97th Congress
2d Session } COMMITTEE PRINT { CP 97-17

Reimbursement of the Providers of Health Services

SUBCOMMITTEE ON HEALTH

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of the

COMMITTEE ON FINANCE

UNITED STATES SENATE

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SEPTEMBER 1982

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
98-313 O WASHINGTON: 1982

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ACKNOWLEDGMENTS

Staff wishes to acknowledge the generous assistance of members of the Congressional Research Service in preparing this document.

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REIMBURSEMENT OF THE PROVIDERS OF HEALTH SERVICES

At the heart of third-party health insurance contracts and programs are the provisions which determine the amounts and methods by which providers of health services—namely, institutions and practitioners—are paid for the rendering of care to patients. In addition to establishing ultimate payment levels, reimbursement provisions also contain important features that can affect both the cost and price structures of the services provided to insured persons.

It is the purpose of this print to provide general background information and current practices for the reimbursement of health care providers.

PART I

HOSPITAL REIMBURSEMENT

A. General background

Around the turn of the 20th century, hospitals operated on what today would be called an "all-inclusive rate" basis—i.e., hospitals charged each patient a flat daily rate designed to cover all of the services rendered to the individual, including room and board, general nursing care, routine laboratory services, and the like.

But changes in both the character and the kinds of services provided by hospitals soon produced changes in the ways in which the institutions billed patients for certain services:[1]

> The development of aseptic techniques in surgery and the increased use of anesthesia resulted in departure from the all-inclusive daily rate system and the establishment of special charges for the use of the operating room and anesthesia. The discovery of the Roentgen ray in 1895 resulted in another special charge for x-ray service. Special charges for laboratory services, electrocardiograms, physical therapy, drugs, and many other services followed, until by the 1920's it was not unusual for the total amount of special charges to exceed the regular daily service charge.

Dissatisfaction with the variety and amount of these new special charges led many hospitals to reconsider use of the all-inclusive rate system for the pricing of their services. Some institutions established a separate all-inclusive rate for the special services, thereby averaging such charges among all patients of the respective facilities. Others established an all-inclusive rate for all services, routine and special, varying them only by length of stay and by type of hospital accommodation.

[1] Mannix, John R., "Blue Cross Reimbursement of Hospitals—Current Methods and Their Evolution," from a paper presented at the University of Michigan—Ann Arbor Center for Continuing Education; July 14, 1969.

From a historical standpoint, reemergence of all-inclusive rates was important. The use of such a system represented an early attempt to distribute and equalize the impact of certain expensive services among all of the patients of an institution. The all-inclusive rates helped to relieve some of the heavy financial burden that might otherwise fall upon the occasional patient who required large amounts of specialized care. The all-inclusive rate also became the principal basis upon which early third-party payers reimbursed hospitals through negotiated payments as Blue Cross developed in the 1930's. (The idea of spreading the impact of hospital charges among all of the users of individual hospitals was carried a step further by the original Blue Cross plans. These prepayment organizations distributed the charges of several hospitals, located in different communities, over the entire enrolled population of the plans in setting enrollees' premium rates.)

In the beginning, Blue Cross plans generally reimbursed hospitals in one of two ways—on the basis of the individual facility's established charges or on the basis of negotiated uniform rates. The latter method seems to have been the more commonplace, since flat negotiated rates made it relatively easy for the plans to estimate their anticipated liabilities (and to establish their premiums).

Reimbursement on the basis of established or negotiated charges, however, was not the only way in which the third-party bulk purchasers of hospital care paid for services rendered. Reimbursement on the basis of hospital costs, rather than charges, began to develop during the early 1920's. One of the first to utilize cost-based reimbursement for hospital care was the Pennsylvania Department of Public Welfare, which reimbursed institutions on the basis of "estimated costs per patient day."

During the 1930's, the Federal Government entered the hospital reimbursement field with payments to non-governmental facilities providing care to crippled children. Since not all costs incurred by hospitals necessarily are related to patient care (e.g., costs of running a hospital gift shop), reimbursement was made to such institutions on the basis of certain "reimbursable" rather than total costs. Cost reimbursement was subsequently employed in a variety of governmental programs (including medicare and medicaid), and has since become the predominant, though not exclusive, basis used by third-party payers to reimburse hospitals.

B. Current Reimbursement Practices

1. Payment on the Basis of Charges.—Like other businesses, hospitals assign various prices, or charges, for different units of service they supply to their patients. For example, specific charges may be established for room and board, by type of accommodation. Additional, separate charges may be made for specific ancillary services, such as the use of an operating room. Taken together, the sum of these charges constitute the bill that is presented to the patient upon the latter's discharge. For the self-paying patient, such charges are also the basis for reimbursement.

