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Health Planning and Reimbursement

Planning and Money: Love At Last Sight

The National Health Planning and Resources Development Act (PL 93-641) passed by Congress in 1974, mandates the establishment of a national network of over 200 Health Systems Agencies (HSA) which integrates all previous health planning efforts. These agencies have the power and responsibility to determine the amount and types of health services within their geographic areas. The law provides for the funding of six state demonstration studies of innovative rate-setting techniques to contain costs. In order to effectively achieve planning goals, HSAs must be the same or work in concert with those bodies which control reimbursement to providers. This connection is self-evident and logically inescapable although it has been difficult to achieve politically.

A Call for Order Needs Law

For many states the concept of a combined rate-setting and planning organization is premature because most states do not have any rate-setting mechanisms in operation. Arizona, Colorado, Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island and Washington are the only states that now have rate-setting bodies. For all other states a call for joint rate-setting planning functions is unrealistic because those states do not have legislation requiring a rate-setting body. Without government recognition of its responsibility to monitor third-party reimbursement rates to medical care providers and to establish this responsibility in law, local HSAs have greatly reduced power to implement health planning goals.

HSAs: A First Step

To be effective, the HSAs must develop methods to achieve their planning goals. Each HSA is required to review no less than once every five years all health institutions in its area. The HSAs must develop a Health Systems Plan (HSP) and an Annual Implementation Plan (AIP) which outlines how the goals of the HSP will be achieved. The State-wide HSAs will be advised by a State-wide Health Coordinating Council (SHCC) which is empowered with specific review, and coordination. (For more information on HSAs, see *Health Perspectives*, Vol. 3, No. 2, "Health Planning: A Consumer View".)

Congress passed PL 93-641 which establishes the HSAs as the means to correct quality, accessibility and cost deficiencies, after reflecting on the growing proportion of the gross national product (5.2% in 1960 and 8.3% in 1975) spent for health care and the fact that the "massive infusion of federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources."

This new health planning legislation, however, does not clearly designate rate-setting as a government responsibility nor does it legally tie together health planning and reimbursement controls.

The start of meaningful health planning is hampered because HSAs have not yet been designated in parts of the country, while the ones already designated are bogged down in political infighting and a lack of planning expertise.

Priority #9: A Toothless Dollar

The PL 93-641 includes ten national health priorities. The ninth national health priority is:

> "The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health services institutions."

Therefore, each HSA must address the problem of reforming reimbursement to health providers as a cost control method. PL 93-641 also authorizes six demonstration grants to integrate the HSA goals with state rate-setting agencies and to create cost control incentives. It leaves the decision to establish demonstration programs and the responsibility of devising the mechanisms to implement this national goal to the states.

Sharing is OK If You Agree To Share

The fifth national health priority is:

> "The development of multi-instititutional arrangements for the sharing of support services necessary to all health service institutions."

This priority calls for the use of reimbursement mechanisms to develop institutional sharing of services where feasible. Most health institutions, acting as individual fiefdoms, have resisted the concept of sharing services and have fought being brought into regional health systems. The independent attitude of hospitals is perpetuated by the archaic and outdated governing body (i.e. Trustees, Boards of Directors) structure of voluntary hospitals. (For a fuller discussion on the structure, role and failure of governing bodies, see *Health Perspectives*, Vol. 1 No. 3, "Profile of Governing Bodies of New York City Voluntary Hospitals".) The HSAs must reverse this institutional independence and develop sound programs to regionalize health services. The HSAs must restructure the governing bodies of voluntary hospitals so that they are reflective of broader interests than that of the individual institution and to implement the regional health plans.

Planners and Rate Setters: The Ideal Couple

One way to bring about needed changes is to control the flow of funds to health providers. In the past, health planning agencies have had little input into hospital and nursing home reimbursement rates. Cooperation between the HSA and the state agency responsible for setting reimbursement rates is necessary to control the in-

flationary spiral of hospital and nursing home costs, unnecessary duplication of services and unneeded care. The nine states that have rate-setting agencies must require coordination and integration of the HSA with the rate-setting agency to reach their common goals.

