
STATE RATE SETTING: A STATUS REPORT

by David A. Crozier

In the thirteen years since New York imposed state rate controls on its hospitals, six other states have followed suit and developed their own mandatory rate-setting programs, spawning a movement to check the rising cost of medical care through a public utility model. The political pressures that led these states to act—sharply increasing Medicaid expenditures coupled with general fiscal woes—remain, but powerful interests with an economic stake in health care are divided over whether state rate setting is a policy course that should be pursued in the future. The tenor of the debate may be changing, however, creating what amounts to a second generation of controversy surrounding state-level hospital cost regulation.

States that have invested in rate setting as their preferred policy course remain largely committed to it, though not in some cases without a continuing political struggle. Besides New York, states with mandatory rate control programs include Connecticut, Maryland, Massachusetts, New Jersey, Washington, and Wisconsin. On the other hand, certain states have acted to reject this form of regulation. Colorado killed its rate-setting program. And the California and West Virginia legislatures, after contentious debates, abandoned state rate setting this year as a policy course.

The antiregulatory mood that currently pervades many state capitols and which remains a central theme of the Reagan administration, together with empirical questions about the effects of rate setting, have assisted well-organized hospital lobbies in their efforts to kill this form of regulation. Among hospital organizations, the Federation of American Hospitals has been the most aggressive foe of state rate setting.

Throughout the 1970s, the federal government was more or less a friend of the state rate-setting concept. Be the administration Democratic or Republican, there was a general propensity to encourage interested states—through federal financial support and other policy steps—to pursue health care cost containment through rate setting. The Carter administration was perhaps more enthusiastic about this policy course than the two Republican administrations it succeeded, but nevertheless,

none opposed state rate setting. Congress also advocated pursuit of this course and to some extent still does.

The Reagan administration, though, is another matter. It is skeptical of the likelihood that state rate setting will yield significant savings over the long term. In a broader context, the administration opposes most forms of government regulation, though in health care the President and his lieutenants have demonstrated a willingness to attack the cost problem in any way that might produce savings. Patrice Hirsch Feinstein, associate administrator of the Health Care Financing Administration, said in an interview: "This administration will take whatever steps are necessary-competitive or regulatory- to slow the growth rate of hospital costs."

Dr. Robert J. Rubin, Health and Human Services' assistant secretary for planning and evaluation, explained his skepticism about the state rate-setting model in a statement prepared for this article. Rubin said that "typically, state rate-setting programs are evaluated on only one measure- the effect they have on total costs," rather than a set of measures including their impact on quality of patient care, the impact on the growth in admission rates, access of the poor to hospital services, and the regulatory burden imposed on hospitals.

Using the measure of their effect on total costs, Rubin said state rate-setting programs have made an impact. "A variety of studies published throughout the literature . . . have shown that rate-setting programs have reduced the rate of growth in hospital costs by approximately 4 percent per year. The studies vary with respect to their comprehensiveness and the number of factors which they control for their analysis. Most of the data is several years old and looks at the experience during the 1976 to 1979 period. The department is currently funding a comprehensive study of this issue and the final results are expected next year."

"My concern about all of these studies is that they study the effect of rate setting for only a few years," Rubin continued. He said the phenomenon of the regulated industry capturing the regulatory agency "has been well reported in the economics literature" and thus "particular attention should be paid to the performance of state rate-setting programs over the long run. . . . In 1980, the last year for which we have complete data, hospitals located in the eight states with mandatory rate-setting programs were significantly different from other hospitals in a number of important areas. Expenditures per admission were \$2,179 in states with rate-setting programs, or \$410 higher than they are in states without rate-setting programs. Average length of stay was 8.7 days compared to 7.3 days in states without rate-setting programs." Generally speaking, state rate-setting agencies operate in northeastern states where many teaching hospitals, that care for sicker patients as a rule, operate.

Thus, these differences in cost and utilization may suggest more about the kind of health care provided in these states than the effectiveness of regulatory agencies in restraining costs.

Rubin concluded: "From the federal perspective two considerations about state rate-setting programs are paramount. The first is that the department is developing its own prospective payment system. While this development is occurring, we shall be evaluating the existing rate-setting programs. Second, when the federal program is implemented, there will be an opportunity for new experimentation. We shall continue to look for innovative programs on a local or state level. One of the important criteria for evaluating these new proposals will be the expected cost to the Medicare program. We will expect that the proposals will result in a lower total outlay by the Medicare program in that state."

The American Hospital Association (AHA) shares the Reagan administration's opposition to state rate setting, but such was not always the case. Throughout the 1970s, the AHA pursued a course favoring the proliferation of state regulatory agencies as a preferred path in the face of growing federal encroachment on the operations of hospitals. In July, 1980, less than a year after Congress rejected the Carter administration's Hospital Cost Containment Act of 1979, the AHA's House of Delegates voted formally to abandon its promotion of state rate setting, though for all practical purposes the association's lobbying arm had given up pressing for this course several years earlier. The AHA's thinking was influenced significantly by the strong campaign waged by the Federation of American Hospitals against state rate setting.

