HEALTH PERSPECTIVES

A NON-PROFIT TAX EXEMPT ORGANIZATION

Vol. 2 No. 5 PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. Sept.-Oct. 1975

Pub. 3/76

HOSPITAL REIMBURSEMENT: IMPORTANCE TO CONSUMERS

COSTS RISE

Like almost everything else, the cost of hospital care is going up. The rate of increase, however, is considerably more than for other commodities and services, i.e. health expenditures in 1965 were $38.9 billion and in 1975 climbed to $118.5 billion. The increased costs of hospital care are greatest in states like New York with its relatively advanced medical facilities, but hospital care is more costly than it used to be all over the United States and in many other countries as well.

Why have hospital costs risen so sharply? No one is quite sure. Patients may be demanding more treatment; doctors may be charging much more; or hospitals may have built too many beds and purchased too much equipment. Much attention has focused on this last possibility, since the cost of hospital care is a matter of vital concern to people—and to health insurance agencies, like the Blue Cross organization committed to paying full hospitalization costs.

PROFIT: BAD MOTIVE

Most American hospitals are nonprofit organizations. This doesn't mean that they don't make profits, but that if more money comes in than is paid out, the surplus is called net income. It isn't distributed back to the governing body, as in a corporation, but is available to be used for expansion or new services. Many hospitals have had net income which was used to improve services, physical expansion, administrative salaries, new equipment, etc. According to hospitals, these expenditures are necessary and beneficial. According to critics, hospitals are prone to "empire building" and the use of net income was not always justified.

SAVE OR CHANGE SYSTEM

When public discontent with hospital costs seems about to lead to some form of regulation to control government health expenditures (something which few hospitals find acceptable) plans are proposed by hospitals to encourage health providers to put their own house in order. Since Blue Cross plans and Medicare and Medicaid pay most of the nation's short-term hospital bills (87% in 1971) they might have used the power of their purse to encourage hospitals to contain costs and devise incentives to motivate health providers to operate more efficiently. These third party hospital payers have not exercised that power. By coordinating with the goals set by health planning bodies (i.e. Health System Agencies) hospital reimbursement formula could be used to reorganize the health delivery system; reduce costs and provide a higher quality of care.

Specific plans to encourage cost containment in various ways have been developed. Some offer incentives to hospitals designed to increase labor productivity. Others seek to reduce duplication of hospital facilities in an area. Some deal with hospital budgets, management controls and decision-making, while others try to influence physicians to use certain hospitals or other types of health services. Rarely have reimbursement methods been developed to finance a new health model. Few third party representatives identified what they wanted the health system to be like or designed plans to revamp the present system.

REASONABLE COSTS?

The generally accepted method of reimbursing hospitals is based on "reasonable costs" determined after the money is spent. It does not offer any real incentive for containing costs. In fact, this payment method seems to invite hospitals to add new staff and equipment, raise wages and expand services in the expectation that these expenses would be added to a patient's bill and be paid by an insurer.

PROSPECTIVE REIMBURSEMENT

Under prospective reimbursement, however, rates for some future period are established based on prior years' experience and projected cost increases, or on qualified or negotiated financial need during an upcoming budget year. The money reimbursed to a hospital is expected to cover the costs of budgeted services. When hospital administrations know that no more money will be forthcoming, they'll be motivated to operate more efficiently, and institute stricter controls over accounting and budgeting procedures. In reality, hospitals have sought to cut costs by cutting staff or services instead of seeking better economies.

Generally, the prospective reimbursement plans, for this is what they are called, are based on different approaches. One approach is to contain hospital costs by making health care in an area more efficient. This is done by stopping needless duplication of medical facilities, encouraging sharing of expensive equipment, and matching facilities with the needs of patients in a given geographic area. The other approach is to concentrate on the individual hospital. Performance is monitored to make the running of the place less wasteful. Other measures include reducing a patient's length of stay, reducing admissions and, in general, rationalizing a hospital's operating procedures.

AREA EFFICIENCY

The first approach is a little harder to implement. Hospital administrations and medical and lay boards have a vested interest in being associated with an institution that provides comprehensive care—and they also argue that to eliminate duplicate facilities would curtail teaching and research programs the consequences of which would be felt in the future. This type of control requires outside intervention with legal and financial controls.

HOSPITAL APPROACH

The second approach, improving the efficiency of the individual hospital, also presents problems. Are efficiency methods applicable in the field of hospital care? Attempts to cut costs might not trim a hospital's operation as much as the quality of a patient's care. Most of these plans don't consider the most costly and expensive area in a hospital: medical decision-making.