The HSAs have the power to prevent the construction of new institutions or the expansion of existing institutions where deemed unnecessary. The implementation of the goals of the Health Systems Plan requires the HSA to control the flow of money paid to health institutions. Penalties and rewards for fulfilling the goals of the HSA must be built into rate-setting procedures.

Planners Looking for Setters

Forty-one states have not authorized a state agency to set rates. Therefore, the agency with which the HSA must coordinate its efforts in those states does not exist. To correct that deficiency in health planning, the immediate establishment of a rate-setting agency is needed or the delegation of rate-setting responsibilities to the HSAs within the state must be legislated.

The planning and rate-setting functions can reside in the same state agency as they do in Rhode Island. In that state there is no HSA, but the State Health Planning and Development Agency performs rate-setting as well as HSA functions. One drawback to the delegation of HSA functions to another agency is that this arrangement may subvert the state health (planning) needs (i.e. champion of community needs, the evaluator of quality, evaluator of the need for additional services) to financial considerations (i.e. balanced budget, reduction of taxes). However, the operation of one agency handling health planning and another rate-setting authority may lead to interagency red tape, bureaucratic rivalry and secrecy. An open flow of ideas and information and a coordinated health policy can be hurt by agencies in conflict. A situation is thus created where decisions of one agency undermine those of the other.

Regardless of these problems, consumers on HSA boards must work to pass legislation that establishes a state rate-setting agency or authorizes the HSA to establish rates, or in the nine states that have a rate-setting agency, the effective coordination of the HSA and the rate-setting agency.

Consumers—Money—Care

It is important for consumers to understand the relationship of the reimbursement formula and health planning because the method of reimbursement of health services directly affects the quality and availabiltiy of services. The local HSA must establish an educational program on reimbursement to help consumers master reimbursement formulas and understand the impact on the delivery of care.

Maximizing reimbursement rates is so important to health care institutions and providers that the highest paid consultants in the health field specialize in this area. Incredibly, payment for these specialists is a reimbursable cost item paid for by Medicare, Medicaid and Blue Cross. The public pays for these consultants, but does not necessarily benefit from their efforts.

New York—One of Nine But Climbing

New York State passed its Hospital Cost Control (1969) and State Health Planning (1964) Acts which provide the needed resources to have effective health planning and cost controls. Part 86 of the State Health Department's Regulations "Reporting and Rate Certification For Medical Facilities" details the mechanisms by which Medicaid and Blue Cross reimbursement rates are established. Medicaid and Blue Cross payments exceed 50% of the annual operating income of hospitals in New York State so that cost controls over these rates are crucial to health planning.

The Medicaid program is funded by federal, state and city sources, but the methodology of determining its rates is somewhat limited by federal law. Blue Cross develops its reimbursement rates based on a formula which must conform to the requirements of Part 86. The State Health Commissioner is responsible to review and approve requests by Blue Cross to change its reimbursement formula or rates.

Formula Change Adds $35 Million to Tab

Recently, Blue Cross submitted its 1976 reimbursement formula to the State Health Commissioner for approval. In the past, acceptance would have been worked out almost exclusively between sympathetic government officials and Blue Cross. But, over the last year and a half, consumer groups have had considerable impact on these proceedings by forcing changes in Part 86 and in Blue Cross' reimbursement formula. These efforts led by the Hospital and Medical Care Committee of the New York City Central Labor Council received support from the New York State Consumer Protection Board, the New York City Department of Health, the Consumer Commission on the Accreditation of Health Services and the Chairperson of the City Council's Health Committee and the President of the City Council.

This consumer advocacy coalition pointed out inconsistencies between Part 86 and the Blue Cross/Blue Shield reimbursement formula* which, if implemented, would have cost the public many millions of dollars. Through efforts of the coalition, which included the New York City HSA, on this issue the major disputes were resolved in favor of consumers for 1977. But the inconsistencies as they apply to the 1976 formula are unresolved. Should the 1976 formula remain as proposed by Blue Cross, it will add a minimum of $35 million per year to subscriber costs. Several consumer groups have indicated a willingness to litigate this issue if it is not resolved satisfactorily.

