population. Statistical evidence from our enrollment reveals that longevity is increasing noticeably.

In addition, the Board makes some connection between the statewide increase in the use of hospital services and its effect on increased costs. Over recent years Blue Cross has experienced some dramatic changes in the utilization of hospital services by our subscribers, changes that must have had a significant impact on statewide utilization figures. Blue Cross and Blue Shield of Maine enrollment is equal to over forty (40) percent of the population of the entire state and, thus, decreased utilization by Blue Cross members has a significant impact on statewide utilization and cost figures.

For a number of years we have experienced a steady annual reduction in in-patient hospital utilization. The days of in-patient hospital care for Blue Cross members in 1971 was 874 days per 1,000 members. In 1981, that figure was 557 days per 1,000 members, a reduction of 36% over eleven (11) years. In 1974 Blue Cross expanded outpatient benefits to include coverage for hospital out-patient laboratory and pathology services so that testing once done on an in-patient basis, could be done in a less costly out-patient area. In 1971 the figure for Blue Cross out-patient cases per 1,000 members was 284 and in 1981 the out-patient cases per 1,000 members had risen to 826. Even more noteworthy is that in recent years the increase in Blue Cross out-patient surgical cases has been double the increase in our overall out-patient cases. We think this latter activity is the direct result of our focused utilization review efforts.

The Board focuses on increasing volume as a contributing factor in the increase in hospital costs. However, if statewide utilization of in-patient services has experienced a major increase in recent years, what has caused the increase, especially, in view of the huge decrease for the Blue Cross population, almost half the total population of the State? What are the effects of these and other significant shifts in utilization on the various causes of hospital cost increase? What has happened to the utilization figures for the non-Blue Cross patients? In this section, the Board has raised some interesting and informative points, but we feel that this section of the report gives rise to unanswered questions.

Comments - Current Financing System

The Cost Review Board's assessment of the current financing system is another section of the report that we feel presents an opportunity for further analysis. A major issue that it fails to address is that of assessing the relationship between the financing system and the financial status of Maine's hospitals. We are aware of no evidence that the existing financing system has in general created a financial strain on Maine's hospitals. The report strongly recommends that something must be done to improve the financing system and thereby enhance the hospital's ability to acquire their financial requirements. Are Maine's hospitals, now, not receiving their financial requirements? This question cannot be answered from the study because it did not address the meaning of the phrase "financial requirements," a very complex issue, and did not compare Maine hospital experience against these requirements.

We believe the Board should have thoroughly examined the issue of determining financial requirements. The hospital's financial condition could then be assessed against such requirements. A complete analysis should include an examination of the various categories of payors and of what each category of payor is presently contributing to hospital financial requirements.

An important component of hospital financial requirements that must be included in any examination of the current financing system would be an examination of hospital bad debts. It is important to examine how bad debts contribute to hospital financing problems. For example, what are the sources of those bad debts? Are the sources of bad debts the result of uninsured patients, patients who have coverage with deductibles or coinsurance amounts or low level indemnity policies, or patients with Blue Cross, Medicare or Medicaid coverage?

On page 22, the report states, "On the average, revenue from services to patients is ninety percent or more of total revenue for Maine hospitals." Hospital needs are not met by the amount of the charges for services rendered to patients, but rather by payment actually received for the services provided. It is essential to examine the sources of patient revenue and to determine by payor category where the contributions and shortfalls appear. This examinatio can be done through a so-called level-of-payment analysis which would focus on amounts received by hospitals from each payment source rather than amounts charged by hospitals to each payment source.

The report implies that the current hospital system, that is, all hospitals and all services, must be maintained and that the "financial requirements" of all existing hospitals must be met. It also suggests that this would be done by somehow shifting or changing the payment system to meet all the requirements of all the hospitals. The report contains no analysis of efficiency or inefficiency among hospitals. The report focuses on the payment system to be the cause of high cost with no examination of hospital behavior or, and more importantly, physician behavior. The report blames the alleged hospital financing problem on the retrospective cost reimbursement system and the report seems to draw conflicting conclusions about the present system. An example of an area that warrants further examination is on page 15, where the report states that new technology is purchased by hospitals (which contributes to higher costs) and goes on to say how the retrospective cost reimbursement system provided the money and the incentives to purchase this new technology. On page 27, however, the report criticizes the retrospective cost based reimbursement system for failing to meet the financial needs of hospitals.

It also states that because of the way it has been implemented, it can actually threaten the financal viability of the hospitals. In short, the blame for the financial ills of the hospitals, if there are any, is put on the retrospective cost reimbursement system with no analysis of what those ills are. To state that this system of payment, in and of itself, may threaten the viability of Maine's hospitals is inappropriate and not substantiated by any evidence.