Still, some method of preventing hospital costs from increasing faster than the cost of living had to be tried, and various prospective reimbursement plans were sponsored by Blue Cross Plans with the cooperation of local hospitals. Other cost-saving plans were mandated by State government.

We'll look at a few of these plans in some detail because prospective reimbursement seems to be the currently fashionable way of containing hospital costs. In fact, twenty-seven Blue Cross Plans representing slightly over 40% of Blue Cross Plan subscribers, now use a type of prospective reimbursement, most of which are experimental and limited to a few hospitals.

HOSPITALS COOPERATE: WHY?

Hospitals seemed to prosper under the formerly used retrospectively-determined "reasonable cost" system, so why should they cooperate in a plan to limit their operations? And why should an insurer like the Blue Cross organizations, which simply passed the costs on to consumers, want to get involved in the workings of a hospital? It can be assumed from hospital industry representatives' own statements that hospitals and Blue Cross are experimenting with prospective reimbursement to forestall legislation that would bring further hospital regulations thereby weakening their power bases. Blue Cross plans cannot raise their rates without justifying the increase to the public and government agencies. This justification is becoming increasingly difficult, so they have good reason to cooperate. Hospitals, dependent on funds from third-party insurers, were forced to go along. A self-imposed and self-administered limitation is more acceptable than one imposed from outside. In some cases the federal government has applied pressure through the Department of Health, Education and Welfare (HEW) which has provided grant money for these experiments.

REIMBURSEMENT PROGRAMS

Reimbursement programs are expected to encourage hospitals to contain costs, increase operating efficiency, reduce admissions and average lengths of stay. In response many hospitals have controlled the types of patients; they admit less complicated cases which are easier to treat and less costly to treat. This doesn't mean that patients with complicated cases do not receive treatment; they are referred to hospitals equipped to handle more complicated cases. Hence, a shift towards a more efficient use of area resources is developed.

A simple payment to a hospital to cover costs is not, of course, the only method of reimbursement used. Rather than allow the hospital full discretion in how the money can be used, a third party may involve itself in prospective budgeting for each of a hospital's departments.

Although some prospective reimbursement programs tried so far have demonstrated a degree of cost containment, third-party rate setters and hospitals seem still to argue about reasonable costs. What is a simple medical procedure for one hospital can be very complex for another, and hospital administrators argue that an effect of standardizing costs will result in standardizing hospitals.

A HOSPITAL IS NOT A HOSPITAL

Hospital representatives say that their hospitals are not identical in character and each has its own unique mix of staff, services and patients. Hospital personnel claim that prospective reimbursement formula tend to treat hospitals in a uniform manner. But these formulas have made adjustments for patient mix, size of hospital, degree of teaching at the facility, etc. Proponents of prospective reimbursement argue that each hospital be individually treated. In some states efforts have been made to overcome this objection by establishing groups or categories of hospitals. Many hospital officials feel that reimbursement programs may result in forcing an unnatural uniformity on hospitals.

TWO SETS OF BOOKS

Another matter of major dispute between third-party rate-setters and hospital administrators are hospital financial accounting techniques and reports. Although third-parties require hospitals to use uniform reporting forms, the way direct, indirect, fixed and variable costs are actually reported is left pretty much to the hospital. Attempts to standardize accounting procedures are rarely accepted by hospitals which object to the external controls.

Of course, while accurate and reliable financial accounting is necessary to prospective reimbursement, some hospital representatives view it as yet another attempt to erode hospital autonomy and impose an unnatural uniformity.

PROSPECTIVE REIMBURSEMENT SCORECARD

We'll review some of the prospective reimbursement plans now in effect in a number of states, discuss the situation in New York and then try to evaluate the different approaches. We haven't attempted to assess the success of such plans, other than in New York and New Jersey.

RHODE ISLAND

All of Rhode Island's 15 short-term hospitals participate in a prospective reimbursement system. Responsibility for the program is shared by Blue Cross of Rhode Island, State representatives, the local hospital association and health planners. The Blue Cross Plan payments account for 40% of the revenues of these hospitals. Prospective rate setting was implemented in fiscal year 1971-72, but operation was suspended due to the initiation of the federal Economic Stabilization Program (ESP). Outside review of hospital budgets is a continuing feature of the Rhode Island program. The hospital budget is the basis of payment for the prospective rate.

