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ASPECTS OF NATIONAL HEALTH INSURANCE: PROSPECTIVE HOSPITAL RATES

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The purpose of my talk is to report on the introduction in Colorado of a system for budgeting state Medicaid reimbursements based on future cost estimates rather than on computations of incurred costs retrospectively determined. I shall also describe some of the difficulties with the incurred costs system and some of the background leading to the decision to change.

In November, 1970, Mr. Con F. Shea, executive director of the Colorado Department of Social Services, expressed to me his concern for the department's ability to meet the calls on its funds. He felt he might be forced to prorate monies then remaining of the appropriation granted for inpatient hospital care over the rest of the fiscal year ending June 30, 1971. The magnitude of retroactive cost adjustments had not been anticipated in the budget. If the legislature should refuse to approve a supplemental appropriation, he would have no choice other than proration.

Many of the states have had this budgetary problem and several–notably California and New York–have been prominent in newspaper articles about efforts to finance and control their Medicaid programs. The Georgia Medicaid program announced in June 1971 that beginning July 1 it would reimburse only 90 percent of the amount of Medicaid bills submitted to it.

In the spring of 1971, the Colorado Department did receive a supplemental appropriation for inpatient hospital care, but the hearings were rough. The Joint Budget Committee of the legislature asked why the department could control so well the much larger nursing home program but was seemingly not in control of the hospital program.

SOME REASONS FOR THE DIFFICULTIES

There were, of course, many reasons, but primarily it was because no one in Colorado knows what hospital costs have been until cost reports are received. Too many Colorado hospitals were accepting the same interim rate of payment for a Medicaid patient as they received for a Medicare patient,

even though the Social Security Administration contended before Medicare began that elderly patients incur less than average costs because of their longer convalescing stay. The Senate Finance Committee Report on HR17550 (proposed Social Security Act amendments) said that there was every reason to believe Medicare and Medicaid patient costs would *not* be the same.

Many of our hospitals were inattentive to the Medicaid interim rate because Medicaid patients were a relatively low percentage of their total census. A problem was also caused by the lag in adjusting reimbursement rates to rising costs. It had to be proved that costs had increased to a new level before a new rate would be approved, and the new rate would be in effect for a future period during which costs would continue to rise. This has been relatively immaterial to the hospitals because corrections are made in final settlements based on cost reports, but it has been disastrous to Social Services Department people responsible for budgeting.

The Joint Budget Committee of the Colorado Legislature said some other way had to be found to pay for hospital care. The committee understands how the number of cases can increase over those projected, but seems impatient with errors in unit costs. The Department of Social Services wants a system in which the hospitals are paid in terms of current costs, are afforded an opportunity for profit, but are not guaranteed against loss.

RECOMMENDATIONS BY THE AMERICAN HOSPITAL ASSOCIATION ADVISORY PANEL ON MEDICARE REIMBURSEMENT

I wish to quote some of the recommendations made by the advisory panel on Medicare reimbursement on November 14, 1969 to the board of trustees of the American Hospital Association (AHA):

> Although the statement on financial requirements currently states that many methods of payment may be employed in the implementation of the financial requirements approach to reimbursement, the association should reject the continued use of a retrospectively determined cost basis of reimbursement for the financing of patient care services. Such cost-based methods of reimbursement are not in the best interest of the consumers, contracting agencies or health care institutions. The retrospective method of measuring allowable cost is, by its nature, extremely costly from an administrative standpoint, because of the complexity of cost finding and the resulting necessity for duplicative audit by numerous agencies. Such cost-based methods are even more inefficient in the sense that they significantly diminish the hospital administrator's ability to control cost within the health care institution. Frequently, the administrator is faced with requests for additional personnel or new

services with the single and underlying rationale that such costs are reimbursable under the cost-based method of reimbursement. In addition, many economists point out that a cost basis of reimbursement provides no positive incentive for cost containment or reduction.

The panel also observed that in many current situations the cost-based method of reimbursement has led government agencies to seek methods of cost control through the imposition of arbitrary ceilings on reimbursement. Such arbitrary and capricious attempts at controlling cost without any review of the individual nature and needs of the health care institution must necessarily result in a diminution in the quality of institutional health care.

Community-negotiated rates should be established for the financing of patient care as a vastly superior method to the cost-based reimbursement system currently employed by the federal government and many other contracting agencies. The community-negotiated rate system of reimbursement should include the following characteristic:

The health care institution should propose prospectively (prior to rendering service) a schedule of the necessary payment for services on the basis of demonstrated financial requirements of that institution for the rendering of those services.

The health care institution's proposal for prospectively determined rates should be reviewed by a locally constituted community rate review agency.