Also on page 27, the report states that hospitals must increase prices by four dollars in order to realize one additional dollar of revenue. It should be pointed out that this additional revenue is in excess of expense. The statement also points out the ease with which a hospital can generate additional profit by simply raising their prices. The four-to-one arugment is not true in all cases, however, because of the provision in the Blue Cross contract that guarantees a hospital at least 84% of the in-patient benefit or charge. Thus, to the one dollar of additional revenue, in many cases must be added the .84 dollar from the Blue Cross in-patient payment.

In several places the report implies that all third party cost reimbursers contribute to the hospital's financing problems. The report also points out the problem of the governmental payor "shortfall," or the amount that government payors, Medicare and Medicaid, do not contribute to "financial requirements. We feel that the Board has again done well to identify the problem of government shortfall but, once again, we feel that further examination is warranted. The government shortfall issue is another example of the Board's identifying a real problem in the existing financing system, but failing to thoroughly study the issue.

The report makes some distinction between Blue Cross, and Medicare and Medicaid when it points out that although all three payors reimburse hospitals based on costs, Blue Cross makes a contribution to hospital financial requirements by paying for certain items above costs. The report assumes that because Blue Cross reimburses hospitals through a cost based contract, that Blue Cross is not paying its share of hospital financial requirements. There is no examination, however, of the Blue Cross payment to hospitals. Blue Cross believes that it has always paid its share of hospital financial requirements. We also believe that as a payor category we have over the years contributed to Maine hospitals' financial requirements in an amount at least equal to the contribution made by any other payor classification. Again, it should be emphasized, that Blue Cross can demonstrate the fairness of its payment to hospitals in the context of the present payment system (under which we pay hospitals, in the aggregate, the cost of the services we purchase and, in addition, nearly 12% of these costs). In fact, in 1980, the total Blue Cross payment in addition to Blue Cross costs was $6,558,835 and the net aggregate Income From Operation for forty-seven Maine hospitals was $2,655,170.

On page 24 an inconsistency exists in that the report states that through retrospective cost reimbursement, increased expenses resulted in increased reimbursement while increased efficiency was not rewarded at all. On page 25, however, the report discussed the Blue Cross contract and states that it provides hospitals with incentive programs whereby payments are made as rewards when a hospital achieves the objective of each incentive program. The incentives were included in the Blue Cross contract specifically to help reduce hospital costs. In a recent twelve month period Blue Cross paid an additional $876,593 to Maine hospitals through the incentive programs.

The statement that a hospital's success in realizing its financial requirements depends on having a base of charge payors is not supported in any part of the report, and it is clearly incorrect. Our strong disagreement with this statement is based on the fact that the hospital bad debt problem is attributable to primarily, the charge payer category, and on the fact that Blue Cross, a contract payor, makes a substantial contribution to hospital financial requirements through its existing reimbursement contract.

Comments - Voluntary Budget Review Program

We agree with much of the Board's assessment of the Voluntary Budget Review Program. We also believe, however, that the Board's assessment can only be regarded as premature, as it is inappropriate to finally judge the VBRO after its review of only one complete budget cycle. The Board has done well to point out that the process must be strengthened especially in the area of compliance.

The VBRO has authority to approve or disapprove hospital budgets, however, it should have the authority to make more definitive and binding recommendations to hospitals.

We think it is important to point out that in the current Blue Cross hospital contract negotiations, we and the hospitals plan to utilize the VBRO process in our proposed prospective reimbursement system. For our purposes, as stated above, the process will have to be strengthened considerably. Our view on improvements to the VBRO process are consistent with those that the Cost Review Board has suggested. We believe our intent to utilize the VBRO process will fully address the concerns of the Board about linking the budge process to the payment system, and it is happening voluntarily through the contract negotiation process.

In the summary section on the VBRO, the Board points out among other things, that the law requires determination of payor equity but does not provide a mechanism to deal with it. It is important to also point out, however, that the law also provides for equitable payment without undue discrimination. It is inappropriate to assume that equitable payment means all payor classifications pay the same rate. Payor equity is far more complex than unilaterally including payors in the payment system. Such determinations can only be made after considerable research of this issue.

Comments - Alternatives

As an alternative to the present retrospective cost reimbursement system, the Board suggests a prospective payment system. It also lists the advantages of prospective reimbursement such as the inherent incentive to control costs, and its ability to lend predictability and accountability to the hospitals and the payors. It is for these very reasons that Blue Cross and Blue Shield of Maine and Maine hospitals have been negotiating a prospective reimbursement contract, as stated to the Board in our testimony before them in September.