In testimony submitted June 23, 1982, to the Senate Finance Subcommittee on Health, the AHA articulated its opposition to rate setting. "State rate review is not a sound alternative for addressing hospital cost increases. While such review has resulted in temporary benefits in some states, it poses numerous potential problems. These include: failure to address the demand side of health care costs; creation of ponderous bureaucracies with unwieldy reporting systems; unfair preferences for certain payers, which create inequities; high costs of operating rate review agencies, complying with their regulations, and resolving through litigation the inequities they create; rates so low that hospitals deplete their capital resources, jeopardizing their future financial stability, their ability to serve the poor, and their very existence; and revenue controls without costs controls."

While the AHA has reversed its course on state rate setting, the Health Insurance Association of America (HIAA) has intensified its advocacy of this regulatory concept. The association, which represents the nation's commercial health insurers, has mounted an aggressive campaign against the "hidden tax" of cost shifting, urging state governments to enact rate

controls that would treat all payers alike. Recently, organized labor also came out strongly in favor of state rate setting as a course that should be pursued in the absence of a national health insurance program. Finally, a few of the over 100 private business coalitions which are seeking ways to control health costs have come out in favor of state regulation as at least a short-term way of dealing with the problem.

While the antiregulatory forces have been successful in the last two years in thwarting the adoption of more state rate-setting programs, they have failed to prevent some jurisdictions from enacting programs that deal only with Medicaid. Because of fiscal stringencies and the political ease of implementation, a number of states, including such bastions of free enterprise as Alabama and Mississippi, have introduced prospective rate controls for Medicaid hospital payments.

State fiscal crises are perhaps the most important reason behind the continuing interest in imposing rate controls on hospital expenditures. Medicaid programs represent in many states the single largest budget item. Of Medicaid expenditures, hospital outlays represent more than a quarter - and sometimes nearly half-of a state's Medicaid costs.¹ Federal outlays for Medicaid hospital payments increased about 12 percent annually between 1976 and 1980, with more rapid cost increases taking place since then. State expenditures have followed this pattern, as have outlays for state employees' health insurance.

On the revenue side, federal budget cuts, the tax revolt, and the national recession- which has reduced the tax base through high unemployment in addition to increasing state outlays-have further driven many states to seek budget savings wherever possible. But it is the federal government's reductions in Medicaid spending, and the new rules that guide that spending, that may be the real reason behind renewed debates on hospital cost regulation.

Under the Omnibus Reconciliation Act of 1981 (P.L. 97-35), federal contributions to the Medicaid program will be cut by 3 percent in 1982, 4 percent in 1983, and 4.5 percent in 1984. To make these reductions more palatable to the states, Congress revised some of the requirements regarding how benefits are provided and reimbursements are calculated. Among other things, the act removed the requirement that states pay hospitals on the basis of the Medicare "reasonable cost" principles, putting in its place a new requirement that rates only be "reasonable and adequate to meet the costs of efficiently and economically operated facilities. . . ." This gives states the authority, without special approval from the secretary of health and human services, to develop prospective payment plans based on stringent definitions of "efficiently and economically" operated hospitals.

The act also allows states to restrict the health providers through which recipients receive services, thus altering the "freedom of choice" provi-

sions in federal law that formed the philosophical centerpiece of the Great Society's health programs. States, as "prudent buyers," may now contract with specific low-cost provider groups to serve Medicaid beneficiaries— an important alternative to the traditional methods of controlling hospital costs.

The history of how rate-setting programs became law varies from state to state.² New York and Massachusetts adopted their programs primarily to address fiscal crises. Connecticut, Maryland, New Jersey, and Washington adopted their programs to deal with the broader issue of rising health insurance costs and to establish more equity in the rates paid by the major public and private payers.

All of the programs have evolved over time, with most growing gradually more comprehensive. But only the programs in Maryland and New Jersey regulate all payers: Medicaid, Medicare, Blue Cross, commercial insurers, and self-paying patients. Although the programs are credited generally with slowing the rate of increase in per admission hospital expenditures,³ there remains considerable disagreement over whether these savings come at the expense of the quality of care or the long-term financial viability of affected hospitals.

The fragmented evolution of state rate setting has led to the existence of almost as many forms of state rate setting as there are programs in place. Each state has faced the same essential set of problems and, depending upon its regulatory orientation, political make-up, technical capabilities, and perhaps, the severity of its perceived problems, has chosen alternative approaches to dealing with the issues. For any combination of third-party payers which may be covered, the programs may: cap total hospital expenditures; set budget limits for any one institution; set rates for gross units of service such as a hospital day or admission; set rates for specific services rendered to individual patients; or regulate hospital revenues through various combinations of these methodologies. The mechanics vary substantially from state to state, and sometimes, between two or more programs operating in the same state for different payers.

