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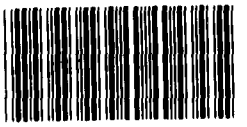
UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION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B-207300

MAY 10, 1982

The Honorable Bob Packwood
United States Senate

Dear Senator Packwood:

Subject: Information on Prospective Reimbursement Systems (GAO/HRD-82-73)

Your January 6, 1982, letter posed three questions relative to the use of a prospective reimbursement system under Medicare. Specifically: What savings could be achieved? Which Government procurement policies would be appropriate under such a system? And how do various procurement policies handle payments for profit and property-related costs? Briefly stated, our responses to these questions are:

--Prospective reimbursement is more a concept than a system. A particular set of rules to pay providers prospectively could be designed to achieve almost any level of program savings desired. Of course, there is a point when a reduction in reimbursement could adversely affect access to care and/or quality of care. Also, if the prospective reimbursement does not apply to all payers, a facility can have an incentive to shift costs to non-covered payers.

--Currently, Medicare reimbursements are based on principles very similar to those used by the Government to negotiate the purchase of other goods and services. Medicare would need to continue using these or similar principles under a prospective reimbursement system if such a system were to have any assurance that reasonable payments are made.

--In general, Government procurement policies recognize property-related costs as part of the cost of doing business and recognize it through depreciation payments. Whether or not profit is specifically addressed normally depends on the type of contract. Firm fixed price contracts resulting from advertised procurement actions normally would not specifically address profits while negotiated cost-plus-a-fixed-fee contracts would.

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Our detailed responses to your questions follow. Our analysis was based primarily on a review of existing Department of Health and Human Services (HHS) and GAO studies, Government contract procurement policies, and Medicare reimbursement regulations and guidelines. Because Medicaid is the primary payer of nursing homes, we used State reimbursement systems as examples in the report. Also, we held discussions with officials of the administering agency within HHS--the Health Care Financing Administration (HCFA). As instructed by your office, our response is limited to reimbursement for hospitals and nursing homes. Our work was performed in accordance with the Comptroller General's current standards for audit of governmental organizations, programs, activities, and functions.

HOW MUCH CAN A PROSPECTIVE REIMBURSEMENT SYSTEM SAVE?

Medicare currently pays most hospitals and nursing homes on a retrospective cost basis; that is, at the end of a period (usually a year) a facility's actual reasonable and allowable costs of providing care to Medicare patients are determined and payments made during the year are adjusted to equal that amount. Under a prospective reimbursement system, Medicare would determine before the services are provided the amount or rate it would pay a facility to provide care.

Under prospective reimbursement systems, facilities normally retain as profit all or part of payments received which exceed costs and normally suffer a loss if costs exceed payments. In theory, a prospective system provides incentives to facilities to be efficient because (1) they know in advance how much they will be paid and that they will suffer a loss if costs are higher and (2) they can make a profit if their costs are below the amount of payments they will receive. Medicare has participated in several localities' prospective reimbursement systems on an experimental basis. The results of these experiments continue to be evaluated.

A prospective system can be designed to achieve almost any level of program savings desired by selecting the appropriate set of rules. However, there is a point when a reduction in reimbursement could adversely affect access to and/or quality of care for beneficiaries. Also, if the prospective reimbursement does not apply to all payers, a facility can have an incentive to shift costs to non-covered payers.

A number of States have established prospective reimbursement systems for hospitals. In establishing these systems, the specific techniques used vary but can be classified broadly as budget-review, formula, and negotiation.

--Under the budget-review approach, the reviewing agency evaluates the projected annual budget and rate schedules of each hospital and sets or approves the budget and rates using the criteria established by the reviewing agency.

--The formula method uses a formula or group of formulas to determine the appropriate reimbursement rate for a facility. Formulas include those using averages, indices, or projections of established cost trends. New prospective rates or rate changes are usually computed annually and may be derived by adding a standard percentage to an institution's base rate or by relating the rates to one or more indices that reflect various rates of cost increase in the general economy.

--The negotiation method usually begins with a budget-review or a formula-derived rate, followed by negotiations between the hospital and the ratesetting authority.