The following features of the program seem to work: The participants appear to be cooperating to achieve mutual objectives and claim to be pleased with the structure and process. Hospitals do not seem to have been adversely affected from an economic standpoint and have been cooperating in terms of a financial reporting system. New medical programs have been channeled to meet community needs.

The lack of reliable output and input yardsticks still make it difficult to determine cost effectiveness. Comparisons between hospitals is still not practical. There are also questions about the validity of the base year data of the hospitals. Until now only budget increases have been controlled. Not the base year data itself. However, measures to simplify and unify reports are being explored and a mathematical model for predicting cost increases is being developed.

INDIANA

The situation in Indiana is somewhat different; it constitutes a system of controlled charges for the

110 Blue Cross Plan reimbursed hospitals. Since 1960, hospital rate increases have been submitted to the Hospital Rate Review Committee (RRC), whose recommendations must then be approved by the Blue Cross Plan's Board of Directors. Although this review and approval system does diminish hospital autonomy, the effect is far from stringent. It must be stated, however, that the system does not seem to have been abused by Indiana hospitals, and costs have been kept down. The system was jointly sponsored by the Indiana Hospital Association (IHA) and Blue Cross of Indiana. No direct State or local input into the setting of rates exists. The aim of the program is to insure that hospitals have sufficient funds to provide services. A 3% operating surplus (a contingency fund, in fact) is built into the prospective rates. Cost containment is definitely a secondary consideration. This may be partially explained by the fact that the IHA has continuously been the driving force of the program with Blue Cross administering and providing technical expertise to it.

One particular feature of the Indiana system should be mentioned. Blue Cross Plan payment rates are identical to those of commercial carriers; no discount is given. The increased revenues thus obtained, in conjunction with those earned from self-pay patients, is used to partially subsidize Medicare and Medicaid patients. This, however, is not an explicit arrangement.

WESTERN PENNSYLVANIA

The approach of Blue Cross of Western Pennsylvania (Pittsburgh) is to combine budget review with a formula to arrive at the reimbursement rate. Institutions' budgets are reviewed and tentative rates are set. At this point a formula is applied which sets ceilings on rates according to external (non-hospital) economic indicators. For the one year in which results of this system have been analyzed, an $800,000 total reduction in the budgets of five experimental hospitals was experienced. The Blue Cross Plan reviews not only requests for new facilities, but existing services as well, working closely with the hospital council and area hospitals.

This program is in the experimental phase, and as such has placed a great deal of emphasis on documentation. Blue Cross and the hospitals share equally in positive or negative deviations from the projected rate. The system does not seek to reveal or punish inefficiencies in the base year, but to reduce them through the rate-setting mechanism.

CONNECTICUT

Blue Cross of Connecticut instituted a prospective reimbursement system in all of the State's 36 short-term hospitals in 1972. This program had the support of Connecticut's Hospital Association and the hospitals. A situation in which good internal management, as well as possibilities of cost containment, was envisioned. However, a short time after the inauguration of the Plan's program, a State Commission on Hospitals and Health Care was mandated. This Commission has far-reaching review powers over rates and budgets. Ultimate responsibilities for the State's health care costs has yet to be determined, and significant divergence of approach has been noticed between the two would-be regulators.

The Blue Cross Plan program stresses negotiation; and appeals result in an arbitration procedure. Appeals to the Commission result in judicial proceedings. Under CBC hospitals are reimbursed on a per diem basis, the rate being based on a prospective budget. Standardized forms, approved by both the Plan and CHA, are used. The budget merges actual cost data, when possible, with projections. The per diem rate is determined from the budget, and hospitals have an option as to whether they wish to participate at the 50% or 100% level of gains and losses. Preliminary results reported by Blue Cross of Connecticut indicate a net savings, for all hospitals combined, of $174,000.

WISCONSIN

The Blue Cross of Wisconsin program is experimental and as with many other such plans, its development was spurred by a desire to avoid governmental regulation. Its aims are primarily cost containment, the placement of health care decision-making in the context of community needs, and the encouraging of better hospital management techniques.

The base of the system is the prospective budget on the basis of which hospitals are reimbursed for prospectively approved charges. The Wisconsin Regional Community Health Planning Agency is very much involved in determining community needs. Hospital per diem costs are reviewed quarterly. Hospitals are required to obtain Plan approval for proposed increases in either room charges or ancillary service charges. Such requests are examined in the light of the experience of other hospitals, the hospital's financial needs and the need for specified services in the area. The Blue Cross of Wisconsin's potential impact on subscribers' fees are also considered.

