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0220 Costs of Health Care (Committee on Health, Environment, Welfare, and Institutions I)

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Report to the Colorado General Assembly:

1976 INTERIM COMMITTEE ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS I

COSTS OF HEALTH CARE

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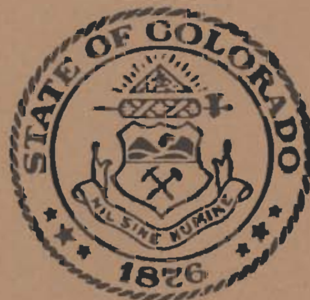

COLORADO LEGISLATIVE COUNCIL

RESEARCH PUBLICATION NO. 220
December, 1976

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OF THE

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* * * * * * *

The Legislative Council, which is composed of six Senators, six Representatives, plus the Speaker of the House and the Majority Leader of the Senate, serves as a continuing research agency for the legislature through the maintenance of a trained staff. Between sessions, research activities are concentrated on the study of relatively broad problems formally proposed by legislators, and the publication and distribution of factual reports to aid in their solution.

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no. 220

COLORADO LEGISLATIVE COUNCIL

RECOMMENDATIONS FOR 1977

Colorado. Legislative Council. Committee on Health, Environment, Welfare, and Institutions I.

COSTS OF HEALTH CARE

Committee on:

Health, Environment, Welfare,
and Institutions I

Legislative Council

Report to the

Colorado General Assembly

Research Publication No. 220
December, 1976

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To Members of the Fifty-first Colorado General Assembly:

In accordance with the provision of House Joint Resolution No. 1047 and Senate Bill No. 28, 1976 session, the Legislative Council transmits the accompanying report relating to costs of health care.

Respectfully submitted,

/s/ Senator Fred Anderson
Chairman
Colorado Legislative Council

FOREWORD

Under directives in House Joint Resolution No. 1047 and Senate Bill No. 28, 1976 session, the Colorado Legislative Council appointed a committee to study methods of control of the costs of health care and to continue the study of Colorado Blue Cross-Blue Shield which had begun in the 1975 interim.

This volume includes the report of the Committee on Health, Environment, Welfare, and Institutions I, which report was accepted by the Legislative Council at its meeting on December 6, 1976. A staff report is also presented as a summary of some of the information presented to the committee.

The committee and the Legislative Council are appreciative of the cooperation of the numerous persons who assisted the committee in its hearings and deliberations this year. Representatives of the many organizations and persons speaking for themselves provided information which will continue to be valuable in future consideration of the topics of health care costs and Blue Cross-Blue Shield.

December, 1976

Lyle C. Kyle
Director

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COMMITTEE REPORT

COMMITTEE ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS I

The HEWI I Committee submits the following report concerning issues relating to the control of health care costs, although no recommendations for legislation are being submitted. The directives to the committee were as follows:

> A study of controlling the costs of health care limited to: methods of payment; uniform charges for comparable services; physicians' demands on the system and their relation to cost; uniform systems of accounting for facilities; provision of statewide high quality health care; other states' measures for controlling costs; impact of medicare and medicaid; relation of suppliers' cost to hospital costs; and continuation of the review of Blue Cross-Blue Shield pursuant to S.B. 28, 1976 session. (H.J.R. 1047 and S.B. 28, 1976 session).

Five meetings were held during which the items in these directives were discussed with numerous organizations and individuals having an interest and expertise in health care matters. As the study evolved, the committee focused on three major areas: health care planning, utilization review of health care services and facilities, and rate setting for health care providers. Outlined below are the problems identified and alternative approaches to health care cost containment from the perspective of the three areas noted. A more detailed summary of the committee's activities and findings is contained in the staff report of this volume.

While closely related to the cost of health care, a separate portion of the directive concerned issues relating to Colorado Blue Cross-Blue Shield. The committee's report on these issues is at the end of this report.

I. Health Care Cost Containment

Four separate proposals directed toward controlling health care costs were prepared by individual committee members. Two draft bills were submitted to create a rate review commission. A third proposal would repeal and reenact the state's certificate of public necessity statutes and the fourth proposal would increase the authority of the state's health planning and licensing agencies to permit the decertification of health care facilities. Since these proposals, or some variations thereof, will probably be presented in future legislative sessions, this report outlines their major provisions. The committee, however, submits no recommendation concerning legislation.

Rate Review Commissions

Representatives Stephen Lyon and Morgan Smith presented draft legislation to create a rate review commission. The Lyon and Smith bills were similar in most important respects, a major exception being that different commissions would conduct the rate review. The Lyon bill, a version of H.B. 1224 introduced in the 1976 session, would create a new, independent commission for the purpose of conducting the rate regulation activity; the Smith draft would add this to the functions of the Public Utilities Commission. The PUC would be strengthened with the addition of specialists in health care economics to its staff.

The Lyon bill would add two other major provisions not included in the Smith bill: (1) establishment of a formal relationship between health planning and the rate review functions; and (2) creation of a technical advisory council for the rate review commission.

Provisions of the two bills are described below.

Application. Both bills would apply rate regulation to licensed health care facilities, including general and psychiatric hospitals, nursing care facilities, and rehabilitation centers. Community mental health centers, doctors' offices, federal facilities, and facilities providing treatment through prayer or spiritual means would be exempt. Services regularly provided as a part of the health care facility would be subject to rate regulation, but the personal care services of physicians performed at the licensed facility would not be subject to rate regulation.

Comparative information. Under both proposals, health care providers would be required to disclose accounting practices, financial information, and other reports through a uniform reporting system. On the basis of this information, the commission would establish and approve rates. Facilities could be classified in peer groups by size, location, form of ownership, and services provided, so that comparisons could be made between institutions within each peer group. A request for an increase in a rate could not be approved if the current rate is greater than 115 percent of the average applicable rate within the same peer group classification.

Setting of the rates. Rates would be determined on a prospective basis at a level calculated to meet the facility's reasonable financial requirements for a designated period of time. Under both bills, the factors which the commission would consider in setting rates include:

- efficiency in operation;
- direct and indirect costs of providing health care;
- interest on moneys borrowed for operating cash and capital requirements;

- research and educational programs related to patient care which are not controlled by earmarked funds;

- losses due to unpaid charges and from charity cases;

- depreciation, based on historical cost; and

- a variable factor for net income, adequate to provide working capital, debt retirement, reasonable capital reserves, and maintenance of the credit position required to obtain borrowed or invested funds as needed.

A rate schedule established and approved by the commission could not be altered without approval of the commission. If a change in the rate schedule is desired, the facility would submit a budget proposal to the commission at least 90 days prior to the beginning of the facility's fiscal year. The commission, within 60 days (Smith bill) or 45 days (Lyon bill), would review the data, hold a public hearing, and approve or modify the rate request. Procedures are included for a facility to request reconsideration of the decision of the commission. The time limitations for rate approval could be suspended if the data submitted were not adequate or acceptable for the rate making process.

Variations in rates. Provisions were included in both bills to allow variations in approved rates, "based on an unusual occurrence beyond the control of the health care facility." Regulations of the commission would provide for a determination of what constitutes an "unusual occurrence" which would result in a significant positive or negative variation in the expected budget of the facility. If such a situation occurs, the facility would apply to the commission for reconsideration of its approved rate.

Variations in rates also could be granted under alternative methods of rate determination and payment. The commission would be authorized to "promote and approve experimental alternative methods" for reimbursement of health care costs.

Disclosure of rates. Public disclosure of rates would be required by the commission and by each facility under both bills. The commission would publish both the approved dollar rates for each facility and the percentage changes in the rates over the previous year. Facilities would post their approved rate schedules and would also be required to have another copy available for public inspection.

Incentives. Both bills would provide incentives for efficient management and operation of facilities by allowing a facility to retain any surplus earned because of efficient operation. However, if a facility is less efficient than anticipated, it would incur a deficit rather than simply make an upward adjustment in its rate structure.

The commission and health planning. The bill draft presented by Representative Lyon included provisions for coordination of information between the commission and health planning agencies. For example, all requests for rate changes would be referred to Health Systems Agencies (HSAs) for their comment and advice.

In addition, the annual budget of each facility, plus information on the utilization of services and proposed changes in either existing or new services offered would be submitted to the state division of health planning. This information would be furnished at least 90 days before the beginning of the facility's next fiscal year. The state division would have 45 days in which to respond to the commission as to whether the services proposed to be offered are necessary to meet the needs of the region and whether the projected utilization figures are reasonable. If a particular service in a facility is determined to be unnecessary by the division, the commission would not include this service in its consideration of the facility's budget. The costs of phasing out the service, or for the continuation of the service pending an appeal of the decision would, however, remain in the budget.

Technical council. Under the Lyon proposal, a health care technical council would be established to provide assistance and advice concerning regulatory legislation. The fifteen member council would consist of representatives from hospitals, nursing homes, and practice of medicine, health insurers, accountants specializing in health care accounting, educators, and the State Department of Social Services.

Health Care Planning - Repeal and Reenactment of Present Statutes

A proposal received from Representative Traylor suggested the repeal of the existing certificate of public necessity legislation, and the replacement of the health facility advisory council established under the public necessity law with a new board. Representative Traylor recommends repeal of the existing certificate of public necessity statutes because, in his opinion, this legislation and the administration under the law have not been demonstrably effective in controlling the expansion of health care services. (Data on the results of decisions under the Colorado statutes are included in the staff report section.)

In the opinion of Representative Traylor, planning for health care should be separated completely from regulatory activities in the health field. Confusion between regulatory types of functions and planning functions has resulted in inadequate planning. The state needs a comprehensive health plan and the health planning division has not had the time or resources to develop such a plan because its primary efforts have been devoted to the issuance of certificates of public necessity.

The Health Facilities Advisory Council would be replaced by a three or five member part-time commission. However, Representative Traylor suggested that there be a moritorium on all new major construction for hospitals until a state health care plan can be developed through the HSAs or by a state agency which has this responsibility as its sole charge.

The commission replacing the Health Facilities Advisory Council would act on requests for new facilities which total over $150,000 in cost and which involve a change in service offered by the facility. If a certificate is granted by the commission, third-party payers, including Blue Cross or the state, which purchase services for Medicaid patients, could refuse a contract with a facility for the reason that there is a surplus of available beds or because a duplication of services exists. The intent of this recommendation is to provide an administrative arrangement in which there would be one organization involved in the granting or denial of certificates of public necessity and that agency would be responsible for programs involving reimbursement of public or quasi-public funds. The state commission responsible for the certification process would need to be well funded and adequately staffed to carry out its assigned functions.

Under-utilization of Facilities and Services

Another approach which would increase the authority of the state in controlling health care costs was developed by Representative Wayland. This concept would enable the health department to impose limitations on the continued use of unneeded services or under-utilized facilities by placing conditions on the license of facilities. In general terms, the proposal would require that the Health Facilities Advisory Council develop an annual listing of health care facilities and services no longer deemed necessary. This list would be submitted to the State Board of Health and the board could then decide whether limitations would be imposed in the renewed license.

Key aspects of this proposal are the standards by which existing facilities would be evaluated in terms of their continued usefulness in meeting health care needs. Criteria were included for determining the need for services and facilities, the finding of any two of which would be grounds for imposition of the sanctions in the bill. These criteria were:

(a) whether existing facilities or services contribute substantially to a significant overcapacity in the region in which the facility is located;

(b) compatibility of a facility's services with standards, plans, or criteria adopted pursuant to P. L. 93-641;

(c) whether the cost of continuing the services or facilities results in unreasonably high patient charges; and

(d) whether the services and facilities could be converted to more cost-effective methods of supplying health care.

Under present law, the council has "maximum flexibility" to survey health care needs in the state, to recommend a program to reduce or eliminate unnecessary duplication of existing services and facilities, and to encourage the development of health care facilities and manpower in areas where shortages are found to exist. These general directives would be made more specific through Representative Wayland's proposal.

Data would be required concerning the cost and the utilization of existing facilities and services and the need for maintaining emergency facilities and services. Recommendations would be made by the council as to the possible discontinuance of facilities and services in the interest of cost containment and efficiency. Representatives of facilities would have the right to appear before the council prior to the transmittal of the council's report to the state board.

Conclusion -- Health Care Costs

The committee submits no recommendations concerning these alternatives to the present situation. However, it can be noted that the problems of increasing health care costs involve questions which are likely to be in the public attention for some time. One such question is whether the public, including industry and labor, will be willing to continue to pay, both directly and indirectly, the increasing costs of health care, or whether the public may demand some external controls to reduce these costs.

Another question might be whether the public might demand greater efficiency in its health care system in order to assure a greater extent of cost control than is now found in the system. How many hospital beds are needed in a given area and how much duplication of costly equipment among the hospitals can be tolerated?

A further question is whether hospitals will take voluntary steps to control the rate of increase of their costs without state intervention. The Colorado Hospital Association is developing a uniform system of accounts which will provide a basis for comparing costs and charges of hospitals which adopt this system. Whether this system and other cooperative efforts lead to measures which can result in effective cost control for hospitals, such as greater voluntary sharing of equipment and facilities or the voluntary elimination of inefficient services by hospitals, should be monitored in the future.