Many States pay nursing homes a fixed per diem rate established on a prospective basis for the care of Medicaid patients. States use various techniques, some of which are very complex, to develop the rates of payment. Some States have established uniform rates by type of facility or level of care while others have established rates on the basis of additional characteristics, such as nursing home size and location. Examples of the techniques used are as follows:

--In Texas, the rates by type of facility (SNF--skilled nursing facility, ICF--intermediate care facility) are developed based on the allowable costs for patient care, dietary, facility, and administration. The State arrays the patient care costs by type of facility and sets the costs of the facility at the 60th percentile as the patient care subrate. Using the same procedure, separate subrates applicable to all types of facilities are developed for dietary, facility, and administrative costs. The sum of the four subrates becomes the statewide rate for each type of facility.

--California establishes rates for SNFs based on the 50th percentile of the costs of facilities arrayed by several bed size groups and regions within the State. ICFs receive 80.5 percent of the SNF rate for the applicable bed size group. Special amounts are added to the rates for facilities providing special services to the mentally disordered and separate rates are established for the developmentally disabled.

--In Minnesota, prospective payment is based on each facility's cost experience plus its projected cost increases. The maximum amount payable is limited to 125 percent of the average costs of facilities providing the same level of care, with the same type of ownership, and within the same region of the State.

Setting a rate in advance (prospective reimbursement) theoretically provides a health care provider the incentives to better plan and manage because it knows the amount it will receive and that it will suffer a loss if it exceeds that amount. Conversely, under a retrospective system, planning and management is said to be less important because final payment reflects the actual costs incurred with little consideration of whether the costs were incurred economically or efficiently. However, Medicare's present retrospective system does contain some features which should provide an incentive to be efficient.

Section 223 of the Social Security Amendments of 1972 authorizes the Secretary of HHS to prospectively establish limits

> "* * * on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title."

Using this authority, the Secretary has established prospective maximum amounts Medicare will pay for hospital per diem costs, home health visits, and skilled nursing home care.

Regarding the certainty of payment amount issue, retrospective adjustments to rates established under a prospective reimbursement system have taken place. For example, in Maryland and Washington, periodic adjustments are made if projected hospital revenues and expenses substantially increase or decrease beyond what was projected. Also, in New York State, where a prospective ratesetting system has been implemented for a private insurer and Medicaid:

> "the typical hospital experienced approximately seven rate changes in 1974, six rate changes in 1975, and five rate changes in 1978 for its inpatient care activities. Thus, it appears

that the implied benefits of prospective reimbursement were eroded by the frequency of the rate changes." 1/

Several studies have been made of prospective reimbursement systems and all have discussed differences in how these systems are implemented. In August 1980, HCFA's Office of Research, Demonstrations, and Statistics published a report entitled "The National Hospital Rate-Setting Study: A Comparative Review of Nine Prospective Rate-Setting Programs." The report pointed out that prospective reimbursement systems can and do vary greatly from State to State. Also, the report stated that:

"Rising Medicaid budgets and insurance premiums were the two primary reasons for adoption. Secondary objectives for adoption were to reduce payer cross-subsidization and to demonstrate a viable, decentralized, nonfederal approach to hospital regulation.

"The greater the perceived financial crisis in Medicaid budgets and insurance premiums, the greater the authority vested in the rate-setting body.

"The political orientation of states toward government regulation influenced the type of program adopted: the more laissez-faire, antiregulation the state, the more decentralized and voluntary the approach."

In a September 1980 report to the Congress, we made a comparison of States using retrospective reimbursement systems with those States using various types of prospective systems. The report is entitled "Rising Hospital Costs Can Be Restrained by Regulating Payments and Improving Management" (HRD-80-72, Sept. 19, 1980). For the years 1975-77, the average expenditures per case for all community hospitals increased 14.9 percent annually; for States having retrospective systems, the annual rate of increase was 17.9 percent, and for States using a prospective system, the expenditures increased on the average 13.9 percent per year.

1/Ruchlin, Hirsch S. and Rosen, Harry M. "The Process of Hospital Rate Regulation: The New York Experience," Inquiry, Vol. 18, No. 1, Spring 1981.