COLORADO

Colorado currently has two distinct prospective reimbursement systems, one of which is run by Blue Cross Plan. 42% of Colorado's population is covered by Blue Cross of Colorado. This experimental program applies to eight hospitals which are reimbursed according to a prospective budget at a certain rate. However, the Blue Cross Plan reimburses only that percentage of the budget that it represents of hospital's revenue. Individual characteristics of each hospital are taken into account in the budget review process. Both the Blue Cross Plan and the Colorado Hospital Association cooperated in formulating the program, but Plan dominance is clear. The other prospective system, the State Medicaid program, is applicable to all hospitals.

NEW JERSEY

The Health Facilities Planning Act of 1971 (HFPA) created a clear mandate for the state-appointed Commissioner of Health to regulate the health care industry. Instead of the New Jersey Hospital Association-controlled Advisory Committee, State authority would be brought to bear on the rate-setting and budget review processes. The Commissioner was empowered in the following areas:

- —to approve New Jersey Medicaid hospital charges;
- —to regulate hospital charges to The Blue Cross Plan (with the Commissioner of Insurance);
- —to oversee the implementation of uniform accounting and reporting systems by the hospitals. The HFPA also created the body known as the Health Care Advisory Board, which has the right to approve all rules and regulations issued by the Commissioner of Health.

HOSPITAL INDUSTRY CONTROLS

The HCAB, appointed by then Governor Cahill was composed of seven members with direct ties to hospitals or nursing homes, a junior-high school principal, the Vice-Chairman of Johnson and Johnson, and a registered lobbyist of the New Jersey Automobile Dealers Associa-

tion. The last three comprised the "citizen" component of the ten-person Board. Vacancies filled since 1971 continued this imbalance.

As a result of considerable criticism of the New Jersey plan—or its implementation—reforms were undertaken. Health Commissioner Cowan and then Insurance Commissioner Clifford initiated a policy shortly after HFPA became operative. Because the State required implementation within 90 days but provided no additional funds, the Commissioners continued to rely on the Advisory Committee to set hospital rates, functioning as it had before the new law became effective. Commissioner Cowan instituted the new Certificate of Need activities within the required 90-day period.

With the advent of the Byrne Administration, Commissioner of Health, Dr. Joanne E. Finley, and Commissioner of Insurance, James Sheeran, took the hospital rate-setting activity into the direct administration of the Department of Health. By agreement between the Governor, the New Jersey Hospital Association and the Commissioners, during 1975 the process relied on the HRET reporting system. During 1975, with the assistance of Haskins and Sells, under a publicly bid contract, the Department of Health designed a standard hospital accounting and rate evaluation system. This requires uniform cost and statistical reporting by hospitals, subjects the hospital budgets to zero base budget review by examining the reasonableness of the previous year's spending levels and then allows increases based primarily upon general económic factors and predicted patient day volume changes.

During 1975, the system reduced planned hospital spending by $58 million. The goal for 1976 is to restrict the rate of increase in hospital budgets to 9% on a statewide average. Budget submissions for 1976 showed the hospitals requesting more than 17% which drops to approximately 13% after adjustments for patient day volumes are taken into account. 13% still appears to be excessive and is beyond the 9% goal for the State. The Departments are planning to continue the development of the rate setting system to take account of hospital case mix patterns and to better account for the costs actually associated with patient care.

In at least one study of the New Jersey cost containment program (see Bureaucratic Malpractice, a report by the Center for Analysis of Public Issues, Princeton, N.J. 1974) the suggestion is made that political pressure undermined the program's effectiveness.

THE NEW YORK STATE PLAN

The New York State Cost Control Act of 1969 directed that:

> "Payments for hospital service and health-related service made by... corporations organized and operating in accordance with article nine-c of the insurance law shall be at rates approved... by the superintendent of insurance..."

and further, that:

> "Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for payments for hospital and health-related service are reasonably related to the costs of [providing] *efficient production of* such service. In making such certification, the commissioner shall [specify the elements of *cost* taken into consideration.] *take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies...*"

The need for such a plan was obvious. Hospital costs in New York were rising at an alarming rate. It was hoped that such a plan would, by limiting increases to those consistent with the inflation in the non-hospital economy, contain costs.

But, at the end of 1975, Blue Cross of Greater New York, which paid for the hospitalization of a large proportion of hospital patients, asked for permission to increase its rates by an amount more than twice that applying to the hospital cost increase index.