For all of these differences, once a state has chosen to regulate hospital revenues, the major issues of implementation boil down to just two: how base rates should be established to maximize the equity among hospitals and to approximate an acceptable level of aggregate expenditures; and second, how these rates should be updated each year to account for changes in inflation, volume, intensity, and the relative sickness or "case-mix" of patients.

What follows is a state-by-state account of different hospital cost control programs either in place or under active consideration. Emphasis is placed on political and regulatory developments in the last two years,

describing not only the mechanics of specific programs, but also attempting to convey the reasons why different states have either embraced or rejected alternative methods of regulating hospital expenditures.

Recent Legislative Action On Rate Setting

In the last two years, a number of states have sought legislative remedies to rising hospital costs through the creation of rate-setting agencies. But no state, after considering this option, went forward with its enactment, unlike the seven states which some time ago put in place regulatory agencies.

West Virginia.

In West Virginia, the state senate in early 1982 rejected a proposal advanced by Gov. Jay Rockefeller IV to establish a three-member commission which would have developed a prospective payment system for Blue Cross, commercial insurers, and self-paying patients. Observers in West Virginia who watched the debate say that Rockefeller's bill, modeled roughly after the program in neighboring Maryland, was hampered by a labor-endorsed amendment that would have exempted wages from controls. The measure was killed as a consequence of a well-orchestrated effort mounted by West Virginia's hospitals.

Bruce Carter, president of the West Virginia Hospital Association, said in an interview that "people quickly recognized the fallacy" of removing wages-60 percent of hospital costs-from the purview of the program. "We tried to point out that controlling hospital revenue does not necessarily help control hospital costs; that the costs of increased wages, improved technology, and increased utilization have to be addressed to get at the sources of the problem. I think that the legislature ultimately decided that the state bureaucracy could not do a better job than we are currently in the private sector."

State Senator Si Galperin, a Democratic member who has sponsored a variety of rate-setting bills throughout the 1970s and who was a cosponsor of this year's measure, believes that hospital rate setting is of "vital interest" to taxpayers. But in an interview he said there still are more legislators "who are beholden to the hospital association and big business than who are concerned about people and their health care." He said that the bill was defeated this year, despite its endorsement by Rockefeller and the senate Health Committee, because it concerned a complicated area that most legislators know very little about. Several legislators serve on hospital boards and, in Galperin's view, were able to enlist the support of key senate leaders, trade for unrelated political favors, and paint the would-be rate commission as a powerful public-service type regulatory body for which there is little public support. Galperin believes that

the “devastating” prolabor amendment gave senators an excuse to vote against the bill.

Carter, of the hospital association, concedes that the legislation will probably be introduced again next year, just as it has every year since 1971. In the meantime, the state faces fiscal difficulties which have led it to cut back on interim hospital Medicaid payments and develop a plan to create a separate prospective payment plan for Medicaid alone.

Connecticut.

The Connecticut Commission on Hospitals and Health Care, one of the oldest state programs in operation, suffered a serious setback last year when the legislature considered its reauthorization under the state’s sunset law. Hospital lobbyists persuaded legislators to approve a modified program which allows most institutions to escape detailed budget review and controls. According to Janice Hills, director of the commission, “The legislature was carried away on the tidal wave of deregulation, citing the actions of the Reagan administration as an example for them to follow.”

Previously, the seventeen part-time members of the commission reviewed each hospital’s proposed budget for inpatient revenues on the basis of an “overall test of reasonableness.” Hospital budgets which failed this test were subjected to detailed regulatory review and modification. In the last year of the old program, which had been credited by proponents with saving Connecticut consumers \$300 million over five prior years, only fifteen of the state’s thirty-six hospitals escaped the stringent budget reviews.

The restructured commission is made up of three full-time members appointed by the governor. If the commissioners find that an institution’s proposed expense per equivalent admission (EPEA) and summary budget is less than the “superscreen” allowance-set according to Health Care Financing Administration’s (HCFA) estimated inflation for Connecticut hospitals, plus 2 percent to account for increased volume and intensity of services-the hospital avoids further review. If the budget exceeds the screen, the review continues as in previous years. By accepting the EPEA as the key indicator to trigger stringent reviews, the volume of hospital admissions and total hospital expenditures are effectively eliminated from the commission’s domain. In the first year of the new program, in contrast to the year before, thirty of the state’s hospitals avoided the detailed budget review and regulation, although only seventeen have been exempted for their fiscal 1983 budgets.