Another item of interest is the development of the population-based data system proposed for Colorado by Dr. Anthony Robbins, Executive Director of the state Department of Health. This plan, outlined in the staff report, would attempt to identify the

utilization of particular health services by various groups in certain areas of the state. Data obtained from such a system are useful in evaluating exceptional differences in utilization. The General Assembly may be asked to make a decision of whether compliance with the proposed data system should be required on the part of health care providers if voluntary compliance does not occur.

II. Colorado Blue Cross - Blue Shield

Two reports concerning Colorado Blue Cross-Blue Shield were reviewed by the committee. Within the last year, reports on the Blues were prepared under the direction of the accounting firm, Arthur Young and Co., and for the state Insurance Commissioner by an ad hoc committee established to study health care cost containment measures needed in Colorado. The report of Arthur Young and Co. was a performance audit, concentrating primarily on internal problems and operation of the Blues, such as the corporate structure, administrative and organizational recommendations, relationships between the Blues and the providers, adequacy of benefits, and the handling of subscriber complaints. However, the study also included recommendations in the area of cost containment and stated that Colorado Blue Cross-Blue Shield should exercise more aggressive leadership in several specific areas. Among the recommendations relating to efforts toward cost containment were the following:

-- experimentation with alternative health care delivery systems, such as health maintenance organizations, outpatient surgical centers, and pre-admission testing;

-- benefit plans which include deductibles and coinsurance features;

-- reimbursement of providers on a prospective basis, subject to a system of independent rate review; and

-- greater emphasis on independent utilization review, to provide information on length of stay and utilization of services.

While there are differences in emphasis between the Arthur Young report and the report of the Insurance Commissioner's committee, there is also similarity in the recommendations concerning the role of the Blues in efforts toward cost containment for health care. The Insurance Commissioner's committee, chaired by Kenneth Monfort, former State Representative and President of Monfort of Colorado, developed recommendations relating more directly to the health care issues in the state than to the internal management problems of the Blues. Major topics addressed by the Monfort committee were:

-- strengthening of health care planning by the state;

- -- review of the prospective reimbursement contract between Blue Cross and the hospitals;
- -- increasing the efforts of the Blues in regard to utilization review and peer review;
- -- encouragement of alternative methods of providing health care, including increased use of outpatient services, paramedical personnel, and health maintenance organizations;
- -- changing the benefit structure of the plans to include use of deductibles, copayments, and coinsurance; and
- -- increasing public health education efforts to promote greater public understanding of health issues.

Conclusion - Colorado Blue Cross-Blue Shield

No recommendations are submitted by the committee in regard to Colorado Blue Cross-Blue Shield. A number of the most significant recommendations contained in the Arthur Young and Insurance Commissioner's committee report could be drafted in the form of proposed legislation for consideration by the General Assembly. Other recommendations are matters of internal management and will need to be resolved by administrative action.

Actions taken by the Blues in response to the reports were reported to the committee. Changes have been made toward correction of the specific deficiencies cited, such as the problem of overstaffing. Plans are under consideration for addressing the longer-term issues, such as restructuring or consolidating the corporate boards of directors.

The extent to which some of the other recommendations can be implemented is partially dependent on factors not under the control of the Blues. For example, the development of prospective reimbursement contracts with hospitals is a matter in negotiation between Blue Cross and the Colorado Hospital Association. The legislature will also be facing a decision in regard to the extension of the prospective reimbursement pilot project. While the Blues can influence the direction of how much will be paid and the mechanism for payment, Blue Cross and Blue Shield cannot unilaterally make all of the decisions which affect health care costs in Colorado. One idea that is clear, however, is that the General Assembly will continue to monitor the roles and the responsibilities of Colorado Blue Cross and Blue Shield.

STAFF REPORT

STAFF REPORT

I. INTRODUCTION

A staff report of the HEWI I Committee has been prepared with several considerations in mind. Issues pertaining to the costs of health care are of importance to all segments of the society, not simply to the individuals, institutions, and organizations which furnish health care services. It appears highly unlikely that costs of health care will be reduced or remain the same. Indications are that increased costs will be the rule, not the exception.

A substantial number of indicators have been cited by various sources which dramatize the increased costs of health care over recent years:

-- Total hospital expenses in the United States increased approximately 50 percent in the 30 month period between December, 1973 and May, 1976. (Increases reported were from $2.41 billion for January, 1974, to $3.83 billion for June, 1976.) 1/

-- For Colorado, the total operating expenses of 70 general hospitals show a total increase of 48 percent during a four year period of 1972 through 1975. ($279.5 million operating expenses for 1972 to $415.4 million for 1975.) Since Colorado's population also increased during this period, these figures were also computed on a per capita expenditure basis, and the adjusted figures indicate a 34 percent increase in operating costs on a per capita basis. ($118.02 per capita for 1972, to $158.91 for 1975.) 2/

-- Dollars appropriated by the Colorado General Assembly for certain medical assistance programs have increased dramatically. For example, inpatient and outpatient hospital care under the Medicaid program has increased from $15.68 million for FY 1973 to $30.22 million for FY 1977. (Figures include federal monies of approximately 55 percent.)

-- As for individuals faced with hospital expenses, national data for the cost of semi-private hospital room charges increased 79 percent between January, 1970, to June, 1976, in contrast with an increase of 44.5 percent in the general consumer price index for the same period. 3/

1/ American Hospital Association, National Hospital Panel Survey, reported monthly in the publication Hospitals.
2/ Data compiled from the American Hospital Association, Guide to the Health Care Field, 1973 and 1976 editions.
3/ Data compiled from reports in the Monthly Labor Review of the U.S. Bureau of Labor Statistics.

One result of continuing increases in the costs of health care is that the role of government in controlling costs will continue to be a subject of debate. The extent of state intervention, the form which additional controls might take, and the prospects of success of intervention are matters which the HEWI I Committee discussed this year and similar discussions undoubtedly will continue.

Substantial time was spent by the committee in meeting with persons and representatives of organizations interested in the role of the state in controlling health care costs. This report summarizes some key problems cited, the regulatory activities presently in use, the alternative solutions suggested, and some of the data and information prepared for the committee. Questions of public policy which may confront the General Assembly are raised following a discussion of each of the principal areas of regulatory activity. Appended to the report are reference items which might be of value in future discussions of the appropriate response of the state concerning the containment of costs of health care.

This report concerns three primary mechanisms developed for the purpose of controlling health care costs: (a) health planning; (b) rate review or rate setting; and (c) utilization review. These three mechanisms are interrelated and, in the opinion of some persons who testified, implementation of only one or two of these mechanisms will not provide adequate control of the increasing costs of health care. These methods of control also provide a convenient format for a discussion of alternative approaches of regulatory activity.

Some programs in these three areas have been implemented by a variety of public agencies and private institutions and this report outlines the extent of their present usage in Colorado. While some hospitals, for example, have been conducting some forms of utilization review of their facilities, this report is concerned primarily with the programs which have been developed to apply external controls or conditions on health care facilities.

The major focus of the committee was on the containment of health care costs for hospitals, rather than on health care costs throughout the health care industry. There are two reasons for this emphasis on hospitals. First, the amount of money spent for hospital care is greater than for any other segment of the industry and other states have directed their primary cost containment activities toward hospitals. Second, hospitals are key facilities in providing health care and the rates charged for services they provide may be considered as important as the rates of public utilities.

It is important to emphasize that this report does not review all methods of health care cost control in use in Colorado. Many hospitals have adopted internal controls which have resulted in greater efficiency, less waste, and improved management. As one specific example, implementation of a uniform system of accounts, developed through the Colorado Hospital Association, is expected to begin shortly. This system will provide comparative information concerning

the internal management and the financial condition of the hospitals which adopt the system.

As a further note of explanation, the final section of this report concerns the activities of the Massachusetts Rate Review Commission. The reasons for including the summary of that commission's activities were the same as the reasons for the committee meeting with the commission's chairman -- to achieve some understanding of the actual operation and the philosophy behind the implementation of a rate review commission.

II. RATE REGULATION -- AN OVERVIEW

The purpose of rate regulation is to contain hospital costs. The controls generally are exerted by an authority which is external to the hospitals, although rate regulation may also involve varying degrees of hospital participation.

In contrast with the other cost containment measures reviewed in this report, namely health planning and utilization review, hospital rate regulation activities have been primarily conducted at the state rather than the federal level. 1/ This section describes three principle methods of controlling the future reimbursement which hospitals receive -- state rate review commissions, prospective reimbursement by third party payers, and regulation of Blue Cross insurance rates. A more detailed review of the regulatory activities presently used in Colorado is in the following major section.

State Rate Review Commissions

One method which has been implemented in at least nine states is the regulation of hospital rates by an independent state rate review commission or through an agency of state government, such as the Department of Health. State rate review commissions are distinctive in the scope of their regulatory activities because they regulate the hospital rates charged to the private pay patient and commercial insurance carriers, as well as the rates charged to Blue Cross and Medicaid patients. In contrast, third party payers, such as Blue Cross, may exert some control over the rates charged to their insureds. In addition, while rate determinations by a state rate review commission, or other state agency, may be mandatory, rates are generally established by third party payers through a process of negotiations with hospitals.

The chart on page 8 summarizes the regulatory functions conducted by state government in ten states, including Colorado. Five states other than Colorado have established commissions and the four other states use existing state agencies to regulate hospital rates. As outlined on the chart, the states vary with regard to the extent of regulatory control exercised and the type of rates which are regulated.

1/ The only nationwide effort to control health care costs was the Economic Stabilization Program which lasted for 32 1/2 months from August, 1971 to April, 1974. The Economic Stabilization program mandated ceilings on the extent to which hospitals could increase their annual revenues due to increases in charges.

The regulatory powers of the state commissions range from an approach in California of mandatory public disclosure of hospital costs, to the review and approval of hospital charges by commissions in four states. (Connecticut, Maryland, Massachusetts, and Washington). In Arizona, governmental review of hospital rates is mandatory, but compliance with rate determinations is voluntary. In other states with rate review commissions, compliance is mandatory.

State rate review commissions may also control one or more of the payers for health services and often separate procedures are used in the same state for determining the rates paid by different types of payers. While the consumer ultimately bears the cost for health care services, most health care costs are paid directly by third party payers. These third party payers include the federal and state government under the Medicare and Medicaid programs, Blue Cross and other non-profit insurance carriers, and commercial insurance carriers. Of course, some health services are paid directly by the patient.

The rate review commissions in four states, Connecticut, Maryland, Massachusetts, and Washington, establish the rates for the private or "self-pay" patients. The commissions in Maryland and Massachusetts also approve the hospital rates charged to Blue Cross subscribers. In Arizona, a bureau in the state Department of Health Services reviews rates for private and Blue Cross patients, although hospital compliance with the department recommendations is voluntary.

The amount of available evidence to support the success or failure of rate regulation by commissions is limited. Establishment of a commission to review hospital budgets and to set hospital rates is one approach to the problems of increasing costs; however, no one would claim that it is a panacea for the problems of continuing increases in health care costs. No doubt more information concerning the commissions will be available as they proceed with their activities, but evidence on their effectiveness appears limited at this time.

Prospective Reimbursement by Third Party Payers

In several states, including Colorado, third party payers, Blue Cross and state government, have exerted influence on the amount or rate they will pay for services rendered to their clientele in a future time period. State governments are involved as a third party payer because they purchase hospital services on behalf of Medicaid and other public assistance recipients. Prospective reimbursement is a method of rate regulation exerted by third party payers through the establishment of the amounts or rates of payment to hospitals in advance of the period in which the rate is to be applied. Hospitals are paid in accordance with these amounts or rates, regardless of the costs which they actually incur. In contrast, the customary method used by third party payers to reimburse hospitals has been retrospective reimbursement under which payment is made to hospitals

for costs or charges actually incurred by subscribers in a previous time period.

At present, the federal government as the third party payer for Medicare recipients, and the federal and state governments as third party payers for Medicaid recipients primarily reimburse retrospectively. However, three states, Colorado, Massachusetts, and New York received approval from the federal Department of Health, Education and Welfare (HEW) to reimburse hospitals for Medicaid patients on a prospective basis. Prospective reimbursement rates for Medicare patients are accepted in Rhode Island under a special waiver. 2/ In addition, reportedly 22 of the nation's 74 Blue Cross plans currently negotiate or establish prospective rates for their member hospitals. 3/

Regulation of Blue Cross Insurance Rates

The regulation of Blue Cross health insurance rates is a third method of regulation which indirectly exerts control on the future reimbursement which hospitals receive. In Colorado, the Commissioner of Insurance must approve increases in Blue Cross rates prior to their use. Regulation of Blue Cross premium rate increases provides Blue Cross with strong incentives to attempt to contain hospital charges for Blue Cross patients. While regulation of Blue Cross premium rates may be helpful for consumers insured by Blue Cross, such regulation is limited in its effective control over health care cost increases. Blue Cross cannot act as a rate commission would act in containing health cost charges; rather, it negotiates rates charged with the hospitals. Further, Blue Cross subscribers may represent about one third of the state's population and the extent to which other segments of health care can be influenced through Blue Cross regulations is limited.