We concluded that while the hospital expenses per case continued to grow in all States in recent years, the rate of increase had generally been lower in States with prospective ratesetting programs. This lower growth rate suggested that the ratesetting programs had successfully diminished the cost escalation spiral. In some States, the rates of increase in hospital costs had dropped dramatically. This was especially true for States with mandatory-regulatory-type 1/ prospective ratesetting programs. Thus, it appeared that the mandatory-regulatory-type program offered the greatest potential for controlling hospital costs.

A more recent study published in the "Health Care Financing Review/Winter 1981" also shows differences in prospective reimbursement systems and that they have had some success in reducing hospital expenditures. The study--entitled "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures"--concludes that

> "The statistical evidence indicates that some PR [prospective reimbursement] programs have been successful in reducing hospital expenditures per patient day, per admission, and per capita. Eight programs--in Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, and Rhode Island--have reduced the rate of increase in expenses by 2 percentage points or more per year and, in some cases, by as much as 4 to 6 percentage points. There are indications, although less strong, that PR programs also reduced expenses in Indiana, Kentucky, Washington, western Pennsylvania, and Wisconsin. There are no indications of cost reductions for programs in Colorado and Nebraska.
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> "An analysis of the relative effectiveness of the various programs suggests that mandatory programs have a significantly higher probability of influencing hospital behavior than do voluntary programs. Some voluntary programs, however, are shown to be effective."

1/Mandatory-regulatory indicates that the program was created to comply with the requirements of a State governmental act or resolution either distinct from or as an addition to an existing law. Such programs have the authority to determine or alter rates, charges, costs, or revenue of a health care institution.

The study cautioned, however, that only part of the evidence that deals with the effects of prospective reimbursement has been examined and that the results must be considered preliminary.

With respect to nursing homes, in October 1981, the Office of Research, Demonstrations, and Statistics published a report on prospective reimbursement entitled "An Overview of Medicaid Nursing Home Reimbursement in Seven States." The report examines the experience of seven States using prospective reimbursement and while it does not estimate any savings, the report again provides considerable insight to the widely varying ways that a prospective reimbursement system can be implemented. Also, among other things, the study concluded:

> "* * * although reimbursement procedures are technical in nature and replete with specific accounting procedures and reports, they are, in fact, the end result of political decisions made by the state with or without the involvement of the industry. * * * designating a system prospective or retrospective provides not only incomplete but often misleading descriptions of payment system. Both a facility independent system without adjustments (e.g., a flat rate) and a facility specific system with a host of pass throughs, exceptions and adjustments can be termed prospective although the latter in fact bears closer resemblance to a retrospective payment method because it makes such large allowances for costs incurred after the fact."

WHICH GOVERNMENT PROCUREMENT POLICIES COULD BE APPLIED TO MEDICARE?

Although Medicare reimbursements are based on principles very similar to those used by the Government to negotiate the purchase of other goods and services, they differ in some cases because of program differences. Medicare would need to continue using similar principles under a prospective reimbursement system if such a system were to have any assurance that reasonable payments are made. This is because reasonable prospective rates can only be set based on a knowledge of current reasonable costs of efficient and economic providers. Therefore, a set of rules establishing what constitutes reasonable costs would still be necessary.

The Federal Procurement Regulations (FPR) are issued by the General Services Administration and are contained in chapter 1 of subtitle A of title 41 of the Code of Federal Regulations

(CFR)--Public Contracts and Property Management. Chapters 2 through 49 of subtitle A contain procurement regulations issued by individual government agencies which implement and supplement the FPR. Chapter 3 contains these for HHS programs.

The Medicare law states that providers of health services 1/ shall be reimbursed "reasonable costs." The implementing regulations are contained in 42 CFR 405 subpart D--Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians. Additional program guidance is provided in Medicare's Provider Reimbursement Manual. As a condition of participation in the Medicare program, providers of health services agree to abide by applicable Medicare laws and regulations. This "provider agreement" in effect could be viewed as a "contract" between the Medicare program and health care providers.

A general comparison of the FPR with Medicare's reimbursement regulations shows a great deal of similarity. For example, both provide that cost be reasonable and related to the activity at hand and both allow certain costs while disallowing others. Some differences exist between the two. The FPR, for example, do not allow interest or bad debts' expense. Conversely, Medicare allows interest expense, and allows bad debts to the extent that they result from Medicare patients' failure to pay deductible and coinsurance amounts.