[Consumers, contract agencies and/or intermediaries, and health care institutions should have equal representation on the community rate review agency, whose function is to review performance, financing and utilization of previous periods, as well as to approve the reimbursement rate for the next fiscal period. An appropriate appeal mechanism for all parties should be established. (We did not propose equal representation from consumers in the Colorado system.)]

The community-negotiated rate basis of payment inherently provides incentives for efficient and effective management. Negotiation, prospectively, of a predetermined amount per unit of service per given time period provides incentives to contain or even reduce costs. A health care institution is thus rewarded for savings realized through effective provision of health care during that time period. This method of payment also results in a rational disclosure of operating and financing reports through the rate review process, which should serve to further augment the incentives for effective management. In addition, it will provide sufficient visibility of hospital operations to serve as a further incentive for economy.

The community-negotiated rate process should result in a significant simplification of the reimbursement process by the elimination of multiple audits and by equating the information needs of sound managerial practices with those of the rate review process.

The AHA, in 1969, did propose modification of Medicare reimbursement, as follows:

> The much simpler and more prevalent method of using an average per diem method of apportioning costs to the Medicare program (total allowable costs, divided by total patient days, times the number of Medicare patient days) can be undertaken, which will recognize the inherent differences in the utilization and cost patterns of the Medicare patients. This method can be accomplished by using a percentage of per diem instead of the full 100 percent per diem which is used for other programs having beneficiaries representing a more complete spectrum of patients. The proposal is as follows: Average per diem, as calculated in the traditional sense, would be adjusted for a utilization factor recognizing the actual Medicare patients' experience in utilization of inpatient services and a nursing activity care factor recognizing that the elderly patient requires more nursing service than other patients. This method should be made available to all providers for periods ending after July 1, 1969 to provide some degree of retroactivity as relief from the unilateral elimination of the 2 percent allowance in lieu of specific costs.
>
> Although the percentage per diem method outlined would significantly reduce the administrative complexity of the reimbursement system, the method employed is a retrospective cost basis of reimbursement, i.e., hospitals would have to submit cost reports to the Social Security Administration or its intermediary, and these reports would have to be audited and reviewed for consistency with the administrative regulations before a final settlement could be reached. In addition, hospitals receive payment for all allowable costs actually incurred. There has been much discussion about developing a payment system in which hospitals would agree to price services to Medicare beneficiaries before the performance of service. These prospective methods of payment, it is argued, would even more significantly reduce the administrative complexity of the program and provide incentives for the hospital to contain or reduce the costs of providing institutional health services.
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> The AHA believes that provider institutions should be given the opportunity to negotiate for prospective reimbursement in a manner consistent with the percentage per diem method. Such a method would involve the determination of a specific per diem reimbursement rate prior to an operating period, and payment would be based throughout the time period on the negotiated rate. Because this method, although much discussed, has not been employed in any significant degree, the AHA recommended that a departmental task force be assigned the responsibility of developing a specific proposal for an all-inclusive negotiated rate method of payment.

SYSTEM PROPOSED FOR COLORADO

The system proposed for the Colorado Medicaid program is principally based on those recommendations originally made by AHA for the Medicare program. Some restrictions are required, however, in the system proposed by

reason of regulations of the Social and Rehabilitation Service of the Department of Health, Education and Welfare:

1. The established accounting principles and regulations of Title XVIII are to be utilized. At this time, these principles and regulations are not fully responsive to AHA's statement of financial requirements.
2. A subsequent evaluation of the system must be made. Cost reports will be necessary from July 1, 1971 to the end of the fiscal year of the hospital.

Each hospital is to submit to the Department of Social Services its projected patient day statistics, budgeted or projected expenses, adjustments to expenses, and its net expense summary. The accounting forms supplied are based on Schedule A and Schedule A-5 of the Medicare cost reports. All prior period data are to be copied from the Medicare report for that period. If the expenses are deemed reasonable, the department will notify the hospital of its decision and ask that the Hospital Administrative Services (HAS) cost allocation forms be prepared and sent to HAS for processing and separation of expenses between inpatients and outpatients. For this purpose, it is believed that last year's revenues or the current period's revenues on an annualized basis can be used. The relationship of inpatient and outpatient revenue to total revenue tends to be the same from year to year at most hospitals. Some hospitals have been expanding their emergency room services and should consider more current trends in projecting revenues.

From the report returned from HAS, an average, all inclusive, per diem can be determined. Each hospital's average per diem is to be weighted by the percentage above or below average that the Medicaid patients were in the last previous settled Title XIX cost report. For example, if the Medicaid patient cost was 105 percent of the average patient day cost, the projected average per diem in the HAS report would be multiplied by 105 percent to determine the rate to be effective July 1, 1971. This rate will remain in effect for at least the next six months and will change when a hospital submits new data. The period that the rate would be in effect can be greater than six months if a hospital wants it. It is hoped that, after this transition, all reporting will be related to the fiscal year of a hospital. The state people would like a rate effective for a year, but the Colorado Hospital Association committee members preferred a six month effective period until experience demonstrates that they could be comfortable with a rate effective over a longer period.