Blue Cross Word Game Costly and Confusing

The following analysis of the Blue Cross formula points out the complexity of reimbursement and the need of consumers to have experts available to help them.

Part 86 provides for the 1976 prospective (per diem reimbursement) rate to be limited to 100% of the weighted average allowable expenses of the group to which the hospital is assigned for the base year 1974, *plus:*

(a) the application of the intervening inflationary factors for 1975 and 1976 subject to the exceptions under paragraph 86.17

The Blue Cross 1976 prospective rate is similarly limited to 100% of the weighted average per diem for the base year 1974 plus:

(a) such percentage of the individual hospital's base rate as equals the estimated percentage increase in allowable *expenses* for the year 1975 over 1974 provided that such a percentage increase does not exceed by more than 20% the weighted average per diem increase for the assigned group.

(b) the maximum percentage described in (a) shall never be less than the inflationary factor for the year 1975 over 1974.

The Blue Cross reimbursement formula for 1976 thus substitutes:

(a) the inflationary increase in hospital allowable expenses for the inflationary increase in the overall economy. The difference amounts to $35 million in added hospital payment.

Under the projected 1977 Blue Cross reimbursement formula the intermediate year concept has been elimi-

*Copies of the Blue Cross formula and Part 86 are available from the New York State Health Department, Albany, New York.

nated and the 1975 operating expense plus the application of the Part 86 formula provides the prospective 1977 reimbursement rate for each hospital.

Consumers Fight Confusion: State Fights Costs

State officials have been responsive to consumer demands that the Blue Cross formula contain hospital costs. State action has so far restricted the increase for 1976 to about 4%. Some of the changes are shown below:

(1) The base year ceiling was reduced from 115% to 100% of the weighted average of hospital group;

(2) Additional payments of up to 2% of expenses were eliminated for cost increases other than inflationary increases;

(3) Intermediate year expense based reimbursement was eliminated from the projected reimbursement formula for 1977 and thereafter;

(4) Workload requirements for open heart and other procedures were instituted with financial penalties for hospitals not meeting quotas.

The cost savings to New York State and City and Blue Cross subscribers is significant and is the main reason why the financially strapped State and City even considered listening to consumers' demands. But the role of consumers has now been established and even if there is no financial crisis in the future, government will have to be more responsive to consumer organizations.

Planners and Money: What a Marriage

HSAs must play a more active role in the development and analysis of reimbursement rules and regulations. Fiscal measures must be used to ensure the successful implementation of local and state health plans. THe HSAs must be involved in the development of Part 86 regulations (or equivalent local legislation and administrative regulations) and in their application to specific reimbursement formulas.

NYS: HSA Can Act Now

These recommendations are based on a memorandum from the Consumer Commission dated Aug. 2, 1976 to the NYC HSA.

Even without changing Part 86 there are areas in which New York State's HSA can act now. The SHCC can identify those sections of Part 86 to be performed by local HSAs that would provide leverage over providers to control costs. The following sections in Part 86 can be explored by an aggressive HSA to improve care and reduce costs:

Section 86.20

"Less expensive alternatives. Reimbursement for the cost of providing services shall be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served as effective alternatives or substitutes for the whole or any part of such service."

Section 86.21(e)

"Allowable costs shall not include expenses or portions of expenses reported by individual facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item."

The HSA can make a significant contribution to hospital cost savings under the provisions of these sections. The HSA can evaluate proposals to develop lower cost central services for two or more institutions. HSA findings will be referred to the State Health Department for action. When hospitals choose not to follow HSA recommendations, the Health Department can limit reimbursement as an incentive to obtain their cooperation.

This type of action is in accordance with the fifth national health priority. The NYC HSA on Oct. 12, 1976 recommended regionalization of services of hospitals in the City and has urged a sharp reduction in reimbursement to hospitals that refuse to share expensive services and equipment.