Section 101 of the Proposed Blue Cross Reimbursement Method specifies that the rate of increase in costs for the individual hospital is to be used in computing the rate for the intermediate year (subject only to the group maximum provision). This clearly contradicts the 1969 Cost Control Law which states that in determining that proposed rate schedules are reasonably related to the costs of efficient production of such service that: "the commissioner shall take into consideration... economic factors in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located."

In order to remedy this situation, Blue Cross of Greater New York retained the services of Dr. Michael Gort of the Faculty of the State University of New York at Buffalo. His assignment was to develop a hospital price index (HPI) to be used in establishing reimbursement rates for member hospitals of the Associated Hospital Service of New York. The Index had to satisfy the requirements of the Cost Control Act of 1969 which prescribed that reimbursement rates be based on projections of prices and that they also be "reasonably related to the costs of efficient production...service. His assignment was: To satisfy the requirements of the law necessitated the development of a set of 'proxies' —that is, *prices in the economy outside hospitals* in the New York City area of the type of goods, services and labor that hospitals have to procure.

Professor Gort has completed his report, and the Blue Cross Plan staff had recommended its implementation in determining the rate for the intermediate year and the rate year. However, in meetings between Blue Cross Plan staff and the hospital industry's Blue Cross Negotiating Committee (of the Greater New York Hospital Association), the adamant opposition of the hospital industry was made known and the Blue Cross Plan abandoned the use of the Hospital Price Index for the determination of rates for the intermediate year, and instead used the hospitals' actual operating experience—again, in contradiction to the Cost Control Law and the Gort Report.

In our view, the New York State reimbursement plan has failed for the following reasons:

1. The government agencies charged with the responsibility for insuring that the Blue Cross Plan and the hospitals complied with the law, were lax.
2. The laws themselves failed to provide any penalty for noncompliance.
3. It is a retrospective cost formula parading as a prospective one since the application of all prospective rate adjustments are applied to the costs of prior years. This method, of course, does not refer a rate increase to a cost-of-living index but to a much more inflationary index, that of the prior two years' experience. Furthermore, it has been possible for a hospital to substantially expand its facilities, define the additions as amounting to a new hospital, and escape the limitations imposed by the present formula altogether.

Furthermore, the hospitals themselves campaigned through negotiating committees to subvert the limitations imposed on them, which, perhaps is another way of saying they acted in bad faith. In testimony before the Commissioner of Health and the Superintendent of Insurance, the Executive Secretary of the Hospital and Medical Care Committee, New York City Central Labor Council,

pointed out that the Blue Cross of Greater New York's prospective reimbursement formula violated the Cost Control Act of 1969. A number of other groups including the New York State Consumer Protection Board, protested a reimbursement formula that would automatically lead to an increase in reimbursement rates. The New York State Insurance Department froze reimbursement rates for hospitals for both the Blue Cross Plan and Medicaid for 1976. The New York State Health Department is currently reviewing the reimbursement formula. (Blue Cross received a 3.9% increase but not the 20% they requested and hospital rates were frozen at the 1975 level.)

We would also point out that the very need for consumer groups to protect the public suggest that elected public representatives are not doing their jobs. In New York and New Jersey, where containing hospital costs became a matter of public law, hospital costs continued to rise. We attribute this both to inadequate cost containment plans and to state-appointed officials who would not or could not enforce the laws.

HAS QUALITY BEEN AFFECTED?

Unfortunately, no adequate data exists to answer this question. The determination of what is quality medical care is confounded by a lack of information. The reports of the JCAH which represent organized data on hospitals are kept secret. Other data which relates to the quality of care, for example, utilization of hospital resources and most importantly follow-up on the outcome of care, is not even being tabulated. Under such conditions how is it possible for even the most informed of consumers to determine if the quality of care has in fact been affected by the various Blue Cross Plan experiments?

Ideally, in a free market, where everyone has access to the pertinent information, an inadequate hospital would soon lose its patients. But nothing like a free market exists in the health care business.

Most of the prospective reimbursement plans don't venture into the sensitive areas of medical decision-making which accounts for nearly two-thirds of *all* hospital costs.

EVALUATING PROSPECTIVE REIMBURSEMENT

Evaluating the success of the various prospective reimbursement plans depends largely on what criteria are used, and whether these criteria are subject to critical analysis. To what extent can, for example, a decline in costs be attributable to reimbursement or cost control plans, its implementation, or other factors?

As we suggested earlier, hospitals are lending support to prospective reimbursement experiments to prevent government control over themselves and their insurers, like Blue Cross Plans. This is important to hospital administrators, but doesn't seem to be valid for consumers. In the area of cost control, the results are ambiguous. Generally, hospital costs have continued to rise faster than the cost-of-living index. It is nearly impossible to prove that costs would have risen even more or less without prospective reimbursement.