Charges may also be the basis for reimbursement in instances where the patient is insured through a third-party mechanism. The third-party may reimburse the insured directly, who, in turn, settles with the hospital. Or, the third-party may be authorized to pay the hospital directly on behalf of the insured. Charges-based reimbursement is a common method of payment among a number of the Blue Cross and Blue Shield organizations in the United States. Some of these plans reimburse on the basis of "billed charges" (or "uncontrolled charges"). Others pay on the basis of charges, if such charges can be shown to be "cost-related." In the latter case, the plans are notified of tentative changes in a hospital's charge schedule. The hospital supplies the plan with a budget and other materials showing cost justifications for each of the proposed changes. Still other plans pay on the basis of "negotiated charges." Prior to the implementation of any changes in an institution's schedule of charges, the plan examines a budget not only to determine that the proposed changes are cost-related but also that the hospital has exercised reasonable levels of management efficiency and effectiveness.

Nearly all commercial health insurers in the United States rely upon charges as the basis for reimbursement for hospital care. Certain services, such as room and board, may be reimbursed on a "full charge" basis. Usually, however, various ceilings are placed on the overall amount of the charges for which the insurer will assume liability. The insurer will "indemnify" the insured up to these specified ceilings (usually expressed as some dollar amount). Charges in excess of the indemnified amounts are either borne by the patient entirely, or are reimbursed according to some sort of cost-sharing schedule (e.g., a percentage of billed charges in excess of the dollar ceilings).

One of the key features of charge-based reimbursement arrangements—especially those that pay on the basis of uncontrolled charges—is the freedom and latitude granted to hospitals regarding their revenue expectations. Institutions that receive a sizable proportion of their income on the basis of charges are in an excellent position to obtain whatever target revenue levels they desire without much concern for the rationality of their pricing policies. Charges for certain services may be entirely unrelated to the costs associated with the production of such services. Cost increases are countered easily by changes in the charge structure of an institution. There is little, if any, external pressure on facilities so reimbursed to economize or to resist cost increases in their operations.

Some degree of cost containment or control may be achieved if a hospital is obliged to demonstrate that changes in its charges for services are both cost-related and warranted. Similarly, payment on the basis of "negotiated" charges may achieve some measure of cost control, particularly where the third-party stipulates maximums on the charges it will pay during a prospective contract period. Price increases in excess of such maximums would not be reimbursable by the third-party during such time frame.

2. Reimbursement on the Basis of Costs.—Reimbursement on the basis of hospital costs is today the predominant method used by public and private third-parties to pay for hospital care. Basically, cost reimbursement involves determinations, usually in accordance with certain

established cost principles, of the actual costs incurred by a facility in the rendering of patient care. The actual charges incurred by a specific patient do not directly affect the basis of payment, except (1) where patient charges are used as measures of relative hospital use in the process of apportioning the liabilities of different third-parties (see below) or (2) where the reimbursement contract provides that payment to an institution will be on the basis of charges, if charges are less than costs.

There are several ways of reimbursing hospitals on a cost-basis. For many years, third-party payers, such as Blue Cross and Blue Shield, paid on the basis of "average per diem costs." Under this arrangement, the total costs of operating the inpatient services of a facility are summed and certain "non-allowed" costs (e.g., bad debts, collection agency fees, etc.) are deducted from the total. The adjusted total is then divided by the total number of inpatient hospital days to arrive at an "average per diem cost." This "per diem" rate is then multiplied by the number of days actually used by persons covered under the third-party plan. From the estimated total liability are deducted various amounts for certain disallowed services, non-contract charges, and the like. The balance then constitutes the third-party's liability to the institution in question.

Cost reimbursement on a "per diem" basis, however, fails to take into account differences in the utilization patterns among the various users of hospital services, particularly between aged and non-aged patients. It is the nature of hospital care that the greatest use of ancillary services, and thus the highest costs, usually occurs during the first few days of the confinement. Since the aged remain hospitalized longer than other patients, their average per diem costs for ancillary services are spread over a lengthier time frame and, thus, are lower than those for non-aged patients. If a third-party program is composed largely of older persons (or others who have longer than average lengths of stay), it may find itself subsidizing a portion of the costs of the younger patients in a facility, if reimbursement is made on the basis of the "average per diem cost" for the total patient population.