The Connecticut Hospital Association argued that the commission in the past had been “arbitrary” and had created an “administrative nightmare” for hospitals. Joseph Coatsworth, the association’s chief lobbyist and former deputy house speaker, said that the commission’s

“overaggressive effort to control costs without looking at the other side of the issue” was responsible for state hospitals losing \$24 million in the commission’s last full year of operation.

Michigan.

In his 1982 state-of-the-state address, Michigan’s lame duck governor, Republican William Milliken, voiced his support for a statewide cap on hospital expenditures. Health planners in the Department of Management and Budget had drafted legislation that would set regional limits on hospital expenditures, starting with Medicaid, and possibly expanding in later years to cover Medicare, Blue Cross, and other payers. However, the plan did not receive the support of the legislative leadership and thus far has not been formally introduced.

Michigan’s fiscal problems are well known. In absolute terms, the state’s fiscal 1982 budget of \$4.3 billion is less than its budget for the year 1978; adjusted for inflation, the state has cut its “real” spending by about 30 percent during this period. With a constitutional requirement for a balanced budget, Michigan has this past year cut \$700 million in planned spending and raised taxes in order to avoid a billion-dollar deficit. However, relatively little has come from the Medicaid program. Jay Rosen, director of planning for the management and budget office, said this is because the automotive industry’s recession has swelled the number of Medicaid beneficiaries to a million people, around 11 percent of the state’s population. In addition, Rosen says, the “very potent” medical and hospital lobbies have been extremely effective in their dealings with the legislature.

Michigan’s Medicaid program still pays hospitals on the basis of Medicare’s “reasonable cost” principles. In cooperation with Blue Cross, hospital budgets are reviewed and targets are set in advance: institutions which stay under the limit are entitled to keep a portion of the savings; institutions which exceed their targets can initiate an appeal. The state is likely to withdraw from the joint budget process with Blue Cross, Rosen believes, because Blue Cross “has been so generous in accepting the appeals that the state can no longer afford to be a part.” Michigan has also implemented around fifty small, technical changes in the Medicaid program, affecting ancillary services, weekend admissions, and other areas, so the program looks significantly different from when the hospital association issued its support a few years ago.

The Michigan Hospital Association and the state have engaged in acrimonious disputes over the last several years regarding Medicaid and the prospect of imposing a ceiling on hospital spending. Ken Raske, an association official, said in an interview that many policy changes have been made by the state that “without the urgency of the fiscal crisis,” would not otherwise have been possible. “In our view the crisis is no

excuse for bad regulations.”

Contrary to the view of most state officials, Raske sees the new policy direction that emerged in the budget reconciliation act as a significant step backward for future hospital involvement in Medicaid. “When the reconciliation act eliminated the reasonable cost reimbursement requirements, we knew that it would probably do more to obliterate the Medicaid program than any other change in the last fifteen years.”

Rosen has a sharply different view of what the increased flexibility will mean for the state as it moves to reduce Medicaid expenditures. “It gave us some reason for hope. We are now only obliged to pay for the reasonable costs of efficient hospitals, rather than the reasonable costs of a poorly run institution. It gives us a chance” to develop a new definition of reasonable in an effort “to demand better performance.”

Illinois and Wisconsin.

Both Illinois and Wisconsin have backed away from their prior commitments to comprehensive approaches to hospital cost regulation. They have done so on the grounds that these methods, which treat all payers similarly, did not produce adequate savings for the state Medicaid programs. Meanwhile, both states have implemented Medicaid-only prospective payment systems that are designed to limit outlays and help cope with both states’ sizeable fiscal problems.

Illinois had received a waiver from the Health Care Financing Administration which would have made it only the third state, along with Maryland and New Jersey, to have the authority to impose rate controls on all payers, including Medicare. Despite having personally fought for the waiver, Gov. James Thompson recently decided to allow the authority of the would-be rate-setting commission, the Illinois Health Finance Authority, to expire later this fall under the sunset provisions of state law. It appears Medicaid participation in the comprehensive program would have cost the state some \$25 to \$40 million more than if the state set its own limits for Medicaid payments.

The Illinois program would have set up several screens to assess proposed hospital rate increases. Hospitals would have had the discretion to accept the rate calculated by the commission, to go through a limited budget review of only a few questionable departments, or submit to a full budget review, which might have led to disallowance of many costs and possibly a lower payment rate than would have been established in the first place.

“The financial authority would have saved the state a great deal over the long run, even if not in the first year,” contended Daniel R. Thomas, a spokesman for the Health Insurance Association of America, during an interview. HIAA provides staff and financial support for the Illinois Health Care Coalition, a broad-based group of Insurance companies,

employers, and providers which lobbied actively in favor of the rate-setting agency. "The coalition and HIAA are convinced that the rate-setting law was the best way to address the cost-shift problem and general hospital cost escalation as well." While coalition members have not yet regrouped since the bill's defeat, Thomas notes a sense of disillusionment among many in the business community in recognizing the minimal likelihood of another bill being passed in the next legislative session.