A review of the available evidence suggests that prospective reimbursement plans are of limited help in containing costs; however, the evidence is based on the experience of the *experimental* plans in operation. In New York and New Jersey, the two states where prospective reimbursement plans are mandated, the experiences have been dismal. It seems that public officials in the past have neglected their responsibility to monitor the expenditure of public money for health care, and a strong suspicion exists that some public officials have actually obstructed legal remedies for abuses found.

Two other major issues affect the future of prospective reimbursement. First, while controls are directed at hospitals, nothing of substance is being done to regulate or monitor the physicians who practice in the hospital and little is being done to control the paid staff of the institution. Admissions, case mix, treatment, ordering of tests, use of facilities and length of stay are in fact controlled by medical, not institutional decisions.

DOCTORS' ROLE

Physicians have not been brought into the cost control programs. Until physicians' decisions and actions are considered as an area that affects costs and reasonable incentives are established to make doctors more responsive to cost and quality problems, hospital prospective reimbursement plans will be less than successful.

The reimbursement formula must place sanctions on an institution which fails to meet either minimal standards or fails to control the poor and inefficient use of medical facilities. As hospitals are presently organized and reimbursed the hospital administrator and board of directors have little control over the kinds of care provided by the medical staff. The medical board and the individual practitioner exercise a disproportionate amount of control over the institution. The prospective reimbursement formula combined with a comprehensive utilization review program can be effective in dealing with these problems.

Very briefly, *utilization review* is the term given to describe some form of third party review of a hospital's admissions to determine whether the admission is necessary.

Prospective reimbursement, as now used, places short-term limits on the total dollars that a hospital can receive. It does not require cost sharing or the appropriate use of the facility. A hospital is paid on an all-inclusive daily basis for any person hospitalized and insured.

Second, the entire area of quality care is completely interwoven with medical decisions on how the patient is to be treated (in- or outpatient), what tests are needed, how long the patient must stay, etc. The quality of care is of increasing concern to health consumers, and it is unlikely to expect that quality can be traded to gain economic efficiency. Therefore, ways in which high quality of care and efficient operation can be integrated are still far from a reality, but not impossible to attain.

The Consumer Commission recommends:

1. That where prospective reimbursement programs do not exist, they be instituted. Such programs should limit hospital costs to a rate no greater than the increase in the overall cost of living.
2. That where prospective reimbursement plans exist, consumer groups, minority coalitions, labor organizations, etc. exercise vigilance to see that the public is protected from government laxity.
3. That legal sanctions be used to prevent non-compliance by hospitals to control costs.
4. That consumers be involved in the administration and regulation of all third-party reimbursement programs. Union officials and consumer representatives should be on all negotiating committees of Blue Cross Plans and other third-party payers.
5. That Medicare adopt a strict prospective reimbursement program for participating hospitals.
6. That prospective reimbursement be tied into national and regional health planning goals established by health systems agencies.
7. That a national uniform prospective reimbursement mechanism be built into national health insurance legislation.
8. That reimbursement plans involve medical decision-makers.

Prospective Reimbursement: Another View

Prospective reimbursement is a term that is frequently thrown about in discussions of hospital cost control. It is a term that has no fixed meaning. On the simplest level, prospective reimbursement means simply that a hospital should plan and budget in advance and should be told the amount of money that it can plan on receiving at the beginning of the year. Certainly, that is a good idea. But the critical questions are: How is the content of the hospital budget to be determined? Who is to make those decisions?

Some prospective reimbursement schemes are positively destructive. For example, in New York, under the so-called Hospital Cost Control law, hospital reimbursement rates for inpatient services are determined on the basis of what a hospital spent the year before. Now the last thing in the world that a New York hospital wants to do is cut down on their inpatient costs. If they manage to cut costs in one year, they will be penalized with a reduction of reimbursement rates in future years.

Another form of hospital cost control that is positively destructive are controls imposed only on services provided to the most vulnerable segments of the population. For example, if the state places a ceiling on Medicaid reimbursement for services provided for poor people, while allowing Blue Cross to continue to pay whatever a hospital wants to spend for services provided to others, hospitals will have a big incentive to avoid providing services to the poor. To be effective hospital cost controls must apply to the entire hospital budget. Or, at the very least, selected controls should not be placed on services for the most vulnerable and unpopular portions of the population.