The similarities and differences between Medicare and the FPR with respect to the recognition of profit and depreciation are discussed below.

HOW ARE PROFIT AND PROPERTY-RELATED COSTS HANDLED UNDER VARIOUS PROCUREMENT POLICIES?

Generally, both Government procurement policies and Medicare allow profit for proprietary organizations. Also, both recognize property-related costs as part of the cost of doing business and allow reimbursement for depreciation.

Profit or return on owner's equity

Under Medicare, for-profit health care providers are allowed a return on owner's equity. Equity return is computed at 1-1/2 times the average rate of interest on obligations held by

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1/Providers of service are defined as consisting of hospitals, skilled nursing facilities, and home health agencies.

Medicare's Hospital Insurance Trust Fund. This rate is applied to the provider's equity capital which generally consists of the provider's investment in plant, property, and equipment less depreciation, and working capital maintained for the operation of patient care activities. The current rate used in the equity capital computation is about 20 percent. Also, in recent years, some nonprofit hospitals have attempted to obtain reimbursement for a return on equity; however, they have not been successful. Several cases are currently being appealed in the courts on this issue.

The FPR allow profit organizations a profit on negotiated fixed-price and cost-reimbursement contracts. The amount of the profit allowed is largely left to the discretion of the contracting officer; however, he/she is required to consider such factors as contractor efficiency, difficulty and nature of the work, and total investment required.

Depreciation

Under the FPR, depreciation is generally based on the acquisition cost of the asset or the fair market value of a donated asset at the time of the donation. Commercial firms may use any depreciation method that is acceptable for Federal income tax purposes.

The Medicare regulations provide that the asset value be based on the historical or acquisition cost, except that historical cost cannot exceed (1) current reproduction cost less straight-line depreciation or (2) fair market value at the time of purchase. 1/ The regulations generally provide for using only the straight-line method of depreciation. Assets purchased before August 1, 1970, may be depreciated on an accelerated basis.

Accelerated depreciation for assets acquired on or after August 1, 1970, may be authorized only where the cash flow from depreciation on the provider's total assets does not supply funds sufficient to meet the amortization of a reasonable amount of principal on debts related to the total depreciable assets.

A major difference between the FPR and the Medicare regulations for determining the basis of depreciation is that, while

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1/Providers can also depreciate assets donated to them. Similar rules apply to the valuation of such assets for depreciation purposes.

the FPR use acquisition costs, Medicare uses historical cost limited to current reproduction cost less straight-line depreciation or fair market value at the time of purchase. Before 1970 the Medicare basis for depreciation was the lower of (1) cost or (2) fair market value at the time of purchase. The regulations were revised, however, to add current reproduction cost less straight-line depreciation at the time of purchase as a criterion for limiting the basis for computing future depreciation. This criterion was established in recognition of the higher program costs that resulted when facilities were sold for prices substantially exceeding the selling providers' costs.

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On February 2, 1982, before the Subcommittee on Health, House Committee on Ways and Means, HCFA's Associate Administrator for Policy summarized HCFA's views on the shortcomings of retrospective reimbursement and expressed the hope that a viable prospective system could be developed. She stated:

> "This Administration is philosophically opposed to retrospective cost reimbursement. The present system of cost reimbursement of hospitals and skilled nursing facilities for services provided to Medicare beneficiaries stifles competition, carries with it the need for extensive Federal regulation, and is a major factor in the rapid growth of health care costs. In large part, the system of retrospective cost reimbursement has been one of the major contributors to the high rate of inflation.
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> "We are working to design a system of prospective reimbursement, but this is a difficult and complicated process and it will take time to develop. We are working with a variety of both internal and external groups to develop new approaches to reimbursement, and we would certainly welcome this Committee's advice and suggestions."

Along these lines, the Administrator of HCFA received a report from a Task Force she established to study various options with respect to establishing a prospective reimbursement system for Medicare's hospital and skilled nursing benefit. The options presented are now being reviewed by the Administrator.

As requested by your office, we did not obtain comments from HHS on this report. As agreed with your office, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Gregory J. Ahart
Director