In enacting medicare (which reimburses on a cost basis), Congress sought to prevent any cross-subsidization between the medicare and non-medicare populations. This is accomplished by means of the RCC cost apportionment system. RCC is short-hand for the "ratio of beneficiary charges to total patient charges. Under RCC the charges for covered services attributable to medicare patients are divided by the total charges made for covered services to all hospital patients. The resulting percentage is then multiplied by total allowable costs to arrive at medicare's reimbursement liability to an institution. Note that the individual charges to medicare patients affect reimbursement only to the extent that they determine the percentage of allowable costs for which payments will be made.

Because charges are used to apportion costs under RCC, careful examination must be made of the charge structures of individual hospitals. If charges are reasonably related to costs, a third-party paying on the basis of RCC will reimburse close to its fair share of the costs of providing services to its enrollees. If such charges are not cost-related, however, the third-party may end up paying more or less than its

proper share of hospital costs. Care must also be taken to assure that facilities do not manipulate their charge structures in such a manner as to favor one or another patient group solely for the purpose of obtaining unfair or inequitable reimbursement outcomes.

Cost-based reimbursement systems have been widely criticized as lacking in effective cost control features. There is little in the way of pressure on institutions so paid to contain their costs, since any such increases are simply passed along to the third-parties that reimburse on a cost basis.

It has even been suggested that most cost-based reimbursement systems contribute to hospital inefficiencies and wasteful expenditures (and, thereby, to hospital cost inflation), since such systems virtually guarantee payments for costs that (a) are not determined in the usual competitive marketplace, (b) are virtually unregulated by public authority, and (c) are not effectively controlled by the facilities themselves. Cost-based reimbursement may even contain disincentives for hospitals to seek economies or contain costs, since any reductions that are achieved only result in reduced income to hospitals from cost-based third-parties.

3. Rate Regulation.—The steady and dramatic increases in both the charges for and costs of hospital care have prompted a number of third-party payers to establish alternative ways of reimbursing institutions. In some instances, hospitals have entered into such alternative arrangements voluntarily. In other cases, new reimbursement procedures have been mandated by legislation.

The principal purpose of these programs has been to introduce some degree of constraint on charge and cost increases by setting limits on the amounts that will be paid hospitals during some future period. Hospitals may be given incentives for improved efficiency and management through a variety of rewards, if they can perform at or below the level of the "targeted" payments.

Hospitals possess some of the characteristics that liken them to public utilities. The services they provide in most communities are "essential" services. No acceptable substitutes can be found for many of the types of care they render. Hospitals are confronted with high fixed costs and may be in a position to engage in certain monopoly pricing practices. In order to assure that the prices charged by hospitals are reasonable, and not excessive, some attempts have been made to establish rates through one or another rate-setting authority. Third-party payers, in turn, reimburse the institutions according to such "regulated" rates.

Variations of cost-based reimbursement mechanisms have been explored. One of these is known as the "average group cost" method of payment. Under this system, all of the institutions reimbursed by a third-party are grouped according to shared characteristics—e.g., size, services, geographic location, type of ownership, etc. In theory, similarly grouped hospitals should be subject to similar economic conditions and pressures. An "average cost" is established for each of the groups) and individual hospitals within a group are reimbursed on the basis of this "average" cost. Hospitals with higher than average costs are penalized, while those with lower than average costs may be rewarded. In some instances, hospitals with lower than average costs

retain some or all of the difference between their actual costs and the average for the grouping. Hospitals with "excessive" costs are paid no more than some given percentage usually over the group "average."

Another incentive reimbursement scheme is often referred to as "prospective budgeting." Under this approach, the needs of each hospital department are assessed for some future period of time (e.g., a year). Areas of possible saving or economy are noted and an overall target budget is prepared. The target budget takes into account the areas for cost reduction developed during the survey process. At the end of the time period, incentive payments may be made to those hospitals which achieved or performed below their targeted budget or rates. Hospitals that have exceeded their targets are penalized with respect to excess costs.

Cost per case reimbursement is yet another experimental reimbursement system. Average lengths of stay by diagnosis and age groupings are established. Lump-sum payments are made to each hospital by multiplying the expected average length of stay by some daily reimbursement rate. Thus, the institution receives fixed payment amounts for each patient regardless of the actual stay. The incentive for the hospital is to keep lengths of stay down, in order to hold costs at or below the costs established for the "average" case.

Congress has recently approved legislation for the medicare program (in H.R. 4961) which includes (a) a revision of existing limits which use the "average group cost" method of payment, (b) a target reimbursement system with certain incentive payments and penalties, (c) a requirement that the Secretary of HHS develop a medicare prospective reimbursement system, and (d) a means for recognition of State hospital cost control systems.