The expense summaries submitted by some hospitals might raise questions

when reviewed by the Department of Social Services, and the rate review process involving the Colorado Hospital Rate Review Board will be used. This board is to be composed of seven members—three named by Mr. Shea for the state and three named by the Colorado Hospital Association representing the hospital industry. The six members are to select a seventh.

Eighty-five hospitals are in the Colorado Title XIX program. Of this number, 54 have participated in the HAS monthly comparative reporting service. Five special hospitals are not in the monthly comparative report system and probably should not be because their statistics would tend to distort all comparisons. The remaining 26 hospitals were asked to subscribe to this HAS service. At this time, only two of these hospitals have refused to enter. Blue Cross and the Department of Social Services each pay one-third of the cost of HAS services.

BENEFITS SOUGHT FROM THE COLORADO SYSTEM

The benefits sought by the department include the finished cost reports in a common format after identical processing and a monthly composite comparative report by size groups for the state of Colorado alone. In addition, the hospitals benefit by receiving a comparative report for use as an administrative tool. I mentioned earlier that there presently is no knowledge of state-wide trends in occupancy and costs. The composite reports will provide this information 60 days after the end of the month being reported.

ADMINISTRATION OF THE SYSTEM

Mr. William A. Michela, Director of the Division of Hospital Administrative Services, offered to provide HAS staff and assistance to implement the HAS program in all Colorado hospitals. This included seminars on uniformity of reporting and interpretation of HAS reports.

We believe the composite comparative reporting will provide a means of monitoring this program. There are, of course, known and expected differences in comparing one hospital with others in its size group and these can be identified. Other differences may not be easily explained. If a hospital's approved prospective rate turns out to be high or low in comparison with the cost per day shown on a comparative report, the data originally submitted in support of its rate will be reviewed to see whether or not an unintentional error was made. The principal concept of prospective reimbursement is that the rate sits still for an agreed period, but in this first

attempt at such a system every effort is to be made to see that the rates are fair to both the hospital and purchaser.

The Department's budget for the current fiscal year was adjusted to cover all the retroactive adjustments for the period ended June 30, 1971 and also to reflect payment for services on a current basis.

It is important that hospital managements have a good understanding of the effect of determining reimbursement on a prospective basis. The system offers an opportunity for a profit, but does not guarantee against loss. It does force planning; it also assists the administrator in resisting changes having a fiscal impact not planned in advance and not included in the rate. This is the primary feature in cost containment—responses to physicians' requests for additional services should be delayed until the associated costs are included in the next period's projected costs. As the Barr Committee noted, it has been difficult for an administrator to refuse changes when the person asking knows that all of the costs would be reimbursed.

We visited several hospitals that provided services to the largest number of Medicaid patients and reviewed with the administrators and controllers the material to be used. The administrators asked if the billing requirements could be simplified since the bill is now a matter of so many days at a flat rate. This could very possibly come about in the future, along with sight draft payment through the intermediary, which some administrators and controllers have requested. For the initial period, there are to be no changes in the billing procedures or maintenance of logs of charges departmentally for Medicaid patients together with payments received from other third parties and the intermediary. Again, there is to be an evaluation of the system in comparison to the Medicare reimbursement methods.

IMPLEMENTATION OF THE COLORADO SYSTEM

Changing to this prospective reimbursement system caused more work in the hospital accounting offices. Split-billings for patients in the hospital at midnight June 30, 1971 were prepared and sent to the intermediary, Blue Cross. This was necessary in order to isolate the days of care under the old and new systems. Cost reports on SSA–Form 1992 were made from the ending date of the last period reported through June 30, 1971. For the greatest number of hospitals, this was a six-month report or an annual report. Long period reports were acceptable if desired by a hospital. For example, a hospital on a May 31 fiscal year could elect to file a 13-month report.

The forms to be used in presenting the budget or projected expenses were

not in as fine a form as would be produced by a commercial printer. They were reviewed by the members of the Association's committee on this project, which included five hospital controllers, and by a consultant retained by the Association for that purpose. We believe they will be workable. Suggestions and comments for modification, improvements or other changes were requested. The objective throughout was to assure fair and equitable treatment to the hospital which furnishes care and to the government which pays for such care.

At an earlier point, I mentioned physicians' requests for changes in the sense that such changes should be delayed if their costs are not included in the new rate. I think it is important that persons involved in budget preparations discuss with certain members of the medical staff the effect of this type reimbursement system to learn what they presently have in mind. We believe the physicians exercise primary authority over how health care resources are used, and should assist in budget preparation. ●