2/ The Department of Health, Education, and Welfare has generally required states to use the Medicare methodology for developing Medicaid reimbursement rates under which most actual costs incurred by the hospital will be reimbursed. Many people feel that the use of this type of "open-ended" reimbursement approach has substantially contributed to the inordinate inflation in hospital costs during the last decade. ("Commonwealth of Massachusetts Rate Setting Commission Annual Report," Fiscal Year 1975, p. 24.)

3/ Katharine G. Bauer, "Hospital Rate Setting - This Way to Salvation?", unpublished manuscript, p. 11.

HEALTH CARE RATE REGULATORY ACTIVITIES IN TEN SELECTED STATES

(Note: Most states selected, other than Colorado, have budget review, rate approval, or rate setting for health care providers)

State (Citation)	Regulating Agency	Powers and Duties of the Regulating Agencies	Type of Payer Rates Currently Regulated	Health Institution(s) Regulated
Arizona (§ 36-436 *et seq.*, Ariz. R.S. Ann.)	Dept. of Health Services; recommendations from local health planning agencies	Mandatory review of increases in hospital rates; however, compliance is voluntary	Charges to self-pay patients; Blue Cross	All health care institutions
California (39:440, *et. seq.*, Health and Safety Code, Calif. Code Ann.)	Health Facilities Commission (independent commission)	Public disclosure of health facility costs through development of a uniform accounting and reporting system; uniform data gathering system and hospital statistics		All licensed facilities, including nursing homes
Colorado (26-4-105 *et seq.*, 10-16-126, *et seq.*, C.R.S. 1973)	Department of Social Services	Prospective per diem rate setting and reimbursement	Medicaid	Hospitals
	Colorado Hospital Service (Blue Cross)	Prospective rate setting and reimbursement (Pilot project)	Blue Cross	8 hospitals
	Commissioner of Insurance	Approval of all increases in Blue Cross rates prior to use	Blue Cross	Hospitals
Connecticut (s 19-73a, *et seq.*, Conn. Gen. Stat.; amended by Pub. Act No. 75.562, July, 1975	Commission on Hospitals and Health Care (Dept. of Health) (independent commission)	Mandatory budget review, with power to act on proposed rate increases over specified amounts, as provided by statute; determinations on certificate of public necessity applications; utilization review of facilities	Charges to self-pay patients	All health care fa cilities (currentl only review hospital budgets)
	Connecticut Blue Cross	Prospectively sets reimbursement rates	Blue Cross	Hospitals

State (Citation)	Regulating Agency	Powers and Duties of the Regulating Agencies	Type of Payer Rates Currently Regulated	Health Institution(s) Regulated
Maryland (43 § 568H, *et. seq.*, Md. Ann. Code)	Health Services Cost Review Commission (independent commission)	Review and approves of hospital rates established or requested; Compiles financial reports from hospitals and related institutions based on a uniform accounting system; Independent determinations on proposed capital expansions	Charge to self-pay patients; Blue Cross	Hospitals and related institutions including nursing homes
Massachusetts (6A § 31, *et. seq.*, amended by H5416, 1976; 176A § 5 *et. seq*; Mass. Gen. Laws Ann.)	Rate Setting Commission (independent commission) (Blue Cross assists in implementation under contract authorized by statute)	Approval of Blue Cross-hospital contracts and rates thereto; Medicaid prospective reimbursement; Review and approves hospital rates; Compiles and under specified conditions reviews and acts on hospital budgets; Rate-setting for state and county health institutions; Rate-setting for educational, rehabilitation and social services purchased by governmental limits	Blue Cross; Medicaid; charges to self-pay patients and commercial carriers; workmen's Comp.	Hospitals primarily; also physicians and nursing homes for medicaid purposes
	Commissioner of Insurance	Approval of increases in non-group premiums	Blue Cross	Hospitals
New Jersey (26: 2H-1, *et seq.*, N.J. Stat. Ann.)	Commissioner of Health	Sets rates of payment by government agencies	Medicaid	Licensed hospitals and other health facilities, including nursing homes
	Commissioner of Insurance (with assistance of the Commissioner of Health)	Approval of rates to hospitals	Blue Cross	
New York (Public Health Law § 2807, McKinney's Consol. Laws of N.Y.)	Director of the Budget	Formal approval of rate schedules for health services purchased by state and local governments-prospective reimbursement	Medicaid	Hospitals and other health services, including nursing homes
	Superintendent of Insurance	Formal approval of rates for payment to hospitals	Blue Cross	Hospitals

State (Citation)	Regulating Agency	Powers and Duties of the Regulating Agencies	Type of Payer Rates Currently Regulated	Health Institution(s) Regulated
New York (Continued)	Department of Health	Certifies Medicaid reimbursement rates to the budget director and certifies Blue Cross reimbursement rates to the Commissioner of Insurance		Hospitals
	Blue Cross	Prospectively set reimbursement rates	Blue Cross	Hospitals
Rhode Island	State Budget Director with Blue Cross	Approves hospital budgets using Blue Cross staff analysis; set "maxicap" or ceiling on increase in total hospital expenditures in a geographic region through negotiation with hospital assoc. hospitals voluntarily conform with the "maxicap"	Blue Cross; Medicare; Medicaid;	Hospitals and other health institutions
Washington (s 70.39.010, *et seq.*, Wash. Rev. Code)	State Hospital Commission (independent commission)	Review and approve hospital budget and rates; Compiles hospital financial and accounting data in accordance with a uniform accounting and reporting system	Charges to self-pay patients; Workmen's Compensation	Hospitals

III. RATE REGULATION IN COLORADO

Hospital rate regulation, in the sense of external controls being applied, has taken three forms in Colorado. Two regulatory activities are directed at containing reimbursement rates to hospitals, and another activity is directed at containing the cost of Blue Cross and Blue Shield insurance premiums to consumers. The present methods of rate regulation are: (1) prospective Medicaid reimbursement of hospitals by the state and federal government on behalf of public assistance recipients; (2) prospective reimbursement of eight hospitals by Blue Cross-Blue Shield under a pilot project mandated by state statute; and (3) approval by the Commissioner of Insurance of all Colorado Blue Cross-Blue Shield premium rates prior to use.

Only a small portion of the rates directly paid to hospitals for services rendered are subject to regulation. Medicaid reimbursement has been estimated to comprise approximately four to six percent of total revenues for the hospitals which participate in the Medicaid program. (A total of 88 hospitals of 104 hospitals in Colorado participate in the Medicaid program.) In addition, the Blues pilot reimbursement project only applies to rates for eight out of the 104 hospitals in the state. Blue Cross reimbursement is estimated to account for approximately 30 percent of total hospital revenues, although this percentage may vary substantially between hospitals.

Currently there is no regulatory mechanism which regulates the hospital rates paid by the private pay patients or by commercial insurance companies. In addition, Medicare reimbursement to hospitals, which comprise approximately 30 percent of hospital revenues, is not subject to regulation, other than auditing of actual costs by the federal government. Medicare is totally funded by the federal government so the state has no direct control over Medicare reimbursement.

Health care insurance rates are also regulated to a limited extent in Colorado. Only Blue Cross and Blue Shield rates are subject to regulation and these companies are estimated to cover 30 to 35 percent of the total Colorado population. However, while regulation of health care insurance premiums may be helpful in limiting increases in the consumer's out-of-pocket expenses, regulation of premium rates is considered an indirect method for regulating hospital costs.

Medicaid Reimbursement

The state attempts to control hospital rate reimbursement on behalf of Medicaid recipients. Colorado is one of several states which has obtained a Medicaid waiver which enables the state to reimburse hospitals prospectively, based on reasonable costs, rather than a retrospective system based on costs actually incurred.

The Division of Medical Assistance in the Department of Social Services administers the Medicaid program. The division sets reim-

bursement rates through a process of negotiations with each of the 88 participating hospitals. Prior to negotiations with the hospitals, the division projects per diem rates for the next fiscal year, based on the estimates of reasonable costs of hospitals.

The division has adopted two criteria for assessing what the reasonable costs of hospital rates should be for the next budget year. First, a hospital's projected costs are compared with the costs of other hospitals in its peer group. Hospital peer groupings are based on characteristics such as hospital size, patient mix, and the geographic location of the hospitals.

Secondly, the costs of the peer grouping as a whole are projected on the basis of a general index for inflation. Fiscal year 1972, which was the first year the state provided Medicaid reimbursement on a prospective basis, is used as the base year for projecting the cost trends due to inflation. In the course of budget and rate negotiations with the hospitals, the division also reviews the unique features of each hospital's budget, such as new capital construction or acquisition of equipment.

The Department of Social Services has established an advisory rate review board to review rates and to recommend Medicaid reimbursement levels to the Executive Director of the department if the division and a hospital reach an impasse in negotiating rates. The Executive Director ultimately sets reimbursement rates in such instances.

In determining Medicaid reimbursement rates, the division is also subject to the funding levels established by legislative appropriations. In recent years, the General Assembly has specified a maximum "overall average cost per day" in the long bill. Some hospitals' per diem rates will be higher than the average and some will be lower. However, when all per diem rates are averaged together, the average per diem is not to exceed the amount specified in the long appropriations bill. Through appropriations, the General Assembly, in effect, has established limits on the rate of increase in Medicaid reimbursement rates. For example, in the long bill for fiscal year 1977, the maximum average per diem rates for inpatient hospitalization is set at $130.26. This amount is to "provide an average 12.8 percent per diem rate increase over that of the 1974 fiscal year for all hospitals in the program." 1/ In past years, supplemental appropriations have been requested when the original appropriation was not sufficient to cover Medicaid reimbursement costs for the year.

1/ The long bill for FY 1977 (H.B. 1266, 1976 session) further stated that: "The Department of Social Services is directed to contract only with those hospitals in any region which the Department determines can provide, at the lowest cost, reasonable care for that region or which the Department determines are providing unique and necessary services."

Litigation on Medicaid reimbursement. Early in 1976, the Colorado Hospital Association and nine member hospitals filed suit against the state in federal court contending that the state's reimbursement to hospitals for Medicaid patients was too low. The suit asked for increased reimbursement plus retroactive payments for previous underfunding. The suit followed a freeze on reimbursement rates by the Executive Director of the Department of Social Services in compliance with the appropriation bill for fiscal year 1976, which specified a maximum average per diem rate of $117.25. A supplemental appropriation has since raised the 1976 fiscal year maximum average per diem rate to $124.43. 2/ However, the hospitals contend that Medicaid reimbursement rates are still too low, even with the supplemental appropriation.

The state also agreed to reimburse retroactively hospitals for costs incurred during the freeze, provided that the hospitals negotiate such reimbursement amount in good faith pursuant to regulation by the state Board of Social Services which authorizes the negotiations. The federal government has agreed to match the state's retroactive reimbursement. Retroactive reimbursement will date back to December 18, 1975, when the freeze on reimbursement rates began.

Representative Morgan Smith, then Chairman of the Joint Budget Committee, and members of the office of the Attorney General briefed the committee on issues raised by the lawsuit. The central issue is whether the state is reimbursing hospitals for Medicaid recipients on the basis of reasonable costs, as required by federal Medicaid regulations. The hospitals maintain that the level of reimbursement and the methodology used in determining reimbursement rates are in violation of the federal requirement for reimbursement on the basis of reasonable costs. Not only does the lawsuit challenge the freeze on reimbursement rates as a violation of the reasonable cost dictates of federal Medicaid law, but it also challenges the state's provision that hospitals shall receive reasonable compensation within available appropriations (section 26-4-110 (1), C.R.S. 1973).

The suit also will test one of the criterion used by the Division of Medical Assistance in determining the reasonableness of hospital cost increases. Considerable concern has focused on the fact that health care costs have been rising at a higher rate than prices for other consumer services. The division uses a general inflation index tied to the inflation rate in the economy as a whole in assessing increased hospital costs. Hospitals maintain in the suit that hospital cost increases should be judged on the basis of an inflation index unique to hospitals.

2/ H.B. 1267, 1976 session, stated that the "supplemental increase is to provide a six percent average per diem rate increase for all those hospitals affected by the December 18, 1975, freeze."

It was also stated that the lawsuit could affect the administrative appeals process for determining Medicaid reimbursement. Mr. Dennis Sousa, Assistant Attorney General, stated that the lawsuit attempts to ensure that the department's advisory rate review board, rather than Executive Director of the department, would make the final determination of rates. As mentioned earlier, this board currently functions in an advisory capacity to the Executive Director in recommending reimbursement rates.