Other kinds of prospective reimbursement are less destructive, but generally useless. For example, the New York law, as interpreted by the courts, requires that each hospital's prospective rate be allowed to increase at a rate comparable to that of other similarly situated hospitals. Since the entire hospital industry has a rate of inflation almost twice as high as the rest of the economy, this does not do much to control hospital costs. The high cost of hospital care is not primarily a problem of inefficient individual hospitals, but rather a problem of an entire industry that spends money in ways that do not meet people's needs.

From a cost control point of view, the only effective sort of prospective hospital rate setting is one that applies to all hospital costs and which is tied to the general rate of increase in over-all cost of living. This was the sort of control we had under the federal wage and price control program. It was effective in keeping hospital cost increases at about the same level as the inflation in the rest of the economy. Even though this kind of prospective rate setting may be effective from a cost point of view, it has real dangers in human terms. The danger is that if hospitals have less money, and doctors continue to control hospital decision-making, then doctors will cut out services that are not important to them. Services which we might expect would be cut back are: outpatient services, and inpatient services for people who have boring diseases, such as the chronic conditions associated with old age, illness arising out of alcoholism or drug abuse. Unfortunately, many of our most pressing health problems are boring to the doctors who control hospital decision-making.

The only effective form of hospital cost control is that in which some agency that is representative of and accountable to the people looks at the hospital budget and asks, do these services meet the people's health needs? Is this money being spent most effectively to meet the medical care needs of the people who pay for it?

Sylvia A. Law, Author
Blue Cross: What Went Wrong?

Excerpts from—

TESTIMONY BEFORE THE COMMISSIONER OF HEALTH, THE STATE OF NEW YORK, JULY 23, 1975, BY DONALD RUBIN, EXECUTIVE SECRETARY, HOSPITAL AND MEDICAL CARE COMMITTEE, NEW YORK CITY CENTRAL LABOR COUNCIL, AFL-CIO.

Blue Cross of Greater New York is a not-for-profit Health Service Corporation providing health service benefits to nearly nine million New York City area residents. As such, it has the primary responsibility to assure to subscribers the availability of the highest quality hospital service at the lowest possible cost. In furtherance of this, Blue Cross of Greater New York incurs two collateral responsibilities: to assure that funds provided hospitals are used prudently and in the public interest; and that resources are provided hospitals in a manner that makes possible the delivery or high quality service benefits.

Responsible performance of these duties is the goal of Prospective Reimbursement. In order to be successful, a Prospective Reimbursement should limit the spiraling trend of hospital costs and foster the efficient production of hospital service by providing incentives to eliminate unnecessary costs while demanding exacting standards of hospital service excellence.

Also, the successful Prospective Reimbursement method should include strong economic incentives to encourage hospitals to review and eliminate programs which do not directly reflect patient care or facility improvement nor encourage efficiency or community service.

. . . . . .

It is the opinion of the New York City Central Labor Council which represents more than one half of all Blue Cross subscribers that the Proposed 1976 Hospital Reimbursement Formula to be used by Blue Cross of Greater New York now under consideration is unacceptable in many areas, particularly those permitting increases in hospital costs in excess of similar increases in the non-hospital economy. Therefore, the New York City Central Labor Council calls for the restriction of increases in hospital costs, limiting hospitals to rate increases equal in size to increases in the non-hospital economy. To this end, we recommend the use of the Gort Hospital Price Index.

We find that the proposed reimbursement formula does not conform to, nor is it consistent with, the 1969 Cost Control Law and subsequent amendments, or Part 86 of the Commissioner of Health's Rules and Regulations in the following most important ways:

. . . . . .

Section 104 of the Proposed Reimbursement Method specifies that the amount of a hospital's payment rate will be increased "by the following percentages applicable to the groups indicated:

Group 1 and 2	2 %
Group 3	1.5%
Group 4, 6, 7. . .	1.0%
All other hospitals	.5%

This increase in rates is done in order, as Blue Cross maintains, "to compensate hospitals appropriately for costs resulting from the expansion and improvements of services, costs of technical developments and improvements, and costs resulting from changes in use of services by the community. . ."

However, as indicated in the above table and contradictory to the description, the size of the rate increase is not based on the submission of any additional costs, but rather the rate increase is based upon what group the particular hospital is classified in—so that a hospital may even *cut back* on services and programs and still receive the appropriate rate increase. Further, this provision has an adverse impact on the cost of hospital care in high priced hospitals, because the more expensive hospitals are in Groups 1 and 2 where the percentage increase is the greatest (2%); and because the increase is a percentage, the higher the preliminary per diem rate the higher the absolute dollar increase added to it.