The HSA must develop new reimbursement mechanisms that support the implementation of the HSP and AIP and which identify the cost additions and savings of the new mechanisms. Any increases in Blue Cross and Medicaid rates must include a reserve or portion for reimbursement to implement the HSP and AIP, it being understood that the increases must be accompanied by reductions in cost over time.

Section 86.3 deals with financial and statistical reports which must be submitted to the State Health Department by health facilities. The HSA must study the presently used forms and make recommendations to the Commissioner of Health for modification of the statistical and financial reports that improves the use of these reports for planning purposes. For example, the existing reports do not contain information on computers or lab systems; although hospitals which purchase or lease equipment in excess of $100,000 must receive HSA approval under Section 1122 of the Social Security Law before receiving federal reimbursement for their purchase or rental.

Many hospitals in New York State have computer and lab systems budgeted at over a million dollars a year. Neither the State Health Department nor the local planning agencies have any statistical or financial data on these systems. The Health Department does not maintain inventories of fixed or moveable hospital equipment. This failure to maintain inventory data on hospital equipment prevents the enforcement of the provisions of Sections 86.20 & 86.21(e) of Part 86 which specifically refer to the efficient production of service and shared services between facilities. There is evidence that many hospitals have purchased or leased laboratory or computer systems, etc. independently, without considering the possibility of sharing services or obtaining Section 1122 approval. They are thus receiving federal reimbursement in violation of the law. Facilities which purchase or lease equipment must not receive reimbursement for these costs unless approved in advance by the HSA.

Section 86.9(d) sets minimum utilization rates of 60%, 70% and 80% for maternity, pediatrics and medical/surgical beds respectively. Hospitals failing to maintain these utilization rates are penalized by a reduction in their reimbursement rates. These minimum utilization rates must be reviewed and revised upward by the HSA.

Section 86.9(d) gives the State Health Commissioner the power to waive the provisions of this section if it is found to be a matter of public interest and necessity. The Commissioner of Health has not developed criteria to determine when the public interest and necessity call for a waiver. Too often, waivers are granted because of political considerations. The criteria for granting waivers and the recommendation to grant a waiver must rest with the HSA.

Section 86.9(e) contains minimal utilization figures for high cost procedures. Hospitals failing to meet these minimum figures face the imposition of fiscal penalties. These minimal figures apply to coronary angiography and other cardiac invasive procedures, and kidney transplants. Section 86.11 (1 and 2) provides for penalties for radiotherapy services and for renal dialysis services not meeting other minimal utilization standards. The minimal number of procedures contained in these sections must be based in the future on recommendations made by the HSA. The Commissioner of Health has the power to waive these provisions. The HSA must be responsible for establishing the criteria for granting waivers and for making the recommendation to grant a waiver.

Part 86 is limited to those procedures and utilization factors listed above. A study conducted for HEW by ABT Associates, Inc., Boston, indicates that many types of high cost hospital equipment are only used to 50-60% of their capacity. The HSA must determine minimal standards for other services and equipment. There must be minimum utilization standards and bed complements for intensive and cardiac care units, and for high cost hospital equipment (i.e. lab, computers, radiology).

Section 86.17 provides a fiscal penalty of 10% for facilities not maintaining an acceptable level of care. The HSA must develop a definition of "acceptable level of care" and mechanisms to determine which facilities are not providing care at that level. This must be done in conjunction with the PSROs, local consumers and the SHCC.

Section 86.21(b) excludes the costs of open heart surgery and renal dialysis when done in non-approved facilities. The HSA must determine which facilities can maintain open heart surgery and renal dialysis services, etc. This must not be left solely to the State Health Department.

Section 86.21(2) specifies cost and revenue reporting for ambulatory and emergency services. This section must be amended based on HSA determination of which ambulatory care and emergency services are needed. Unnecessary services must not continue to be reimbursed, but instead must be reduced according to a timetable which phases the closing of these services in an orderly fashion that is not detrimental to patients or workers.