"The state is in a position now that any kind of start-up costs are significant," says Alan Chamison of the Illinois Hospital Association. "Instead of coming into the program as an equitable partner with other payers, they decided that the only way they can manage is to take an unfair advantage for themselves by setting their own rates." The state is pursuing an alternative prospective payment system for their Medicaid hospital outlays.

Illinois's neighbor to the north, Wisconsin, has faced a nearly identical situation, and appears to have reacted in much the same way. From 1977 to 1981, Wisconsin's Medicaid program worked with Blue Cross and the Wisconsin Hospital Association to review hospital charges and set rates. Medicaid and Blue Cross each received a discount from the standard rate for each hospital, and the suggested rates to other payers were complied with by almost all hospitals. But as in Illinois, Wisconsin decided, in the words of a hospital association official, that it needed "a system that would give them more control" and "allow them to equate the level of reimbursement to the availability of dollars." The prospective methodology since adopted by the state, fundamentally similar to most others throughout the country, has allowed the state to give itself a differential of about 15 percent under the charges paid by other payers. More changes are in the wind, however, as the state and the hospital association are negotiating about a variety of changes that would establish more positive and consistent incentives for hospitals to economize.

Regulation in Dixie: Southern States Begin To Control Hospital Revenues

State hospital rate control programs are no longer the exclusive province of the traditionally proregulatory states in the industrial northeast. Limited prospective payment schemes have been adopted recently in Kentucky, Missouri, Mississippi, Alabama, Georgia, and North Carolina to address fiscal shortages created by diminishing revenues and rising hospital and long-term care outlays. Several other states have similar initiatives under consideration. Each program is limited to hospital payments under Medicaid, which make up only around 5 to 8 percent of hospital revenues in these states. With the notable exceptions of Georgia and North Carolina, each program uses fairly uncomplicated

methodologies to calculate future hospital rates based on historical costs updated for inflation and changes in volume and intensity. Georgia and North Carolina have each developed alternative approaches to paying hospitals: the former through a case-mix adjustment which attempts to pay hospitals more equitably than under other arrangements; and the latter through incentives which try to inhibit use of high cost hospitals for low-risk conditions.

The programs have been at least politically successful, perhaps because they usually have not required legislative approval. Another explanation is that the hospital lobbies have not, generally speaking, vociferously opposed the programs; only a small portion of hospital revenues are typically covered, and in most instances, charges to other payers can be increased to make up any shortages from Medicaid payments.

Kentucky.

In the face of a severe state budget deficit, Kentucky health officials have implemented numerous initiatives to limit eligibility, benefits, and reimbursement of providers. The Medicaid deficits for fiscal years 1983 and 1984 are each expected to be around \$30 million. Within Medicaid, outlays for inpatient hospital costs, as 26 percent of the budget (second only to intermediate care facilities), became an early target for cutbacks.

Under the prospective payment plan, which is expected to save the state \$11 million in its first year, hospitals are grouped according to number of beds. Per diem operating cost limitations, based on updated Medicare cost reports, are set at 110 percent of the median for each group, with an index that takes inflation into account each year. Hospital costs over this limit are disallowed by Medicaid, leading, according to hospital officials, to the shifting of charges to Blue Cross and the private health insurance carriers. The prospective payment program comes on top of several other benefit and payment changes, including (a) reimbursement of a maximum of fourteen days of care per admission; (b) elimination of payment for weekend admissions and for standard laboratory tests that are not specifically ordered by a physician; and (c) application of a 60 percent minimum occupancy requirement in determining payment rates.

Medicaid director James Gooding expects that some form of prospective hospital budgeting will be in place in Kentucky for some time to come. However, the exact methodology will likely evolve as improvements are developed. For example, Gooding would like to implement a way to "factor into the system some method for taking into account the complex package of services offered by some hospitals."

In the view of Eugene W. Lorenz, an official with the Kentucky Hospital Association, the prospective payment plan is arbitrary, inequi-

table, and in conflict with provisions of the Omnibus Reconciliation Act of 1981. The association believes that the state's payment rates are not adequate to ensure "reasonable access" to quality inpatient services, as mandated by the reconciliation act. "The future looks bleak to me," Lorenz stated in an interview. "We will have fewer dollars to pay for a labor- and technology-intensive industry. The technology that is saving lives is massively expensive. If we have fewer dollars, we have to do more with less, or ration care. It's that simple."

Missouri.

Missouri health officials implemented several program changes in the wake of the reconciliation act in order to avoid a sizeable deficit in the state's Medicaid program. The state hospital association estimates that these changes, combined with other cost containment measures already in effect, created a \$30 million shortage last year in payments to its members for services rendered to Medicaid beneficiaries.