The Prospective Reimbursement Pilot Project

In order to provide a study and evaluation of prospective reimbursement programs, the General Assembly enacted legislation in 1973 which called for the establishment of prospective reimbursement pilot projects involving Colorado Blue Cross-Blue Shield and selected hospitals and nursing homes. Section 10-16-130 and 10-16-131, C.R.S. 1973, Blue Cross-Blue Shield was required to reimburse prospectively at least eight hospitals and four nursing homes for the fiscal years of the institutions beginning on or after January 1, 1974, through June 30, 1977. The Department of Health was required to select the participating hospitals and nursing homes from lists submitted to the department by the Colorado Hospital Association and the Colorado Health Care Association, which represents the nursing home industry.

Prospective reimbursement pilot projects have been implemented in conjunction with hospitals, but no projects have been conducted with nursing homes, as was also required by statute. The reason that nursing homes have not been included is that the Blues subscriber contracts have not historically included nursing homes.

The Commissioner of Insurance is required to report to the legislature before January 30, 1977, on the effect of the prospective reimbursement pilot project on reducing or stabilizing the cost of services to the Blues' subscribers. The Commissioner has been assisted in this reporting function by an advisory committee appointed by the Governor to study the project and to make recommendations to the Commissioner. The advisory committee has consisted of the Commissioner as an ex officio member, two representatives of the Blues (or other insurers organized under the same statutes as the Blues) two representatives of the health care providers, one representative of the Department of Health, and five subscribers of the Blues (section 10-16-132, C.R.S. 1973, as amended).

When the information from the pilot projects is complete, the General Assembly may need to decide whether to continue, expand, or terminate the prospective reimbursement idea in Colorado. If the General Assembly takes no action on this concept, some forms of prospective reimbursement could be continued, voluntarily, by Blue Cross and hospitals under contract with Blue Cross. The Blue Cross hospital contract is still under negotiation but efforts are being made toward a prospective reimbursement approach.

Also under consideration is the adoption of a contract which would provide for prospective control over the charges for health services paid by Blue Cross. A controlled charge contract approach may be similar to a prospective reimbursement system, but it would fall short of a prospective reimbursement system primarily because rates could be readjusted during the year and hospitals would not be held to fixed rates for an entire year. In addition, a controlled charge contract would not regulate the volume of services provided, although the volume of services is subject to regulation through utilization review by PSROs and peer review. A prospective reimbursement system would regulate both the cost of services and also the volume of services.

Policy Questions -- Prospective Reimbursement

The extent to which the concept of prospective reimbursement is adopted in Colorado could depend on action of General Assembly. With the completion of the prospective reimbursement pilot project during the 1977 session, a decision will need to be made as to whether the legislation should be extended to more hospitals, whether it should be terminated, or whether it might be continued on a voluntary basis. The report of the Commissioner of Insurance, and the advisory committee established to assist him, may be helpful in reaching a decision. Some other questions with regard to prospective reimbursement are as follows:

- Blue Cross. Should the state have a role in encouraging or mandating that contracts between Blue Cross and hospitals be based on a prospective reimbursement concept?

- Other insurers. Insurance companies, other than Blue Cross, could be required, by state law, to establish prospective reimbursement arrangements with health care providers.

- State administration. If a prospective reimbursement system were mandated, review and approval by a state agency, such as the Division of Insurance, could be required to determine the extent to which the contracts would conform to the principles of prospective reimbursement.

Regulation of Blue Cross-Blue Shield Premium Rates

Effective January 1, 1974, the Blues were required by statute to file rate modifications for prior approval by the Commissioner of Insurance. 3/ Since January, 1974, the Blues have submitted six filings to the Commissioner of Insurance, three in 1975 and three in 1976, for his approval.

3/ Sections 10-16-125 through 10-16-129, C.R.S. 1973.

The membership of the Blues is grouped into the following major categories: Merit Rated Groups, Community Rated Groups, Non-Group, National Account and Miscellaneous Groups, Major Medical and Medicare Supplemental, and Federal Employees program. All of these categories have had one rate increase approved to date, with the exception of the Federal Employees program. Rates for the Federal Employees program are determined by the national Blues associations. In addition, early in September, 1976, a second request for rate increases for the Community Rated Group, the Non-Group categories, and the Merit Rated groups were approved. The following are the dates rate requests were approved by the Commissioner of Insurance.

Date Approved	Category 4/
August 28, 1975	Merit Rated Group, National Account, Miscellaneous Group
October 7, 1975	Dental Program
October 20, 1975	Community Rated Group, Non-Group
February 13, 1976	Medicare Associated Contracts
April 30, 1976	Legislatively Mandated Offerings and Coverages, Supplemental Benefit Program (major medical coverage), new Merit Rated Groups
September 8, 1976	(Rate request pending for Community Rated Group, Non-Group, and Merit Rated Group)

Testimony was received from the Attorney General's office on the effect of regulating the Blues premium rates on the containment of health care costs. Mr. Tucker Trautman, Assistant Attorney General, stated that the Commissioner of Insurance is indirectly placed in the role of containing hospital costs through the Commissioner's statutory authority to regulate the Blues' premium rates because premium charges, and increases thereto, are primarily used to pay the providers of services. Control over health care costs through regulation of the Blues' premium charges is limited because the Blues, which are a private entity, are thus required to regulate another private entity, namely the hospital industry. Mr. Trautman was of the opinion that the effect that the Insurance Commissioner can have on hospital rates is limited and that a more direct mechanism is needed to control health care costs.

4/ A description of each major membership category is presented in Appendix IV, page 1-d.

Insurance Commissioner Barnes is also of the opinion that regulation of the Blues' premium charges is inadequate to contain health care costs, although premium regulation is necessary as an internal cost control for the Blues and as a control on utilization of insurance by subscribers. Commissioner Barnes advocates the establishment of a rate review agency which would provide greater uniformity in the rates charged by health care providers, and thus the rates paid by all purchasers of health care services.

In summary, Colorado has adopted some forms of direct and indirect rate regulation by several state agencies. One result of having regulatory activity conducted by separate agencies, with different degrees of control, is that disparities in hospital rates will occur. The following example was cited by Mr. Barnes as an illustration of the disparity in rates paid by various purchasers of hospital services:

Actual Hospital Bill for August, 1976, for
Services which Totaled $672.06 for a
Private-Pay Patient

Type of Payer	Charge	Discount from Billed Charges
Private-pay and commercial insurance patient would pay:	$672.06	0
Blue Cross patient would pay:	618.30	8.0%
Medicaid patient would pay:	487.12	27.5%
Medicare patient would pay:	512.74	23.7%

SOURCE: Colorado Division of Insurance.

It was further indicated that there was nothing unique about this hospital bill and that the same relative amounts could be applied to any typical hospitalization.

IV. HEALTH PLANNING AND CERTIFICATES OF PUBLIC NECESSITY

The legislative declaration to the Colorado Certificate of Public Necessity Act makes several references to the relationship between certification and containment of costs of health care facilities and services:

> 25-3-502. Legislative declaration. The general assembly finds that the construction or modification of health care facilities is a factor in the cost of care and the financial ability of the public to obtain necessary medical services. The purposes of this part 5 are...to assist in providing the highest quality of health care at the lowest possible cost; to avoid unnecessary duplication by ensuring that only those health care facilities that are needed will be built or modified;...to reduce or eliminate existing duplication and shortages of health care facilities and manpower whenever possible;...and finally to recognize that the coordinated development of health care facilities and services of desirable size and location which are responsive to the legitimate needs of consumers, providers, and governments, and the encouragement of more efficient, economical, and effective systems for organizing, financing, and providing health care are worthy goals.

Under the statutes concerning the issuance of certificates of public necessity, health care facilities are required to obtain state approval for major capital construction projects and for the addition of major programs and services. This process has been considered to be one of the primary means of exerting control over unnecessary expenditures on the part of hospitals, nursing homes, and other facilities in Colorado. The Office of Medical Care Regulation and Development and the State Health Facilities Advisory Council in the state Department of Health are responsible for this certification activity.

As pointed out in the committee report, health planning may be considered a separate function from the regulatory activity which is involved in the certificates of public necessity process. Whether or not a facility should be permitted to make a major expansion in its number of beds or to extend the types of services offered are regulatory decisions. The adequacy of facilities and services or the need for the expansion of facilities and services are evaluated through use of a state plan and a health systems plan framework. However, some persons have asserted that the planning activities are less than totally effective because the demands for the administration of the certificates of public necessity statutes have diminished the department's capability for planning.

This part of the report describes the procedures under the certificate of public necessity statutes, summarizes actions taken thus far under this act, notes the duties of health systems agencies

(HSAs), and lists recommendations recently developed for improving health care planning. Since issues involving health planning undoubtedly will continue to be surrounded with controversy, some policy questions in this area are included at the end of this section.

Statutory Requirements for Certification

Certification is required prior to a major expansion or modification of physical facilities or before the purchase of major equipment can occur. A certificate of public necessity must be granted prior to a modification involving a capital expenditure of $100,000 or more, or an expenditure on a lease of real property or equipment which totals $10,000 per year or more, with at least one of five specified conditions present such as a change in health care service or a ten percent or greater increase in the number of beds. Appended to this report is a copy of the certification statutes (Appendix I), along with a summary of actions taken under the act. (Appendix II). 1/

The process for making application for and the granting or denying of certificates involves four separate agencies. Applications are simultaneously to the HSA in which the facility is located and to the Department of Health. The HSA may hold a public hearing on the application and has 45 days after receiving an application in which to make a recommendation to either approve or deny the application. Recommendations of the HSA are set forth in detail and failure to submit a recommendation is deemed a favorable recommendation of the application. The state advisory council has a period of time, not to exceed 90 days, in which to approve or to reject the recommendation of the HSA and the state department has ten days in which to notify interested parties of the council's decision. Decisions concerning certification may be appealed to the state Board of Health and judicial review is available after decision of the state board.

Some persons have argued that the 1976 amendments to the certificate of public necessity legislation have strengthened these statutes so that applications for certification are examined under more stringent criteria than was previously possible. (Ch. 125, Session Laws of 1976). The 1976 legislation added additional criteria to the list of factors which the advisory committee is to use in making a decision to accept or to reject an application. The Act now provides that an application for a certificate shall be rejected when the advisory council makes an affirmative finding that one of the following factors exists:

1/ Colorado participates voluntarily in a federal certification program under Sections 221(A) and 1122(A) of P.L. 92-603 (1972 Amendments to the Social Security Act.) The health facilities under this certification process are those which receive federal Medicaid and Medicare funds and all facilities and equipment are subject to review, regardless of cost.

(a) A significant overcapacity within the state planning and management region in which the proposed facility is to be located would exist...except in the event that a proposed acute inpatient or emergency care facility is to be located at least forty-five miles from the closest facility of like nature;

(b) The project is not compatible with applicable standards, plans, or criteria adopted by areawide or state health planning agencies or by the council...;

(c) The proposed capital expenditure is not economically feasible and cannot be accommodated in the patient charge structure...without unreasonable increases;

(d) The project will not foster cost containment or improved quality of care,...

The 1976 amendments, however, did state that if one or more of these factors were found to exist, an application shall be approved if it can be shown that the facility or services would provide health care at a cost significantly below the rates being charged by existing health care providers.

As to the effect of the 1976 legislation during the period from July 1, 1976 through December, 1976, 25 applications were approved for hospitals, nursing homes, and for other facilities, totaling approximately $27,340,000. Six applications were denied which totaled approximately $8,530,000. As indicated in the following table which totals the actions taken since the beginning of the program, the certificates approved total nearly $139,000,000, in contrast with approximately $76,000,000 in projects denied.

Of the projects denied, two were from the same source, the Colorado Electronic Technical College, Inc. The two applications were for a medical facility in Manitou Springs totalling $59,500,000. These two applications represented approximately 80 percent of the dollars of the projects denied thus far. Without these two projects, the dollars involved in the projects denied would total approximately $15,500,000, an amount less than one-tenth of the total projects approved.

Summary of Actions Taken

Under Colorado Certificate of Public Necessity Law

May 30, 1973 through December 2, 1976

Type of Facility	No. of Applications		Dollars in Applications	
	Approved	Denied	Approved	Denied
Hospitals	115*	9	$101,170,005	$72,271,297
Nursing Care Facilities	33*	7	$ 24,745,761	$ 3,636,000
Other Facilities**	14	1	$ 12,937,854	$ 10,000
TOTALS	162	17	$138,853,620	$75,917,297

* Includes one application denied by advisory council but later approved by state Board of Health.

** Includes mental health centers and hospital, outpatient emergency facilities, a renal dialysis center, and a health maintenance organization.

Excess Hospital Beds

Testimony presented to the committee indicated that 85 percent occupancy of hospital beds is generally accepted as the most efficient use of a hospital's facilities. Average occupancy rates approaching 100 percent can be interpreted as indicating a need for additional hospital beds; occupancy rates less than 80 to 85 percent may indicate underutilized hospital facilities.