Sections 86.23 and 86.24 refer to depreciation and interest charges. Many hospitals in the New York City area are leasing equipment at interest rates that run as high as 18% a year. The statistical and financial reports must contain a detailed inventory of all equipment and/or capital construction costs, the amount and method for calculating depreciation, and the interest rates being paid for all purchased and leased equipment. No purchase lease or interest costs must be considered an allowed reimbursable cost unless fully approved by the HSA in advance.

Sections 86.23 and 86.33 require facilities to fund separately that portion of their reimbursement covering depreciation. This money is supposed to be used later to pay for new equipment or capital expenditures. The provision has a clause which permits the State Commissioner of Health to waive this section, thereby allowing a facility to use depreciation funds for general operating expenses. The HSA must analyze capital needs, depreciation and funding for future purposes and make recommendations to the Health Commissioner.

Section 86.29 provides for a return on investment for proprietary medical facilities. In 1975, the rate of return allowed by the Commissioner of Health was 10%. The HSA must be involved in the determination of the rate of return, if any, that might be allowed to profit-making institutions.

Money Talks So HSAs Must Speak

Health planning requires control over the expenditure of public and private funds. The HSAs must work aggressively with consumers and providers to do away with the individual provider or institution attitude that each does not have to be accountable to the public. The HSA must ensure that the private sector doesn't force unneeded operating expenses on the public for buildings, esoteric services and research that have not been approved by the HSA. Unless the HSAs can control the flow of money, they will be undermined, and ineffective and will follow the path of the CHPAs.

HSAs and Consumers: The Ideal Romance

The main failures of CHPAs included their inability to free themselves from the dominance of providers

and to control the flow of health dollars. The HSAs have the legislative and public support to control health costs, to stop unneeded expansion of hospitals and to revamp the health system. But that support is predicated on real, full and equitable involvement of consumers at all stages of the development of the health plan and effective control of (or coordination with the agency responsible for) rate-setting.

In some states the rates paid to hospitals are determined through the prospective budgeting mechanism in which each cost center of the institution's budget has to be justified. In those states, the HSA can expand its role by advising the rate-setting agency as to which aspects of an institution's operation are necessary and efficiently run. The budget for the next year can be adjusted to reflect HSA input regarding individual institutions.

The New York State Cost Control Act which uses trending factors and overall economic indicators does not allow for decision-making at the institutional level. There is, however, room for considerable HSA involvement in rate-setting in New York.

As HSAs develop, they will have to assume more responsibility in the rate-setting area. Whoever controls reimbursement rates affects and effects public health policy. Cooperation between state rate-setting agencies and HSAs is one of the major ways for health planners to implement their recommendations.

The HSAs must take a lead role to develop regulatory cost control savings into new reimbursement formulas, review and approval of rates, certificate of need, coordination of shared services and incentive programs, improved consumer education and relationships with provider and institution licensing agencies, Health Commissioners, PSROs, etc.

The planning vacuum exists, HSAs must effectively fill the void.

The Consumer Commission reproduces below sections on merging health planning and reimbursement contained in the October 12, 1976 New York City HSA draft entitled "The Regionalization of the Health Care Delivery System in New York City."

Financial and Regulatory Incentives

A major reorganization of the fiscal and regulatory inducements for providers must accompany regionalization in order to achieve the quality and financial goals for medical care in New York City.

There are three principal types of existing authority and influence that can be used to implement a regionalization plan. First, the State government's rate-setting authority for Medicaid and Blue Cross could be exercised in a way that creates strong incentives for plan implementation. Second, the HSA can require, as a condition of approving a project proposal, that the applicant make changes in its operations to carry out the implementation plan. Rather than confining its attention to the need for a specific replacement or expansion project, the HSA could make its decision on the basis of the role of the applicant institution in a region. Thirdly, the State Health Department's broad regulatory authority over hospitals and other health care institutions could be used to require cooperation with the regionalization plan as a condition of licensure. A coordinated effort involving the HSA's project review power and the State government's rate-setting and regulatory powers could provide the means for bringing about a regionalized system for the delivery of health care in New York City. A description of each of the three sources of public control follows.