In the area of prospective payment, Missouri has instituted "cost-related" reimbursement through which Medicaid pays hospitals on a per diem basis with diagnosis-related limits for the length of an inpatient stay. The state's changes in its reimbursement methods have not sat well with the hospital industry. "We recognize the state's budget problems, and have attempted to negotiate with them from that basis," says Charles Swisher, an official with the Missouri Hospital Association. But Swisher predicted that "fairly soon I am afraid that we will begin to see hospitals eliminating and restricting services for government patients," simply because they are losing money otherwise. "The real question is how much of the costs hospitals can afford to absorb or to shift to other payers. There is a real limit."

Mike McKenzie, deputy director of the Missouri Medicaid program, said the state is seeking long-term reforms such as those allowed under the reconciliation act. They have initiated "very active" efforts, including an operational project in St. Louis, to move the program in the direction of enrolling Medicaid recipients in prepaid health plans. McKenzie says the state hopes to enroll 20 percent of beneficiaries in the St. Louis area in such plans.

Mississippi and Alabama.

Mississippi and Alabama, two traditionally conservative states with relatively small Medicaid programs, have also opted to regulate hospital payments through a prospective rate-setting methodology. In each state, outlays for hospital care consume about a quarter of the Medicaid budget. While neither state presently has severe funding difficulties, state officials were concerned about the rapid escalation of hospital expenditures. In Mississippi, the state had to contend with a fixed

legislative ceiling on total annual Medicaid outlays; supplemental appropriations are not allowed if outlays exceed the authorizations estimated for the fiscal year.

Both prospective payment programs work by setting per diem limitations based on the historical experience of peer hospitals, rolled forward to account for estimated changes in inflation, utilization, and the amount of available state funds. The Mississippi plan went into effect on July 1, 1981, and is estimated to have saved the state \$4 million in its first year of operation; the Alabama program started on October 1, 1981, and is expected to cut \$2.5 million in Medicaid outlays this year. Both programs have thus far stood up to court challenges from the state hospital associations, although the Mississippi program will be tested again on its merits later this summer.

Mississippi's rate increase for this year was limited to 8 percent over the previous year, while hospital expenditures were increasing at an overall rate of 18 to 21 percent, according to Billy Simmons, director of the Mississippi Medicaid Commission. Simmons, a former hospital administrator, said: "We hospital administrators have been talking to ourselves for too long. We've convinced ourselves that nothing can be done, that our expenses can't be controlled. Well, something can be done, and it will be done, given the right incentives." Furthermore, he maintained reduced revenues will not necessitate the shifting of costs to other payers: "If your personal family budget is reduced for some reason, there isn't anyone to shift your expenses to. You make the necessary cuts because you have to." While conceding that "any reimbursement system has inequities built into it," Simmons argued that the appeals and review procedure in Mississippi is adequate to ensure that adjustments are made for any gross inequities among hospitals.

The Alabama Hospital Association has contended in recent litigation that the peer grouping method used by the state to calculate payments is inequitable. Specifically, the association claimed that the grouping variable for urban and rural hospitals, applied according to whether or not the institution is located in a standard metropolitan statistical area (SMSA), inappropriately categorizes some of its members. W.H. "Hoke" Kerns, president of the Alabama Hospital Association and former head of the state's Medicaid program, also contended that the reconciliation act's requirement that states ensure that "efficiently and economically operated" institutions receive adequate payments to provide quality services is sufficiently vague to allow states to pay nearly any rate they wish. "It may be impossible to develop a perfect system," Kerns says, "but it is possible to develop a better one." Nonetheless, the state's move to prospective payment is in the right direction, Kerns believes. "I have no problem with the concept of prospective payment; my only concern is prospective payment carried out on an invalid basis which might cause a

ratcheting down on future rates.”

Georgia.

Georgia uses a payment methodology which is fundamentally similar to the programs in the other states with Medicaid prospective limits, with one important exception: under a HCFA waiver, Georgia is using diagnostic-related groups (DRGs) to pay hospitals according to the case-mix of their patients. This adjustment, in theory, allows for more equitable reimbursement of hospitals, and is of substantial interest to the federal government in its development of a prospective payment system for Medicare. Donald Woodbury, director of the Georgia project, believes that the program would be “administratively feasible” if implemented on a national level.