The number of hospital beds in Colorado is excessive. During the last four years, the statewide average hospital occupancy rate for general hospitals has held near the 70 percent figure. Using data from both the state Department of Health and from the American Hospital Association (AHA), the surplus of hospital beds throughout the entire state ranged between 1540 and 1600 beds, based on the 85 percent optimum occupancy rate.

However, data for 1972 through 1974 from the AHA and the Department of Health indicates a higher percentage occupancy for

Denver and the adjacent seven county region (State Planning Region No. 3) 2/ than for the state. During these years, the average occupancy for this region ranged from 73 to 76 percent, but the occupancy dropped to 70.6 percent in 1975. Data available indicate that the surplus in the number of hospital beds in the Denver area appears to be between 925 to 960 beds, using an occupancy rate of 85 percent. Expressed in another way, in Planning Region No. 3, the excess beds at the 85 percent occupancy rate, would equate to one and one and one-half times the size of the largest hospital in Denver.

These statistics should be tempered by the fact that hospitals in rural communities having comparatively few beds, usually will have low percentages of occupancy. Another factor is that occupancy rates vary throughout the year. A hospital, in order to maintain 85 percent occupancy, may be close to 100 percent occupancy at times but will be lower during other times during the year. In general, however, the data indicate that there is a surplus of available hospital beds to an extent that some persons have recommended a moratorium on new hospital construction.

Planning in the health care field requires greater sophistication than merely counting beds and determining utilization rates. It is important that clear distinctions be made between the types of beds and services available in a given community or region. For example, a hospital offering services exclusively for children should be distinguished in its functions from a general hospital which operates a pediatrics ward. Planning needs to be done for general acute care beds and for speciality beds, and the different types of services should not be confused.

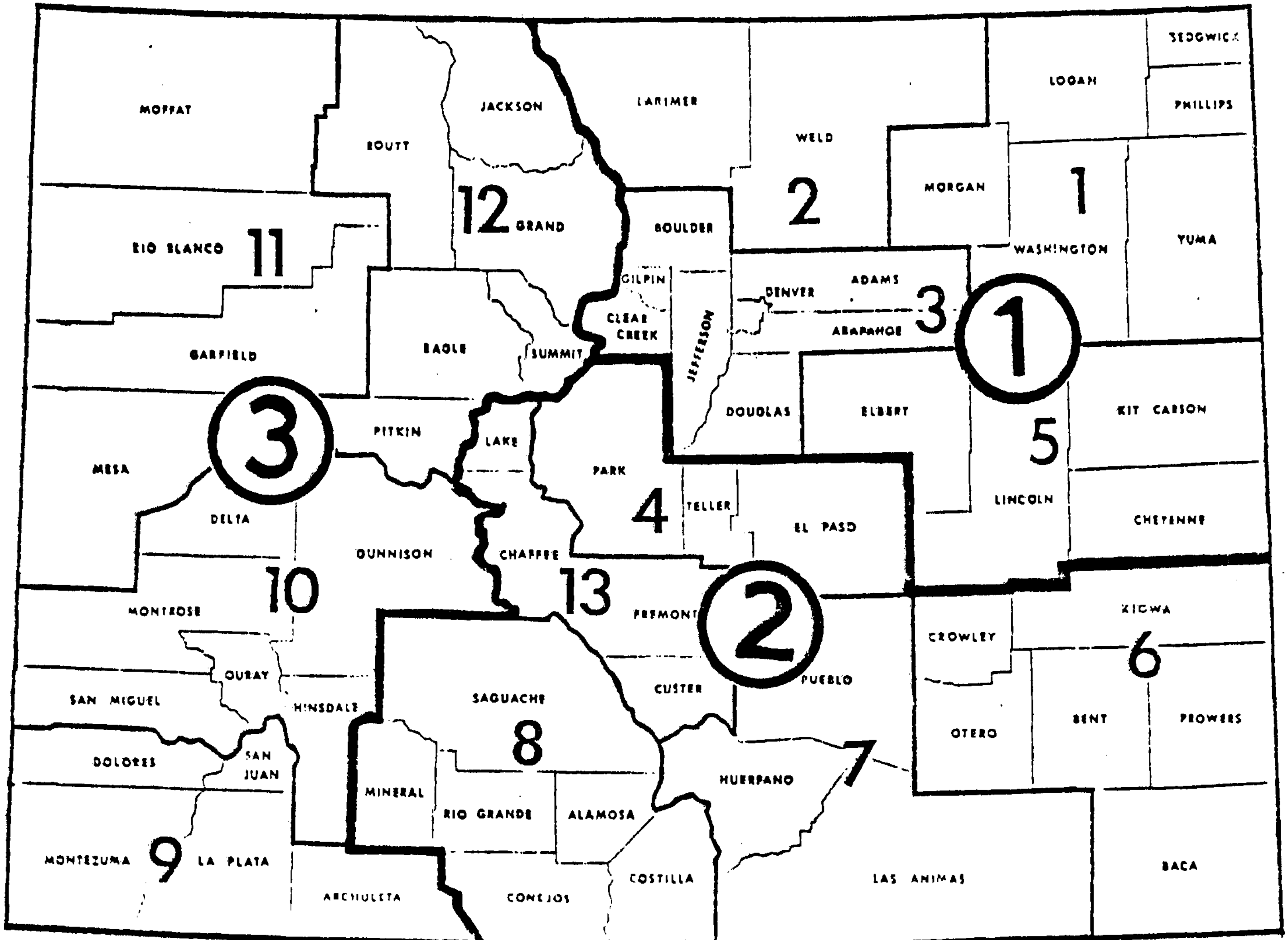
Health Systems Agencies

Of increasing importance to health planning are the health systems agencies (HSA's) established under the National Health Planning and Resources Development Act of 1974. (P.L. 93-641). Under this legislation, three health service areas have been designated in Colorado -- (1) northeast, (2) southeast, and (3) the western slope.

2/ State Planning Region No. 3, consists of the City and County of Denver,and Adams, Arapahoe, Boulder, Clear Creek, Douglas, Gilpin, Jefferson counties.

HEALTH SERVICE AREAS AND STATE PLANNING

REGIONS IN COLORADO



Within each of these areas, effective planning and development of health services is to be conducted by a health systems agency (HSAs), a private, non-profit agency governed by a board of directors composed of a majority of between 51 persons who are not health care

providers, (between 51 to 60 percent), with the remainder to be persons who are providers. The functions of the HSAs were summarized as follows by the Department of Health: 3/

(1) Gather and analyze data on health care resources and utilization in its area.

(2) Develop, establish, and implement a Health Systems Plan, which is a statement of goals and long-term objectives for the area; and an Annual Implementation Plan, which is a work program for the Health Systems Plan.

(3) Provide technical and/or limited financial assistance to organizations seeking to implement the above plans.

(4) Coordinate activities with Professional Standards Review Organizations and appropriate planning and regulatory bodies.

(5) Review and approve or disapprove applications for most federally funded health care projects within the area.

(6) Assist the State in the review of capital expenditures proposed by health care facilities within the area.

(7) Assist the State in assessing the need for new institutional health services proposed for the area.

(8) Assist the State in reviewing the appropriateness of the existing institutional health services offered.

(9) Annually recommend to the State projects for modernizing, constructing, and converting health facilities in the area.

The federal legislation required the designation of a state agency, selected by the governor, as the state health planning and development agency to administer the state's health planning and development program. The Office of Medical Care Regulation and Development has been designated as this agency. One of the responsibilities of this office is to prepare a preliminary state health plan based on the HSA plans developed in each region. Among other duties, the office also administers the state certificate of public necessity program and is also required to review, not less than every five years, all institutional health services in the state and to make findings as to their appropriateness.

3/ "P. L. 93-641...Health Planning to Help People", Colorado Department of Health.

A statewide health coordinating council is to be appointed to review and coordinate plans of the HSAs and the state plan of the Office of Medical Care Regulation and Development. This council is also to review the budgets of HSAs and applications for most federally funded health care projects.

Health Care Planning - Recommendations Submitted

Recommendations which would amend the present certificate of public necessity legislation were developed by two committee members and by the Insurance Commissioner's Ad Hoc Committee on Cost Containment. Representative Traylor recommended that the present certificate of need legislation be repealed and reenacted with the establishment of a new commission to act on applications for certification of facilities and services. Also, the Traylor proposal recommended separation of health planning and the regulatory functions within the Department of Health, based on an assessment that the present combination of the two functions has contributed to a failure of the certificate of public necessity law to adequately control expansion of hospital facilities.

Two approaches to strengthen the certificate of public necessity process were presented, one by the Insurance Commissioner's committee, the second, by Representative Wayland. The basic recommendations of the Insurance Commissioner's committee in the health planning area were as follows:

(1) Extension of the act. The requirements for planning, review, and approval of facilities and services should be extended to areas not now covered by the certificate of public necessity act, such as offices of physicians in group practice. Under this recommendation, the same standards of approval necessary for hospitals, for example, would be made applicable to other providers who might purchase equipment. These additional purchases might duplicate equipment already available in the community.

(2) Continuing review - decertification. Health facilities and service agencies should submit to a continuing review process. Institutions could be required to close facilities, or portions thereof, and to eliminate services and equipment when the need no longer exists.

(3) Appropriation. It was recommended that Colorado Blue Cross-Blue Shield support adequate appropriations for the state's health planning programs.

The Insurance Commissioner's committee urged that the Blues become involved in the health planning process through four specific means: (a) Staff should work directly with planning agencies; (b) Encouragement should be given to closing unnecessary beds and promoting shared services arrangements between facilities; (c) Information

the Blues; and (d) Blues should promote a two year moratorium on hospital construction.

The proposal of Representative Wayland, outlined in the committee report, primarily involved the continuing review and decertification recommended by the Insurance Commissioner's committee. The Health Facilities Advisory Council would review annually and submit recommendations to the Department of Health as to any facilities or services which would be considered unnecessary or underutilized. If the state Board of Health agreed that at least two of four criteria had been met (e.g., high patient cost, incompatibility with health plans, or significant overcapacity of facilities in the region), limitations could be placed on the facility's license.

Policy Questions

The proposals of Representatives Traylor and Wayland indicate some of the alternatives which the General Assembly could be considering in future sessions. Some of the more specific questions of state policy on health planning and the certification process are noted below:

(a) If the certificate of public necessity process is considered ineffective in limiting the expansion of facilities and services, is it realistic to conclude that either more resources or a change in the statutes will alter the effectiveness of the approach?

(b) Should the General Assembly take actions which would more clearly separate the functions of health care planning and the regulatory activities of the certificate of public necessity process?

(c) Will the three HSAs in Colorado provide an effective planning mechanism for health facilities?

(d) Should the Department of Health be given additional authority to decertify facilities that are no longer in use, that are utilized only to a limited extent, or for which there is a greater number than needed?

(e) Should the present legislation be amended by changing the cost limits on construction and equipment subject to the certificate of public necessity law. Proposed capital construction of $100,000 or more are subject to review. Should this amount be lowered or increased to include a greater or fewer number of applications? Should outpatient and other ancilliary facilities be included in the certification process?

V. UTILIZATION REVIEW

The extent of utilization of medical facilities and services has direct and obvious impact on the costs of health care. The number of X-rays taken, the types of lab tests conducted, the length of a hospital stay, or the use of inpatient rather than outpatient facilities are a few examples of the many options of medical diagnosis and treatment about which decisions are constantly being made.

This part of the report summarizes the Colorado utilization review program which is a condition for receiving Medicaid funding under the federal Social Security Act. While not reviewed in this report, a number of Colorado hospitals are also conducting independent utilization reviews as an internal management tool to improve the efficiency and quality of the health care which they provide. Also outlined in this section is a proposal by the Executive Director of the state Department of Health for collecting data on the use of medical services and facilities in Colorado.

Utilization control has two basic purposes: (1) to ensure that consumers receive high quality medical care; and (2) to control program costs by preventing unnecessary and excessive use of medical services. With regard to control of unnecessary and excessive use of medical services, physician peer groups are required to review and certify the medical necessity of inpatient hospital admissions and continued hospital stays. Utilization control is also designed to contain program costs by requiring that the most appropriate type of medical care be used. Inpatient hospital care, for example, must be justified as the most appropriate medical care, rather than outpatient care. 1/

Utilization review conducted by physician peer groups is based on three major assumptions. First, it is asserted that physicians are the most qualified individuals to determine what constitutes appropriate utilization of services based on medical necessity. Second, since hospital utilization is determined by physicians, the best way to influence or modify physician thinking regarding utilization of hospital services is to involve them directly in a utilization and medical quality review program. The third assumption is that physicians who order inappropriate institutional services will be more willing to abide by more appropriate standards and accept the consequences of non-compliance when the decision has the full weight and authority of their statewide peer groups. 2/

1/ Title 42 Section 1320 C-4, U.S.C.A.

2/ "Description of Colorado Admissions Program", Colorado Foundation for Medical Care, June, 1976, p. 4.