This proposed provision, in our view, contradicts the requirement included in the 1969 Cost Control Law that: "the commissioner shall exclude. . . allowance for costs which are not specifically identified"; and also contradicts subsection three of section twenty-eight hundred seven of the public health law requiring that payments must be reasonably related to the costs of efficient production of such service.

In conclusion, we strongly recommend the rejection of this provision. Any adjustment to the reimbursement rate for the purposes outlined above should depend upon approval by Blue Cross as to their need and their efficiency of operation.

Regarding Section 601—The Utilization Incentive, we find absent any mention of the participation of Blue Cross of Greater New York in the New York State utilization review program.

Part 86 of the Commissioner of Health's Rules and Regulations specifies that third parties (including Blue Cross) should participate at all levels in the program, specifically relating to the monitoring of hospital admissions and requiring recertification of continued hospitalization.

We strongly recommend that the present proposal be rejected and not accepted until and unless Blue Cross of Greater New York presents an acceptable plan for participation in all levels of the utilization review program, as required by Part 86.

. . . . . .

In addition, we are herewith submitting to the Commissioner of Health a statement detailing additional specific recommendations relating to the proposed reimbursement method for 1976.

Section 101

The proposal calls for the use of unaudited per diem reimbursable expense for the base year. Timely audits by the Plan could enable the use of *audited* expenses; a situation to be preferred to the use of unverified expense figures. Instituting timely audits would also have the added benefit of permitting speedy decisions on appeals.

. . . . . .

Section 205

In computing the final weighted average per diem reimbursable expense for any group, the group maximum provisions should be reduced from 15% to 10%.

Section 301 & 302

Depreciation on major movable depreciation should be limited to the straight line method. At the same time, lease payments shall not be allowable if they are in excess of what would be paid in straight line depreciation on the equipment to a hospital. Hospitals shall be also requested to indicate in writing in advance their willingness and ability to fulfill the depreciation funding requirements; in the event that an

[Excerpts continued back page]

[Testimony excerpts continued from page 7]

affirmative response from a hospital is not received prior to promulgation of prospective rates, the per diem amount equivalent to depreciation on buildings and fixed equipment should be omitted from the payment rates established for the rate year. Reports should also be prepared by the hospitals and verified by Blue Cross to determine whether the funding requirements are being followed.

Section 501

The Plan should prepare reports based upon audits of Out-Patient Departments to determine whether revenue collection and patient charges are reasonably related to the efficient production of revenue and the minimization of net loss, and whether such costs are reasonably related to the provision of ambulatory and emergency services.

Section 601 & 602

It is our opinion that Section 601 & 602 should be rejected by the Commissioner of Health. The method to control utilization is the New York State Hospital Utilization Review Program (NYSHUR). The method to increase productivity is the prospective method of reimbursement. Therefore, Sections 601 and 602 are unnecessary and will merely serve to increase subscribers' premiums.

Section 904 and 905

We feel that the minimum utilization requirements detailed herein are too low and are not consistent with the efficient production of hospital service. Therefore, we recommend that the rates should be increased by 5% each year for each service until the minimal occupancy requirement for all services is 85%.

Section 1011 & 1104

It is our feeling that the use of group maximum provisions and non-hospital trending factors should not be limited to in-patient services; group maximum provisions and non-hospital trending factors should be used in setting rates for the production of emergency services, and for the production of ambulatory surgery services.

Section 1105

We propose that pre-surgical testing services should be reimbursed on the basis of cost with group maximum provisions and non-hospital trend factors, *not* on the basis of posted charges.

Section 1306

We recommend that Blue Cross of Greater New York should develop a full-time professional staff of accountants to perform hospital audits.

Section 1402

We propose that hospital representatives should not be involved in the determination of rates of reimbursement and in the rate review process. The conflict of interest implications are immense, and in order to avoid even the appearance of impropriety the involvement of hospital representatives should end.

****

At this time we also recommend that the following be incorporated and implemented in subsequent Prospective Reimbursement formulas to be used by Blue Cross of Greater New York:

Open Heart Surgery

We recommend that the minimum utilization requirement be increased to 200 open heart procedures per year in order to provide high quality hospital service at the lowest possible cost.

Reprints of complete testimony available upon request.

PUBLISHED BY CONSUMER COMMISSION ON
THE ACCREDITATION OF HEALTH SERVICES INC.

381 PARK AVE. SO., NEW YORK, N.Y. 10016
TELEPHONE: 689-8959