The state has created eleven groups of hospitals which are comparable according to the DRG-mix of Medicare and Medicaid patients and about thirty other process and structural variables which serve as surrogates for the case-mix of nongovernmental patients. The limits are set at 130 percent of the mean cost per case in each group. Hospitals over the limit are penalized, and hospitals under the mean in each group are given bonuses of up to 2 percent of their total Medicaid revenues. A year-end adjustment is made to account for unpredicted changes in the case-mix or volume at specific institutions. Asked if such a program could make hospital payments perfectly equitable, Woodbury said, “Groupings can be made equitable, in my opinion, although hospital administrators would disagree. Any grouping methodology introduces a bit of competition into the dynamics of the health care system. In the old days of cost-based reimbursement, one hospital’s cost bore no relationship to another’s. Equitable grouping can identify efficient and inefficient hospitals, with payments tied to what other institutions do, in addition to what costs your own hospital may incur. It can publicly identify those 15 percent or so of the hospitals that are inefficient.” The Department of Medical Assistance is attempting to win the governor’s approval to go forward with the already-received HCFA waiver which would place Medicare in the same payment program, increasing the weight of the reimbursement incentives.

The Georgia Hospital Association is continuing to fight the program in the courts, without success to date. It believes that the grouping method harms the hospitals at the upper margins of each group, and that the DRGs are an imperfect basis for estimating case-mix. The association also believes that the program’s methodology has not been sufficiently explained to the state’s hospitals, and that therefore, hospital administrators and physicians have not yet responded to the prospective incentives by changing the way services are provided.

North Carolina.

The state of North Carolina is facing a serious financial crisis in fiscal 1983, and has taken numerous steps in all budgetary areas to limit its deficit—including a freeze on state employees' pay. Seeing a need to cut about 8 percent from its Medicaid budget, the state implemented a twenty-day maximum length of hospital stay and a prospective per diem rate for all hospitals. These steps met with strenuous objections from the large teaching hospitals, which provide the bulk of Medicaid services. The compromise proposed by the hospital association and accepted by the Division of Medical Assistance takes advantage of the new flexibility afforded states in the reconciliation act by developing prospective payment rates with strong incentives for high-cost hospitals to reduce their utilization.

The historical per diem costs are calculated for each hospital on the basis of Medicare cost reports and increased to account for inflation. One-third of the state's most expensive hospitals, including all of the teaching facilities, are given a budget-dictated target of providing no more than 85 percent of the total days of care that they provided to Medicaid patients in 1981. After this point they are reimbursed at the average rate—about \$200 per day—of all other hospitals in the state. In this way the state hopes to become a “prudent buyer” of inpatient services, according to William Oviatt of the North Carolina Hospital Association, and “avoid paying for low-risk patients in high-cost hospitals.”

James Johnson, of the fiscal research office of the North Carolina legislature, is somewhat skeptical of the program, and concerned about the long-term health of state medical programs in light of the outlook for additional reductions in the federal share of Medicaid. “In theory you can shift people into the less costly hospitals,” even if the institutions may not be immediately accessible to the Medicaid patients. “But I don't know if you can change the historical referral patterns that have remained stable for many years. I don't know if hospital administrators will be able to change physician behavior in order to cut their utilization.”

Johnson predicts that the next round of federal Medicaid cuts will cost the state around \$40 million next year. “You can't factor out that kind of money through traditional cost containment programs. We will be trying to put in place more long-term savings measures such as prepayment programs. You can't consider a state-wide HMO for Medicaid and state employees off limits in the future.”

Arizona and California Reject Rate Setting in Favor of “Prudent Buyer” Approach

Traditional hospital rate-setting programs have been rejected in the states of Arizona and California in favor of alternatives wherein the state,

and private organizations on a voluntary basis, can become “prudent buyers” of health care services. Given California’s history as a bellwether state, and the fact that until last year, Arizona had been the only state without a Medicaid program, these are particularly interesting developments.

Arizona.

Last year the Arizona legislature created the Arizona Health Care Cost Containment System (AHCCCS - pronounced “access”), for the first time establishing an indigent health program at the state level. Under the program, the state and participating private businesses contract through a quasi-state agency with groups of hospitals, physicians, and other providers to care for indigent and private patients on a prepaid, per capita basis. Arizona’s voluntary hospital rate review board, which requires public disclosure of hospital financial information, was not substantially affected by the decision to go ahead with the AHCCCS. Nonetheless, the concept of mandatory rate setting was implicitly rejected in favor of reliance on alternative delivery systems operating in a relatively competitive environment.

The indigent population in Arizona has historically received health services through the state’s counties, financed at that level with property tax revenues. When state voters passed a Proposition 13-type limitation on future increases in property tax rates, the counties became actively interested in transferring the responsibilities for the health programs to the state government. At the same time, Arizona’s industrial sector became concerned with the rising costs of employee health insurance and aligned with the counties to develop a state program to provide health services for the indigent and control health costs for the private sector.