Rate-Setting Authority

a. Short-Range. Under present law, the Commissioner of Health is responsible for approving hospital reimbursement rates for Medicaid and Blue Cross payments. Section 2807 of the Public Health Law requires that rates

be "reasonably related to the efficient production" of services and that they take into account "the need for incentives to improve services and institute economies." The manner in which these factors are taken into account is not specified, leaving it to the discretion of the Commissioner to devise the best formula. At present, the Commissioner's efforts have been limited to incentives to achieve internal rather than systemic efficiencies. In other words, the present rates may encourage a hospital to operate its beds more cheaply, but they do not take into account the extent to which the beds are unnecessary, thus contributing to overutilization and waste in the health care system as a whole. Furthermore, as the discussion in Chapter II indicates, the present rate-setting system creates a large number of incentives that tend to perpetuate unnecessary services and disincentives that discourage the consolidation of services and other economy measures.

There are a number of ways in which the Commissioner can use the rate-setting power to encourage the implementation of a regionalization plan and to reduce disincentives to desirable changes. The Commissioner can increase the reimbursement rate to compensate hospitals for the intitial costs and revenue losses incurred from changes called for by the implementation of the regionalization plan. The inclusion of these start-up costs—hereafter referred to as a "coordinated services factor"—would provide both an incentive and financial flexibility for making the changes. As a complement to the start-up cost factor, a negative incentive—referred to as a "negative coordinated services factor"—would take the form of rate reductions for hospitals that refuse to participate or fail to take adequate steps towards implementation of the regionalization plan and, therefore, cause the health care system as a whole to incur unnecessary costs.

The coordinated services factor for most hospitals would consist of a single flat rate, based on a specified percentage of the hospital's reimbursement rate. This would be added to its reimbursed rate. A hospital could apply for a further addition to its reimbursement rate if it could demonstrate that the amount of its reimbursement rate, inclusive of the coordinated services factor, did not cover the hospital's costs in implementing the regionalization.

Although the principal emphasis should be to encourage providers to participate in the regional plan by making it financially feasible for them to do so, another rate-setting process should also make provision for reducing reimbursement for providers who refuse to participate and thereby contribute to the continuation of waste in the system as a whole. This can be accomplished by a reduction of the reimbursement rates of providers who refuse to participate. That reduction should be designed to offset the cost to society of the hospital's non-participation. In other words, the "reasonable cost" of a hospital should be determined in light of its overall role in the health care system, and if that role is one that causes inefficiency in the system, the hospital's reimbursement rate should be reduced. In general, this rate adjustment would parallel the computation of the start-up costs. Because of the difficulty and complexity of computing the cost of systemic inefficiencies, there would be a standard negative services factor, computed on a percentage basis. In addition, where a hospital persists in operating an unnecessary service or otherwise incurs major, identifiable costs that are contrary to the requirements of the Annual Implementation Plan for its region, these costs could be disallowed in full.

The first step in the implementation of the positive and negative incentives would be the establishment by the HSA of annual implementation goals for each region. The hospitals and other providers in the region would set up a plan of specific actions that each would take to meet those goals. That annual plan would set target dates for the completion of each of the specified actions. Upon approval by the HSA and by the State Department of Health, the regional plan would become the basis for measuring each provider's right to receive the coordinated services factor. At the start of the year, each participant provider would apply for the coordinated services factor as part of its reimbursement rate; those not participating would automatically be subject to the negative services factor, as well as to specific disallowances for the cost of unneeded services. The coordinated services factor would be paid from the beginning of the year, with quarterly monitoring of the progress of each provider in meeting the target dates set forth in the annual plan. Failure of a hospital to achieve its goal on the time schedule it had agreed to could result in discontinuation of the payment of the coordinated services factor and, in some cases, imposition of the negative services factor. At the end of the year, the Commissioner would review each hospital's progress toward the objectives of the regionalization plan and decide whether the hospital's progress is sufficient to warrant continued eligibility for the coordinated services factor.