In establishing alternative reimbursement methods, certain factors are important. Administrative feasibility is a major factor in designing and evaluating one or another of the alternate methods to the usual charge or cost-based systems. The costs of administration, for instance, and the costs of whatever rewards are paid "efficient" institutions must be less than the costs savings anticipated from the incentive mechanism.

Rate regulation in general requires the development of standards against which to measure and price various units of service. This is difficult to accomplish in the hospital field, where there are qualitative differences in the various outputs of health facilities.

C. Reimbursement Limitations and Controls

At the present time, hospitals may obtain their revenues from several or all of the reimbursement devices described in the preceding section. Charges are the basis of reimbursement for self-paying patients, for those insured under most commercial contracts, and for many Blue Cross and Blue Shield subscribers. Other income is derived from cost-based payments made on behalf of other Blue Cross and Blue Shield members and on behalf of medicare beneficiaries and medicaid recipients. Still other revenues may be generated through special "incentive" reimbursement arrangements entered into by institutions with the individual third-parties. Each of these generic methods of paying for hospital care has different characteristics.

The acceptability of a rate regulation scheme to hospitals—particularly where participation in such a system is not mandated—is

another important consideration. Acceptance by the institutions probably depends more on the expected payment level, in contrast to existing reimbursement rates, than on the method used to determine rates under the incentive scheme. Third-party payers have found it difficult to obtain voluntary participation in some of the incentive experiments because the hospitals see nothing to gain by giving up, say, cost reimbursement to risk lesser levels of payment.

Another concern of institutions under rate regulation systems is the matter of capital needs. Reimbursement by third-parties has become the major source of capital for hospitals today. Before the institutions are willing to participate in such systems, they must believe that the prospective rates will be high enough to assure them of the capital they feel they need.

Hospitals are also concerned about the ways in which incentive rates would be adjusted for uncontrollable or unforeseen events. It may be unfair to penalize or reward institutions for cost changes beyond their control, and it is not always clear whether certain events that lead to cost changes could have been controlled or anticipated.

PART II

REIMBURSEMENT OF SKILLED NURSING FACILITIES

A. General Background

Nursing homes have a less extensive history of third-party reimbursement than hospitals. Until the advent of medicare and medicaid, nursing homes were largely reimbursed either directly by patients and their families or by welfare agencies on behalf of the needy aged. Payments were generally determined in advance on the basis of charges established by each institution or on a negotiated per diem rate basis. Private health insurance coverage for nursing home care was almost non-existent, and even today, such coverage remains extremely limited. Currently, public sources and private out-of-pocket payments account for most nursing home revenues.

The Federal Government became indirectly involved in paying for nursing home care with the passage of the Social Security Act in 1935. That legislation permitted recipients to use monthly assistance payments to purchase nursing home care. In 1950, the Social Security Act was amended to authorize States to make direct "vendor" payments to nursing homes for aged welfare recipients. The 1960 amendments expanded the benefit to permit vendor payments on behalf of the "medically indigent aged." With the enactment of medicare and medicaid, however, prior reimbursement policies were significantly modified.

Medicare and medicaid are now the major purchasers of nursing home care. Their policies and procedures, developed over the last decade, currently serve as the standard for reimbursement. For this reason, the discussion of current nursing home reimbursement practices will be limited to medicare and medicaid.

B. Current Reimbursement Practices

Nursing homes participating in medicare and/or medicaid are defined as "skilled nursing facilities," and the care which they provide is defined as "skilled nursing care." Although both programs share a

common definition of these terms, the methods used to reimburse skilled nursing facilities (or SNFs) are not always alike. Medicare reimburses SNFs, like hospitals, on a reasonable cost-related basis which is uniformly applied to all participating institutions of equal class and size. As with hospitals, costs are apportioned between medicare patients and the rest of the patient population to determine medicare payment and to insure that neither patient population bears the costs of the other. Reimbursement units are established for inpatient general routine service costs. Proprietary SNFs also receive an allowance related to net capital equity.

Medicaid reimburses SNFs according to policies developed by each State. Effective October 1, 1980, States are required to reimburse SNF's at rates that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with applicable State and Federal laws, regulations, and quality and safety standards. States remain free to implement their own reimbursement approach as long as it conforms with these requirements. The Secretary retains final authority to review the rates and to disapprove those rates if they do not meet the requirements of the statute. States must also assure the Secretary that SNFs will file uniform cost reports and that such reports will be periodically audited by the State.

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