Sandy Spellman, who drafted much of the AHCCCS bill as a legislative staffer, said the state sought examples from other public and private prepaid health programs in order to create its own innovative, market-oriented quasi-Medicaid program. Once the rough outline was drawn, Democratic governor Bruce Babbitt and the Republican Senate leadership approached the Reagan administration with a proposal to gain federal demonstration money and a waiver for Medicaid’s then-existent prohibition against limitations in beneficiaries’ free choice of medical providers. The timing was fortuitous; according to Spellman, the White House saw Arizona’s “pristine provider politics” and untarnished state bureaucracy as an ideal environment for a program that would exemplify the still-evolving, still-under-wraps proposal for a “New Federalism.” The environment remains harmonious, with both Democratic and Republican gubernatorial candidates anxious to take credit for the new program.

The legislation provides for the state to receive bids from private providers to care for subsidized public patients, state employees, and others who voluntarily choose to participate. The provider networks can take many forms—no one structure is prescribed by the state—with physicians, hospitals, pharmacies, laboratories, and others expected to team up in a variety of consortia to provide the services. The hospital association, for which Spellman now works, is supportive of the program, and about half of the state's institutions have indicated their interest in participating in the bidding process when the program officially begins in the fall.

"It's an exciting experiment," Spellman said. "If you look at it within the context of hospital rate setting as practiced in other states, Arizona has begun with the premise not to prescribe the rates that providers would be paid. We are putting the whole purchasing process back into a competitive bidding system with the intent of having the market prescribe what the appropriate rates should be. Ultimately the state will be at risk actuarially to pay its fair share of the costs as determined through the competitive process."

California.

The California legislature recently rejected a proposal to control all hospital revenues in the state in favor of a state-controlled contracting approach for Medi-Cal not unlike that in Arizona. Under the program, which requires a federal waiver, a Medi-Cal "czar" would negotiate contracts for hospital services rendered to the state's Medi-Cal beneficiaries. In last minute legislative action, the state's insurance industry persuaded lawmakers that private insurance companies should be allowed to negotiate the sorts of contractual arrangements that the state is seeking to enter with providers through Medi-Cal. In so doing, California's new law opens up the entire state to the "prudent buyer" concept.

Faced with a constitutional requirement to balance its state budget, California officials were seeking some \$500 million in savings from the state's \$5 billion Medi-Cal program. Gov. Jerry Brown appointed William Guy, who recently retired as president of the Blue Cross Plan of Southern California, as director of the new Medi-Cal contracting program. State officials estimate that the new program will save the state between \$100 and \$150 million in its first year. The California Hospital Association supported the idea of individual hospitals negotiating with the state as an alternative to a rate-setting scheme that would control hospital budgets.

The future of state-level hospital cost regulation will be shaped by a number of factors external to the states themselves. In general, the success of hospitals in voluntarily restraining their expenditures will certainly be important, but perhaps not as important as trends in the general economy which dictate the health of state and federal budgets. Of course, the performance of states like Maryland, in the traditional mode of rate setting, and now California and Arizona, with decidedly untraditional programs, will greatly influence the course to be taken by states which have not yet acted. Yet the most important role may be reserved for the federal government.

The payment methodology selected for Medicare—be it a new form of prospective financing, a continuation of the status quo, or some other method—will affect all aspects of hospital financing in America, since Medicare's sheer size makes its every action felt throughout the institutional sector. If Medicare should depart from its much-maligned "reasonable cost-based reimbursement," it is doubtful that many state Medicaid programs would stay with that approach for long. And if Medicare and Medicaid prospective payment systems simply become an elegant way of imposing massive hospital budget constraints, the allegations of the commercial insurance industry about cost shifting are likely to be heightened. These factors taken together would seem to increase the likelihood of more and broader state programs taking effect.

Finally, the future of state-level hospital cost regulation will most certainly be affected by fundamental changes being debated today in Washington. While none of the "competition-oriented" financing reforms would necessarily usurp the role of states in regulating hospital costs, their implementation might influence many legislatures to postpone initiation of large-scale regulatory programs, and conceivably, could lead some states to dismantle their regulatory apparatus already in place. Lastly, the dark horse of New Federalism—with its ill-defined shadow of a federalized Medicaid looming over the debate—poses the greatest unknown in forecasting the prospects for state-level rate setting in the eighties and beyond.

NOTES

1. Donald Muse and Darrin Sawyer, *The Medicare and Medicaid Data Book, 1981*, Health Care Financing Administration, Office of Research and Demonstrations, HCFA Publication No. 03128 (Washington, D.C.: Government Printing Office, 1982) p. 108.
2. Abt Associates, Inc. *First Annual Report of the National Rate-Setting Study: A Comparative Review of Nine Prospective Rate-Setting Programs*, (Cambridge, Mass.: 1980) Prepared under HCFA Contract No. 500-78-0036.
3. Brian Biles et. al., "Hospital Cost Inflation Under State Rate Setting Programs," *New England Journal of Medicine*, 303, No. 12 (September 18, 1980): 664-668.