Professional Standards Review Organizations

Title XI of the federal Social Security Act requires the establishment of physician peer review groups called Professional Standards Review Organizations (PSROs) in each state to review the utilization of medical services which are supported by federal funds. Hospitals which receive Medicare, Medicaid, and Maternal and Child Health Care reimbursement must comply with the federal utilization review requirements as a condition for receiving federal reimbursement. 3/

The Colorado Foundation for Medical Care, Inc., operates as the professional standards review organization in Colorado. The foundation was created by the Colorado Medical Society to develop more effective programs for managing the distribution, quality, and cost of health care. In accordance with federal law, the organization is a nonprofit professional association composed of licensed physicians in Colorado. The foundation is funded totally by the federal government to conduct utilization reviews for Medicaid and Medicare purposes and receives no state assistance.

Presently, the foundation only conducts utilization reviews of inpatient hospital care under the Medicaid and Medicare programs. The state Department of Health currently conducts utilization reviews of nursing homes under the Medicaid program, but the foundation will begin utilization reviews of approximately 20 nursing homes as a pilot program in March, 1977. Presently, utilization review of ambulatory or outpatient hospital care is not required under federal law and is not being conducted.

A state, regional, and local structure has been developed for administering this utilization review program for inpatient hospitalization. On the state level, a steering committee is responsible for program administration and oversight. The state is divided into five regions with regional councils established to coordinate and monitor the program. Each regional council appoints one physician or hospital administrator to the state steering committee. The steering committee also has one hospital administrator appointed by the Colorado Hospital Association, and one consumer member appointed by the Governor.

On the local hospital level, physician advisors, with the assistance of nurse coordinators who are registered nurses, conduct utilization reviews at the time of patient admission and during the patient's hospital stay. No physician may review any case in which he or she has a financial interest.

3/ The Medicare program is established under Title XVIII, Medicaid under Title XIX, and Maternal and Child Health under Title V of the Social Security Act.

Physician advisors and their alternates are nominated by each hospital and approved first by the appropriate regional council and then by the state steering committee. Nurse coordinators are selected by the administrative staff of the foundation. The physician advisors and nurse coordinators are reimbursed by the foundation on a fee-for-service basis. Rural hospitals, however, use their own employees, e.g., nurse coordinators, to conduct utilization review because the smaller workloads of rural hospitals do not justify additional employees for this function. Such employees are also reimbursed on a fee-for-service basis.

A few hospitals in the Denver area have assumed responsibility for conducting their own utilization review programs. The foundation monitors the program effectiveness of these institutions.

Any health care provider or hospital determined to be out of compliance with the federal utilization review law may appeal such a finding to local, regional, and statewide appeals panels established by the foundation. Ultimately, however, if the state steering committee determines that a health practitioner or any hospital has repeatedly violated the federal law, then the steering committee must forward its findings to the Secretary of the Department of Health, Education, and Welfare (HEW). The Secretary of HEW may determine such practitioner or hospital to be ineligible to provide services on a reimbursable basis, after finding non-compliance in a substantial number of cases, or gross and flagrant violation in one or more instances. 4/

The foundation, under a memorandum of understanding with the Division of Medical Assistance in the state Department of Social Services, conducts utilization review under the Medicaid program. The foundation and the division are currently working on a new memorandum of understanding which will be finalized in the early months of 1977.

The state Department of Social Services is designated, in compliance with the federal Title XIX Medicaid law, as the single state agency for administering the state's Medicaid program. While establishment of PSROs to conduct utilization reviews is a requisite for obtaining federal Medicaid reimbursement under Title XI, neither Title XIX nor Title XI requires the PSRO to be accountable to the state agency which administers the Medicaid program. However, the sharing of information between the state agency and the foundation has been considered successful. 5/

4/ 42 Section 1320C-9 (2) (b), U.S.C.A.

5/ Dr. James Syner, Medical Consultant, Medical Assistance Division, Department of Social Services.

As for the further development of utilization review programs, one of the prime issues under consideration in the contract negotiations between Blue Cross and the hospitals is the definition of an acceptable utilization review program. Such a program would monitor the medical necessity and the appropriateness of services provided to patients who are insured by the Blues.

Population-Based Data System

A new development in Colorado involves the possible establishment of a population-based data system which would generate information concerning utilization of medical services and facilities. Dr. Anthony Robbins, Executive Director of the state Department of Health, described the system to the committee and indicated that its implementation would be a high priority for the department. The program could be effectuated without legislation if hospitals will be willing to provide the necessary information for the program on a voluntary basis. However, it may be too early to know the extent to which a voluntary approach on the part of hospitals and other providers will be possible.

The system proposed for Colorado would work in the following manner. When a patient is discharged from a hospital, the services which had been provided to the patient would be tabulated and reported to the state Department of Health, along with the geographic area in which the patient resides. The geographic area could be based on zip codes, census tracts, or similar areas for which the population is known. A selected group, such as all persons enrolled in the Medicare program, could also be used as the population group for the system. The aggregate number of services provided to the patients in the population group is divided by the total number of people in that population group and the result is the utilization rate. The utilization rates of various groups, such as city A, census tract B, or county D, or between Medicare and comparable non-Medicare populations, can be compared. One writer described the usefulness of these comparisons as follows:

> Generally speaking, the population based data mechanism is most useful as a way to flag exceptions, draw comparisons, or identify trends. It is a tool for asking questions more often than it is a tool for providing answers, but the questions it raises are powerful. 6/

6/ Jennifer Robbins, "The Uses of Population - Based Data for Rate Setting", Harvard University Center for Community Health and Medical Care, Report Services R-45-5, April, 1976, p. 4.

Findings from this system indicate considerable variations in the frequency of services provided. The following three examples of data from Vermont were cited as the ranges of cases per 10,000 population per year (Data for (a) and (b) for females; (c) both sexes):

	Surgical Procedure	No. of Cases Lowest	No. of Cases Highest	Number of Hospital Days Lowest	Number of Hospital Days Highest
(a)	Hysterectomies	30	60	284	670
(b)	Cholecystectomies (Removal of gall bladder)	18	53	---	---
(c)	Appendectomies	14	31	74	188

The author then raises the following questions and suggests what should be studied, based on the available data:

> Who is better off? Does the area with a low surgical procedure rate have people who are sicker or suffer more? Are the people in the high rate areas losing organs unnecessarily? Rate setters are in no way qualified to answer such questions on a case by case basis, but the data make it imperative that epidemiologists and clinicians do seek answers. Certainly if the high rates are directly associated with excess morbidity or mortality, the reasons for such findings should be throughly researched. Licensing, planning and reimbursing bodies can influence the growth and distribution of facilities to make suitable corrections. The human and financial stakes are high enough so that the data must be available to pose these and other questions. 7/

Policy Questions -- Utilization Review

If it chooses, the General Assembly, could determine some of the general directions which would affect the patterns of utilization of health care facilities and services. Some actions could affect state agencies concerned with utilization, and other actions could relate to third party payers such as Blue Cross.

(a) If voluntary participation with the proposed population based data system does not occur, should the General Assembly take action to mandate participation by hospitals and other providers?

7/ Ibid, p. 5.

(b) Many recommendations concerning utilization were directed toward approaches which would pertain to Colorado Blue Cross-Blue Shield. Should there be greater experimentation with alternative delivery systems such as increased outpatient services, pre-admission testing, use of paramedical personnel, and increased home health care? Would the encouragement of more alternative methods of care actually result in the most appropriate care being offered and in the reduction of the total costs of health care?

(c) Some states have penalized hospitals, in terms of Medicaid reimbursement, if occupancy in various departments falls below certain standards. Should Colorado penalize hospitals, through its Medicaid contracts, for under-utilization of facilities?

VI. MASSACHUSETTS RATE SETTING COMMISSION

In the interest of obtaining more detailed information on the functions and operations of a rate review commission in another state, arrangements were made for Mr. Stephen Weiner, chairman of the Massachusetts Rate Setting Commission, to meet with the committee. The following is an overview of the information concerning the Massachusetts Commission provided by Mr. Weiner.

Establishment of the Commission

The Massachusetts Commission was established in 1968 for the primary purpose of setting health care rates to be paid by state and local governments on behalf of public assistance recipients. The commission superseded previous state rate setting activities for hospitals and nursing homes which had been in operation since the 1950's. In 1974, the commission was reorganized and three full-time commissioners replaced the original five part-time commissioners. By statute, the chairman is required to have administrative experience and an advanced degree in business administration, public administration, or law. Another member is required to be a certified public accountant and one member is required to have experience in the field of medical economics. 1/

Mr. Weiner noted that practically all persons familiar with the operation of the part-time and full-time commissions are far more satisfied with the full-time commission.

Duties of the Commission

The duties of the Massachusetts Rate Setting Commission were expanded in 1974, 1975, and as recently as October, 1976. The commission is presently responsible for:

(1) Approving increases in hospital rates to the general public, which would include private pay patients and commercial insurance carriers;

1/ Other states have different requirements for composition of their commissions. For example, some states require that a certain number of members be selected from the general public, with others from the health care industry and state department heads as ex officio members. As for commission size, the full-time commissions usually consist of three members; the part-time commissions range in size between five and 15 members.

(2) Developing methodologies for grouping and comparing hospitals for the purpose of reviewing hospital budgets and proposed rate increases;

(3) Setting reimbursement rates under the Medicaid program and workmen's compensation programs;

(4) Approving the contracts between Blue Cross and hospitals and approving the rates under such contracts;

(5) Rate-setting for state and county health institutions;

(6) Rate-setting for educational, rehabilitational, and social services which are purchased by governmental units; and

(7) By 1978, compiling and reviewing all hospital budgets for the next fiscal year.

The commission is also authorized to adopt a uniform accounting system for health care providers, if such a system is deemed necessary.

This list illustrates that the duties of the commission are comprehensive in scope, including rate setting in non-health areas. 2/

In general, the commission's rate regulation activities are directed at containing the percentage of increase in hospital costs. This approach may be contrasted with methods of rate control which would require a complete analysis of the base costs through the analysis budgets and accounting reports. Previous expenditures are not analyzed for the appropriateness of their cost. Instead, the total revenues derived from patient charges are subject to limitations in the amount of increase.

The commission's rate-setting responsibilities cover the rates for every type of payer for hospital services and, to a large extent, for nursing home services. However, uniform rates are not set for all types of payers, nor are the same procedures used in determining rates for the various types of payers. For example, the procedure used for determining Medicaid reimbursement rates is distinct from the procedure used to review proposed increases in rates to the general public.

2/ The agency's internal structure also reflects the comprehensiveness of the commission's functions. The commission currently has four internal bureaus: (1) Bureau of Hospitals and Clinics; (2) Bureau of Long-term Care Facilities; (3) Bureau of Non-Institutional Providers and Community and Home Health Agencies; and (4) Bureau of Educational and Social Service Rates.

Mr. Weiner said that the most recent amendments to the law contain mechanisms, such as the requirement for budget reviews, which will result in uniform rate regulation in the future. Without uniformity in rates, hospitals may charge higher rates to private paying patients even though rates are contained for other payers, such as Medicaid patients.

Mr. Weiner explained that regulation of rates to the general public will in turn benefit Blue Cross and Medicaid reimbursement rates. The charges established by the commission for the general public tend to act as a ceiling on Blue Cross and Medicaid rates. Further, a major objective of regulating charges to the general public is to make the charges for hospital services closely equivalent to the costs of hospital services. With regard to Medicaid reimbursement, Mr. Weiner was of the opinion that it is not necessarily advantageous to the state to pay the same rates as the general public. While Medicaid rates, under federal law, can be no higher than the rates to the general public, they can be less.

The following sections outline the rate regulation approaches used in Massachusetts with regard to rates paid by the general public, Medicaid reimbursement rates, and Blue Cross reimbursement rates. Massachusetts law provides for only limited control of Blue Cross insurance rates for consumers, in contrast with the statutory requirement in Colorado that the Commissioner of Insurance approve all Blue Cross rate increases prior to use. In Massachusetts, the Commissioner of Insurance only approves rate increases for the "Non Group category" of insureds and, in this process, the expertise of the Rate Setting Commission is made available to the Commissioner.

<u>Rate Setting for the General Public -- Budget Reviews</u>

Regulation of health care costs began with regulation of rates paid by governmental entities under public assistance programs, such as Medicaid, and has evolved to the regulation of rates charged private pay patients and commercial carriers. Mr. Weiner said that responsibility for approving rate increases to the general public and for reviewing hospital budgets was added to the commission's duties because regulation of Medicaid reimbursement rates and Blue Cross contracts with hospitals was not sufficient to control health care costs.

In 1975, the Massachusetts legislature passed an emergency act which required the commission to begin immediate approval of increases in hospital charges. 3/ The provisions of the 1975 law were estab-

3/ Legislation requiring the commission to approve rate increases was passed in July, 1975, effective immediately and the commission had less than three months to implement this provision.

lished as an interim measure, designed to be in effect until 1980. In October, 1976, more comprehensive legislation was enacted which superceded the 1975 legislation. The 1976 law requires the commission to review the budget of every hospital by fiscal year 1978, in addition to approving increases in hospital rates to the public.