The use of the coordinated services factor and the negative services factor described above differ in a number of important respects from other rate-setting incentives that have been used by the State Health Department. First of all, they will no longer be based solely on the costs of a *single* institution without regard to the region's health needs. They will specifically be based on the stated needs of an entire region. Second, the rate-setting incentives will be guided by an overall plan for the structure of the health care system. Third, provision is made to give the rate-setting system enough flexibility to permit it to overcome existing disincentives. The present rate-setting system is so rigid that it often makes it impossible or expensive for hospitals to make changes that are desirable and economical for the system as a whole. Finally, the manner of basing the incentive rate adjustments on regional goals is a first step toward developing a regional structure for the rational allocation of health care resources.

Although the HSA believes that the proposals outlined above represent a necessary first step in changing the financial incentives in health care reimbursement, they are short-term proposals for operating within the present system of cost-based reimbursement. These changes are not a substitute for major restructuring of the present system of reimbursement, but they do represent a means of overcoming the undesirable incentives existing in the present system and a first step toward a major change in the method of reimbursing health care services.

b. Long-range. Long-range proposals must link planning and rate-setting in some way. As noted, present hospital rate-setting practices do not take health planning considerations into account despite the crucial impact of reimbursement rates on the provision of health care in New York City. The form that the link takes may raise difficult policy questions that must be resolved in the context of a thorough reanalysis of the method of reimbursing hospital services.

Any long-term proposals for relating planning and reimbursement must start with the basic changes made in the present structure to reduce present defects. For example, the planning of the allocation of resources in the health field could be simplified if a reimbursement method based on a schedule of standard fees for specified services, capitation payments, or standard payments per spell of illness were adopted in place of the present cost-based method of hospital reimbursement. However, there are very serious practical problems that must be addressed in order to achieve such changes. It is likely that the lack of comparability among hospitals and services will require the retention of some form of cost-based reimbursement. At present, it is not clear how

the administrative, operational and financial problems of restructuring the hospital reimbursement system should be resolved; it is clear that the restructuring should be done with a view to overall health planning considerations.

In spite of the uncertainty about the future of hospital reimbursement, it is possible to define a number of desirable features of the long-term relationship between planning and reimbursement. First of all, it appears that a reimbursement mechanism should proceed from a defined pool of resources that have been allocated to health care, rather than including elements of open-ended funding. Although the prospect of open-ended funding for health is in some respects very attractive, the experience of recent years has shown that it results in misallocations of resources. In addition, when funds are insufficient, the cuts are likely to fall on those parts of the health care system that are most needed and on the providers least able to adjust to them. A system-wide health care budget, within which allocations of funds can be planned offers an opportunity to limit waste of resources and reduce the destructive impact of sudden, unplanned cuts in funds.

Secondly, local consumers and providers should be involved in the planning for the allocation of resources within regions of manageable size. One of the defects of the present system of setting reimbursement rates at the state level is that the decision makers are too far removed from the local area to predict the effects of reimbursement rates on the allocation of resources.

One way to make the resource allocation process comprehensible would be to organize it into tiers. The first stage of the process would be to allocate the funds among geographical regions, probably on a *per capita* basis, although provision could be made for demographic differences. At the regional level, decisions would be made about how funds should be spent, what services should be provided, who should provide them, and how much the providers should be paid for doing so. The regions that the HSA proposes to establish are of manageable size, so that decisions about the allocation of resources among types of services and providers could be made in a meaningful way. The nature and composition of the regional authority that would make these decisions and the payment mechanism that is most suitable for carrying it out are open questions at this time. No matter what new reimbursement system is adopted, a system that incorporates regional decision making is more likely to reflect sound planning decisions than a fully centralized reimbursement system.

Thirdly, a restructured reimbursement system must be used to reallocate the present dispersion of funds among types of service, if health planning is to have a significant and beneficial effect. For example, the reimbursement system must facilitate the transfer of resources from expensive, acute inpatient care to effective and less expensive ambulatory care. The present method of reimbursement makes such reallocations difficult or impossible. It is essential to secure the necessary legislative change to permit reallocations of this kind.

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