Although prospective reimbursement has some important advantages over retrospective reimbursement, it is a change in the reimbursement system and it cannot be considered a panacea for controlling hospital costs. Recent studies (done for the Health Care Financing Administration) find that there is no common denominator distinguishing effective prospective reimbursement programs from ineffective programs. This lends support to the argument that the design of the program is the prime determinent of its cost containment effectiveness.

On page 45, the report states that to the extent that the program includes all payors, a measure of equity is assured. The question of equity has been addressed earlier in this paper.

Comments - Recommendations

In its recommendations for changes in the existing system for financing hospital care, the Board lists the objectives that served as its framework. Blue Cross and Blue Shield of Maine agrees wholeheartedly with those objectives, but as noted previously in this response to the report, we have very strong disagreement as to how some of those objectives might be met.

1. Prospective Payment System.

   We believe public discussion of hospital financial requirements should be held prior to the design of the system that is intended to provide them. We submit that this issue is an extremely complex one and one that carries with it many social and political ramifications.

   The notion of justifying payor differentials is also no simple matter. Under the present Blue Cross reimbursement contract this differential is not negotiated. Essentially, Blue Cross and Maine hospitals negotiate the amounts that will be paid by Blue Cross against the cost of services provided to Blue Cross members plus other financial requirements of the hospital. The hospital then determines the differential by setting its charges above or below this negotiated Blue Cross payment amount. Under the Board's proposed system, the Board would determine the differential given to a payor group. If this is going to be done, it must be done by individuals who have the experience and training to quantify items for which differentials are earned such as:

   - Incurred Bad Debts
   - Prompt Payment
   - Substantial and Available Coverage
   - Open Enrollment
   - Group Conversion
   - Comprehensive Non-Group Coverage
   - Direct Payment
   - Community Education
   - Health Promotion
   - Utilization Review
   - Innovative Cost Containment Programs
   - Broad Underwriting Policies

The Board goes on to recommend that a waiver be sought from the Department of Health and Human Services for the inclusion of Medicare in the prospective payment system. We support the Board's intentions. It is important to point out, however, that in states where HCFA has granted waivers, the process of securing the waiver has taken, on the average, three years and Medicare waivers have not necessarily meant that Medicare pays the hospitals adequately, at least in the minds of hospitals.

In one waiver state Medicare has recently been granted a discount from charges of 11%. The Medicaid discount in that state is 13%. The granting of the waiver has in this case essentially institutionalized the problem that is was intended to alleviate.

What will be the cost of administering the new system? We believe it is of paramount importance to address this question before commiting additional resources from Maine's citizens to the health care system.

The maximum statewide revenue authorization is an idea that holds real potential for controlling hospital costs. We do, however, offer a word of caution in that there could be far reaching ramifications from such action. Limiting hospital revenues can result in the rationing of medical care, which means that the decisions will have to be made on who receives care and who does not. This action, we believe, has the potential for lowering the quality of care that is currently rendered in Maine's hospitals. This extremely sensitive and complex issue, and public discussion of it, must include input from the physician community.

Allocating an approved total revenue limit among the hospitals will be very complicated and may disrupt any balance of revenue distribution that currently exists. For example, if one of Maine's hospitals is able to make a case that their budget must exceed their historical share of the overall revenue, will some other hospital have to make up this difference by reducing their budget?

We have shared our views on the changes recommended for the VBRO in an earlier section of this response. Again, we want to emphasize that we have proposed major changes to the VBRO budget review process in our current contract negotiations with the Maine hospitals and that our proposed changes are not inconsistent with those recommended by the Board.

2. Coordination of Budget Review And Certificate of Need.

The coordination of the Certificate of Need process and the budget review process is indeed very important. Again, this is a complex matter which the Board has not addressed in sufficient detail in this report. How will the coordination take place? We believe that because of the expected effectiveness such coordination can lend to the payment system, it should be addressed as an integral part of the proposed system.

3. Coordination of Budget Review and Utilization Review.

The development and coordination of a utilization review program will be a difficult task. We can attest to this on the basis of our own experience as we had to deal with the many difficult issues in developing the Blue Cross utilization review program which is intended to replace that of the Pine Tree Organization for Professional Standards Review, Inc.

Additionally, the linking of utilization review to the payment system has not been done in any other prospective reimbursement system to our knowledge. It is an area that requires much more examination. Furthermore, it is an area in which there is no substitute for physician involvement.

4. Health Maintenance Measures.

We are pleased that the Board included a statement on health maintenance measures. If hospitals and other health institutions are to affect the use of medical services and reduce the overall cost of services, serious attention must be given to the understanding and development of health maintenance measures, commonly referred to as health promotion. We believe effective health promotion programs have an important role in curbing the use of hospital services and we agree with the Board that further discussions must be held on how to appropriately include health promotion programs in the overall strategy for containing hospital cost.

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