The intent of the 1975 and 1976 legislation was to begin comprehensive cost containment efforts immediately, without waiting to develop a uniform accounting or statistical system. This is in contrast to the approach adopted in other states, such as Washington and California. 4/ However, the 1976 law requires the commission to develop certain methodology for analyzing hospital budgets and proposed budgets by 1978, and authorizes the commission to develop a uniform accounting system for health care providers, if deemed necessary. In addition, the commission was able to apply some of the methodologies used to regulate Medicaid reimbursement rates to regulate hospital rates charged to private pay patients and commercial carriers. For example, a composite index for inflation had previously been developed for assessing the proposed increases in Medicaid rates.

Mr. Weiner emphasized that the commission does not need the same information to conduct rate reviews as is necessary for the administration of a hospital. In his opinion, a uniform accounting system is primarily of benefit as an internal management tool for hospitals, whereas uniform reporting of hospital budget data is essential to rate regulation.

The Massachusetts rate review statute provides the commission with specific criteria and guidelines needed for assessing proposed rate increases and for reviewing hospital budgets. Proposed rate increases are approved on the basis of the following statutory criteria: (1) that the reasonableness of the underlying costs are justified; (2) that the increases are consistent with the rate of inflation in the economy in general, as measured by a composite index; (3) that the increases are due to projected increases in volume of service; and (4) that the increases are due to costs beyond the control of the hospital. Many early rate regulation systems, such as the system used in Connecticut, focused on increases in unit prices or charges and did not regulate increases in the volume of services. The Massachusetts rate review system is designed to regulate both increases in price and in volume.

4/ California began development of a uniform accounting system in 1972 and recently, the California Health Facilities Commission proposed adding rate review and approval functions to its existing duties of gathering data. Although the Washington State Hospital Commission conducts rate review, the commission devoted considerable resources to the development of a uniform accounting system prior to regulating rates.

The emphasis of the Massachusetts Commission is to control total cost rather than to analyze line item costs. The commission does not dictate to hospitals how they should allocate their revenues but sets maximum figures within which hospitals are to operate. The Massachusetts Department of Health examines such major expenditures under the state's certificate of public necessity laws, as is the case in Colorado.

In addition to using the guidelines to analyze proposed rate increases, the commission reviews the ratio between a hospital's total patient charges and total patient costs. Basically, hospitals are allowed five percent in excess revenues, derived from patient care charges, over patient costs. Proposed rate increases cannot produce total revenues to exceed five percent over costs.

While all hospitals will be required to file their budgets with the commission by 1978, the commission will only act on budgets where new or increased rates are proposed, or where total patient charges would exceed total patient costs by more than five percent. In addition, the commission will review any hospital's budget in which the proposed total patient charge-cost ratio exceeds the ratio during the base year period (April, 1974 through March, 1975).

All hospital budgets are initially screened to determine whether they conform with the statutory guidelines and other criteria, as provided in commission regulations. Administrative efforts are concentrated on those hospitals which do not conform to statutory and regulatory requirements.

With regard to the criteria for approving rate increases, Mr. Weiner explained that the commission develops formulae, by regulation, for determining allowable increases in hospital costs due to inflation and for determining allowable increases in volume. The formulae are then applied to each hospital. For example, a hospital's FY 1976 budget would be inflated on the basis of the composite index in order to predict what the 1977 budget should be.

<u>Accomplishments of the Commission</u>

With regard to the commission's impact on hospital costs after one year of operation, Mr. Weiner said that hospitals are more cost conscious. The requirement of commission approval of hospital rate increases has forced hospitals to budget with greater sophistication and has required them to justify cost and charge increases. Mr. Weiner said that a Blue Cross official stated that 40 out of the 130 general hospitals were unable to budget adequately prior to the commission's regulatory efforts.

Administrators of some of the teaching hospitals have indicated that the commission's regulation has given hospital administrators leverage over staff physicians with regard to containment of hospital costs. The administrators are able to tell the staff physicians that

the hospital cannot justify a particular expenditure requested because of the commission's constraints.

Mr. Weiner said that it is difficult to compare Massachusetts' hospital rates with the rates in surrounding Northheastern states because Massachusetts' rates historically had been higher than rates in neighboring states such as Connecticut and Rhode Island. The teaching hospitals affiliated with Harvard Medical School have significantly contributed to the high cost of hospital rates, he said. Mr. Weiner said that last year, the commission disallowed approximately $10,000,000 in cost increases, and $4,000,000 to $5,000,000 in projected increases in revenue.

Commission budget and staff. Mr. Weiner stated that the commission has 16 full-time employees who are assigned to review hospital budgets, at a total annual cost for salaries of $222,000.

Medicaid Reimbursement Rates

Hospital rates. Massachusetts is one of several states in the nation, including Colorado, which reimburse hospitals for Medicaid patients on a prospective basis. Prospective per diem rates are developed on the basis of historic or base costs. Hospital costs in a base year as reported to the commission are projected forward using a standard composite inflation factor to determine per diem rates for the next year. The inflation factor is based on the assumption that hospitals should experience the same inflation rate as the general economy, not an inflation rate unique to hospitals.

The commission sets Medicaid per diem rates for the 200 hospitals in the state. However, Medicaid reimbursement only constitutes about 15 percent of total hospital revenue in Massachusetts.

Prior to 1976, the Massachusetts legislature (the General Court) vested the commission with sole authority for determining Medicaid reimbursement rates. In fiscal year 1976, the legislature began appropriating funds for Medicaid reimbursement conditionally. For the current year, the legislature placed a seven precent cap on hospital reimbursement rate increases and any hospital reimbursement rate higher than seven percent must be approved by the legislature on a case-by-case basis. This requirement for approval means that the legislature mandates the allowable inflation factor rather than allowing the inflation factor to be set by the commission.

The Medicaid reimbursement system also penalizes hospitals for low occupancy rates on the assumption that the Commonwealth should not pay for underutilized, and therefore, unnecessarily expensive facilities. 5/ Maternity hospitals are penalized if their occupancy rate is

5/ Commonwealth of Massachusetts Rate Setting Commission, Annual Report, 1975, p. 25.

less than 60 percent; teaching hospitals are penalized if occupancy drops below 75 percent; and non-teaching hospitals are penalized if their occupancy rate is lower than 80 percent.

Occupancy rates are calculated on the basis of licensed bed capacity. In calculating occupancy rates, the commission encountered disparities between the licensed bed capacity and the operating bed capacity reported by hospitals. An unanticipated result of the penalty for low occupancy was that some hospitals made application to reduce their licensed bed capacity to conform the number of licensed beds with their actual operating capacity.

Nursing home rates. Mr. Weiner stated that the Medicaid regulation for nursing homes provides adequate regulation for this industry. In Massachusetts, approximately 85 percent of the total revenue for the nursing home industry is derived from Medicaid. The Commonwealth currently has 758 nursing homes.

In contrast to the prospective basis used for reimbursing hospitals, nursing homes are reimbursed retrospectively on the basis of audited cost, as is the procedure in Colorado. Interim rates are established by inflating base year costs by ten percent. Final rates are established after audited costs are filed with the commission. The commission establishes a ceiling on specific costs, such as nursing costs or administrative expenses. The cost ceilings are the bases upon which the reasonableness of nursing home costs are judged.

As is the case for hospitals and clinics, a nursing home must maintain a given level of occupancy or it will have its Medicaid rate reduced. Nursing homes must maintain a 93 percent occupancy in order to avoid the penalty. This occupancy penalty is useful in ensuring that the Commonwealth will not be paying the extra expense involved in the under-utilization of facilities, and also encourages these facilities to accept publicly-aided individuals rather than waiting to find privately-paying individuals who will pay more.

One and one-half full-time employees administer the Medicaid rate review functions in the Massachusetts Commission.

Blue Cross Reimbursement Rates

Since 1974, the commission has been responsible for approving contracts between Blue Cross of Massachusetts, Inc., and providers of health services and for approving rates under such contracts. The statutes authorize the commission to approve Blue Cross contracts with participating and cooperating hospitals, long-term care facilities, and pharmacies. The 1975 annual report of the commission indicated that it was satisfied that this approach had been successful:

> ...in exercising this authority, particularly as it relates to hospitals, Commission action has a substantial impact on premiums paid by Blue Cross subscribers, since a major element in

determining premiums is the rate Blue Cross pays to contracting providers. 6/

In addition to the commission's staff, the commission is authorized to use Blue Cross personnel for the analysis of Blue Cross provider contracts and reimbursement rates for health care providers.

Policy Questions - Rate Review Commission

Several important considerations will be before the Colorado General Assembly if the concept of a rate review commission is considered seriously in the legislative process: (a) whether there is a need for some mechanism for review of rates or the budget of health care providers, particularly hospitals; and (b) whether a state rate review mechanism would be an effective means of limiting the rates of increase for certain types of health care. Even if such a procedure would be considered effective, some might challenge whether regulatory activity in regard to hospital rates, for example, is an appropriate role for the state to undertake.

These considerations are complex and considerable data has been collected in regard to arguments concerning these issues. If a decision is made favoring the concept of rate review or rate setting, a number of key questions will then be addressed. Some of these questions are noted below:

-- Scope. Which health care facilities, such as nursing homes and hospitals, should be subject to the legislation? Should the rates of all payers (e.g., Blue Cross, the state, or private pay patients) or only some payers be subject to regulation?

-- Voluntary or mandatory compliance. Would voluntary compliance with recommendations of a commission be acceptable or should the law be mandatory as is the case in most states which have a commission?

-- The commission. Whether a commission would be full- or part-time and the composition of the commission would need consideration. Perhaps an executive agency, with an advisory group rather than a commission, could administer the act.

-- Organizational structure. A decision on the placement of a commission in the organizational structure of state government would have to be made. Perhaps it would be placed in the Department of Health or in other regulatory agencies or added to an existing commission, such as the PUC.

6/ Annual Report, *supra* note 3, at page 2.

-- <u>Review or approval of rates.</u> Should a commission review and approve rates or actually set rates for the providers subject to the statute?

-- <u>Procedures of budget review and rate determination.</u> What procedure should be used for determining rates or for approving budgets: negotiation; allowance of maximum flat increases in budgets or costs; or agency determination through formulae or other analyses.

-- <u>Uniform accounting.</u> A system of prospective reimbursement may depend on uniformity of information from hospitals in order to negotiate contracts. Should the General Assembly mandate hospital compliance with a uniform system of accounts?

APPENDICES

Appendix I - Page 1-a -- The "Colorado Certificate of Public Necessity Act" (Title 25, Article 3, Part 5, C.R.S. 1973, as amended)

Appendix II - Page 1-b -- Summary of Certification Actions Taken by the State Health Facilities Advisory Council (pursuant to the Certificate of Public Necessity Act)

Appendix III - Page 1-c -- A Glossary of Terms Commonly Used in a Discussion of Health Care Costs

Appendix IV - Page 1-d -- Colorado Blue Cross-Blue Shield -- Description of Membership Categories

APPENDIX I

Colorado Revised Statutes, 1973, as amended

Title 25, Article 3, Part 5

CERTIFICATES OF PUBLIC NECESSITY

25-3-501. Short title. This part 5 shall be known and may be cited as the "Colorado Certificate of Public Necessity Act".

25-3-502. Legislative declaration. The general assembly finds that the construction or modification of health care facilities is a factor in the cost of care and the financial ability of the public to obtain necessary medical services. The purposes of this part 5 are to promote comprehensive health planning as contemplated by federal Public Law 89-749, as amended; to assist in providing the highest quality of health care at the lowest possible cost; to avoid unnecessary duplication by ensuring that only those health care facilities that are needed will be built or modified; to provide an orderly method of resolving questions concerning the necessity of construction or modification of health care facilities; to reduce or eliminate existing duplication and shortages of health care facilities and manpower whenever possible; to provide an orderly method for the replacement of nonconforming beds, as defined in section 25-3-503, with new beds in localities where they are needed; and finally, to recognize that the coordinated development of health care facilities and services, of desirable size and location, which are responsive to the legitimate needs of consumers, providers, and governments, and the encouragement of more efficient, economical, and effective systems for organizing, financing, and providing health care are worthy goals.

25-3-503. Hospitals and health care facilities - certificate of public necessity required - when. (1) A certificate of public necessity from the department of health, referred to in this part 5 as the "department", shall be required for:

(a) The construction of any new hospital or health care facility for which the department of health is required to issue a license or certificate of compliance pursuant to the provisions of section 25-1-107 (1) (1), excepting therefrom any facility whose primary purpose relates to residential care;

(b) Any modification or lease of a hospital or health care facility specified in paragraph (a) of this subsection (1), which modification involves a capital expenditure of one hundred thousand dollars or more, or a real property leasing expenditure or an equipment lease expenditure of ten thousand dollars or more per year, and at least one of the following factors:

(I) A change in health care service;

(II) A ten percent or greater increase in the number of beds;

(III) A change in licensure category;

(IV) The purchase, lease, or acquisition of diagnostic or therapeutic equipment, when such purchase, lease, or acquisition is for other than replacement of existing equipment and is consistent with current health care delivery planning;

(V) The replacement of beds or bed facilities not conforming to federal, state, or local standards with beds or bed facilities so conforming.

(c) Utilization of any existing hospital or health care facilities for provision of health care services, which hospital or facility currently is not licensed by the department.

25-3-504. Application for certificate of public necessity - procedures. (1) (a) An application for a certificate of public necessity shall be submitted to the areawide health planning agency serving the state planning and management region, established pursuant to executive proclamation, in which the proposed construction or modification is to take place.

(b) As used in this part 5, "areawide health planning agency" means an agency established to meet the requirements of federal Public Law 89-749, as amended, and designated as such by the state health planning agency.

(c) If there is no areawide health planning agency which has been so designated as provided in paragraph (b) of this subsection (1) in the area to be affected by the proposal, the state health planning agency shall perform the functions and duties of an areawide health planning agency as they relate to certification of public necessity in that area.

(2) Upon receipt of the application, the areawide health planning agency shall send a copy to the department, the health facilities advisory council, referred to in this part 5 as the "council", and to the state health planning agency.

25-3-505. Contents of application - minimum requirements. (1) Every application for a certificate of public necessity shall include at least the following information:

(a) The general geographic area to be served;

(b) The population to be served, as well as projections of population growth;

(c) The anticipated demand for the facility or service to be provided by the proposal;

(d) A description of the construction or modification in reasonable detail, including:

(I) The capital expenditures contemplated;

(II) The estimated annual operating cost, including the anticipated salary cost and numbers of new staff anticipated by the proposal.

(e) So far as is known, the relationship of the proposal to any priorities which have been established for the area to be served;

(f) The availability and manner of financing the proposal including the specific source of funding for contemplated capital expenditures and the time at which any such funding is committed and the estimated date of commencement and completion of the project;

(g) Cost per patient day by type of care at various levels of occupancy and a comparison of such costs with facilities in use.

(2) The areawide health planning agency shall make available to the applicant such information as it may have.

(3) Information submitted in any application for a certificate of public necessity shall be supported by relevant, specific, empirical data and statistics, at least to the extent such data and statistics are generally available to the health care industry.

25-3-506. Recommendation of areawide health planning agency - time limit. Within forty-five days after receiving the application, the areawide health planning agency shall make its recommendation to the council. If the areawide health planning agency holds a public hearing on the application, either on its own initiative or pursuant to the request of any interested party, it shall make its recommendation within said forty-five-day time period. The areawide health planning agency shall either recommend that the council approve or deny the issuance of a certificate of public necessity. The reasons for the recommendation shall be set forth in detail. Failure of the areawide health planning agency to act within the required time shall be deemed a recommendation for approval of the application.

25-3-507. Determination by council. (1) Within forty-five days after receiving the recommendation of the areawide health planning agency or after ninety days following the receipt of the application by the areawide health planning agency, whichever comes first, the council shall review the recommendation and make one of the following decisions:

(a) Approve the issuance of a certificate of public necessity;

(b) Reject the application for a certificate of public necessity.

(2) If the decision of the council is contrary to the recommendation of the areawide health planning agency, the council shall set forth in detail the reasons for reversing the recommendation.

(3) Failure of the council to comply with the time limitations prescribed in subsection (1) of this section shall be deemed approval of the application, and a certificate of public necessity shall be issued by the department.

(4) Within ten days after the expiration of any time period prescribed for action by the council, the department shall notify the applicant and the areawide health planning agency in writing of the decision or lack of decision of the council on the application for a certificate of public necessity and shall issue a certificate on applications approved by the council.

25-3-508. Appeal. (1) A decision of the council to approve the issuance of or denial of a certificate of public necessity may be appealed to the state board of health within thirty days after receipt of notice of such decision either by:

(a) The applicant for the certificate who is aggrieved by an order to deny such certificate; or

(b) More than one-third of the members of the areawide health planning agency if the decision of the council is contrary to the recommendation of the areawide health planning agency.

(2) Not more than forty-five days after the filing of a notice of appeal, the state board of health shall set a time (which time shall not be more than sixty-five days after the filing of notice of appeal) and place (which place shall be set at the approximate location of the proposed construction, expansion, or modification for which the certificate of need has been requested) for a public hearing on the application. Every hearing shall be conducted in conformity with the provisions of article 4 of title 24, C.R.S. 1973.

(3) The decision of the state board of health on such appeal shall be final, subject to the provisions of section 24-4-106, C.R.S. 1973.

25-3-509. Expiration of certificate - extensions - grievances. (1) A certificate of public necessity shall expire if the construction or modification is not commenced within twelve months following the issuance of the certificate or is not completed within twelve months of the estimated time for completion of construction or modification as shown in the application; except that the council may grant an extension of a certificate if good cause is shown why the proposed construction or modification has not commenced or been completed.

(2) (a) A hospital or health care facility which holds a valid certificate of public necessity issued under this part 5 desiring an extension of such certificate shall file an

application for an extension with the areawide health planning agency to which it originally made application at least three months prior to the expiration of the certificate; except that an application for an extension of a certificate may be filed less than three months prior to expiration if the proposed construction or modification cannot be commenced or completed due to an emergency, including a natural disaster, labor dispute, or other situation beyond the applicant's control.

(b) Upon receipt of an application for extension, the areawide health planning agency shall send a copy to the department and to the state health planning agency.

(c) Within forty-five days after receiving the application for extension, the areawide health planning agency shall recommend that the council either approve or deny the granting of an extension of the certificate. If the recommendation is to grant the extension, the areawide health planning agency shall also recommend the length of such extension. Failure of the areawide health planning agency to act within the required time shall be deemed a recommendation to grant an extension.

(3) Within forty-five days after receiving the recommendation of the areawide health planning agency, the council shall review the recommendation and make one of the following decisions:

(a) Grant an extension of the certificate of public necessity for an additional specified time period of up to twelve months; or

(b) Deny an extension of the certificate.

(4) A decision of the council to approve or deny an application for an extension of a certificate of public necessity may be appealed to the state board of health within thirty days after receipt of notice of such decision either by:

(a) The applicant for the extension who is aggrieved by an order to deny the extension; or

(b) More than one-third of the members of the areawide health planning agency if the decision of the council is contrary to the recommendation of the areawide health planning agency.

(5) Not more than forty-five days after the filing of a notice of appeal, the state board of health shall set a time (which time shall not be more than sixty-five days after the filing of notice of appeal) and place (which place shall be set at the approximate location of the proposed construction, expansion, or modification for which the certificate of need has been requested) for a public hearing on the application for extension. Every hearing shall be conducted in conformity with the provisions of article 4 of title 24, C.R.S. 1973.

(6) The decision of the state board of health on such

appeal shall be final, subject to the provisions of section 24-4-106, C.R.S. 1973.

(7) A hospital or health care facility holding a valid certificate of public necessity pursuant to this part 5 which desires to substantially change the information in the original application for which the certificate was issued shall file a request for amendment to the areawide health planning agency to which it originally made application. The request shall be processed as provided in paragraphs (b) and (c) of subsection (2) and subsections (3) to (6) of this section.

25-3-510. Development of general principles to govern agencies - factors. (1) The council shall, after consulting with the areawide health planning agencies and the state health planning agency, develop general principles to govern areawide health planning agencies and the council in the performance of their duties concerning review of applications for certificates of public necessity. These principles shall provide for the consideration of the following factors and may provide other guidelines not inconsistent herewith:

(a) The need for health care facilities and services in the area and the requirements of the population of the area;

(b) Maximum and minimum hospital or health care facilities and bed ratios per one thousand inhabitants of the area, subject to differences in requirements of the various designated areas;

(c) The location of existing health care facilities within the area and the relation of such location to the distribution of population within the area;

(d) The projected growth and movement of population in the area and the impact of such projections on the proximity of existing health care facilities to projected population distribution in the area;

(e) When an application or applications contemplate adding or replacing beds, the capital expenditures contemplated per new or substituted bed;

(f) When an application or applications contemplate adding or replacing beds, the anticipated operating cost per bed per diem;

(g) When an application or applications contemplate adding or replacing beds, and the applicant or applicants have been operating an existing health care facility in the area, the applicant's operating cost per bed per diem over its last three fiscal years or whatever part of such period such applicant has been operating, which shall be substantiated, to the extent available;

(h) The possible economies and improvement in service that may be derived from operation of joint, cooperative, or shared

health care resources;

(i) The relationship of the proposed construction or modification to overall plans for the development of the area including, but not limited to, such state and areawide plans as have been developed pursuant to section 314 (a) of federal Public Law 89-749, as amended;

(j) The availability and adequacy of the area's existing hospitals and health care facilities currently conforming to state and federal standards to meet each of the wide variety of medical needs of the community;

(k) The benefits to the community from increasing the availability and adequacy of other health care services in the area such as outpatient, ambulatory, or home care services which may serve as a possible substitution for inpatient care while at the same time providing high quality health care at a lower cost;

(l) The development of comprehensive services for the community to be served. Such services may be either direct or indirect through formal affiliation with other health programs in the area and may include preventive, diagnostic, treatment, and rehabilitation services. Preference shall be given to health care facilities which will provide the most comprehensive health care services and will include outpatient and other integrated services useful and convenient to the operation of the facility and the community.

(m) The gains that may be anticipated from innovative measures proposed by the applicant for improving the organization and provision of health care.

(2) In applying the general principles to govern review of applications for certificates of public necessity, the areawide health planning agencies and the council shall take into account the extent to which information in any application is supported by relevant, specific, empirical data and statistics where such data and statistics are available to the industry.

(3) In reviewing applications for certificates of public necessity, the areawide health planning agencies, the state health planning agency, the council, and the state board of health shall consider only the public need as provided in section 25-3-505 for health care facilities as defined in section 25-3-503 and applicants' capabilities to meet such public need and shall not discriminate against any applicant on the basis of the nature of its ownership.

(4) The council shall reject an application for a certificate of public necessity when it makes an affirmative finding of any one of the following:

(a) A significant overcapacity within the state planning and management region in which the proposed facility is to be located would exist at the time of completion of the proposed

facility, except in the event that a proposed acute inpatient or emergency care facility is to be located at least forty-five miles from the closest facility of like nature;

(b) The project is not compatible with applicable standards, plans, or criteria adopted by areawide or state health planning agencies or by the council. Such standards, plans, or criteria shall be developed in conformity with the provisions of subsection (1) of this section.

(c) The proposed capital expenditure is not economically feasible and cannot be accommodated in the patient charge structure or the health care facility or health maintenance organization without unreasonable increases;

(d) The project will not foster cost containment or improved quality of care, and lack of cost-effective factors such as ambulatory care, preventive health care services, and home health care shall be considered;

(e) Notwithstanding any other provision of this subsection (4), an application shall be approved if it can be shown to provide health care at a cost significantly below the rates being charged by existing health care providers.

25-3-511. Council - additional authority - report. (1) In addition to the other duties of the council specifically set forth in this part 5, the council shall have maximum flexibility in surveying the health care needs of the state and in recommending a program to reduce or eliminate unnecessary duplication of existing health care services and facilities and to encourage the development of health care facilities and manpower in areas of the state where it determines there is a shortage of such facilities and trained personnel.

(2) In carrying out the purposes of this section to recommend a program to reduce or eliminate areas of duplication and shortage of health care facilities and manpower, the council shall solicit and consider the recommendations of the areawide health planning agencies in the areas affected by such duplication or shortage and the state health planning agency.

(3) In carrying out its duties under this part 5, the council is empowered to make such investigations and confer with such persons, groups, and agencies as it deems necessary.

(4) On or before December 1, 1973, and December 1 of each year thereafter, the council shall report to the governor on its activities under this part 5 and shall include in such report an analysis of the effectiveness of this part 5 in achieving the legislative purposes set forth in section 25-3-502 and such recommendations as it may have with respect to any legislative changes that may be necessary or desirable.

25-3-512. Conflicts of interest - disqualification of vote. (1) Any voting member of the areawide and state health planning

agencies, the council, or the state board of health has the right to vote upon all applications before such member's respective organization and, in so doing, is presumed to act in good faith and in the public interest.

(2) Notwithstanding the provisions of subsection (1) of this section, any member of said organizations who has a substantial economic interest which would be affected by said member's vote on an application, or who has a close relative or close economic associate whose interests would be so affected by said member's vote, or who accepts a substantial gift, service, or economic opportunity from a person or persons whose interests would be affected by said member's vote, or who has personal interests which otherwise conflict with the public interest shall declare himself to have a conflict of interests and shall be ineligible to vote upon any application for which a conflict of interests exists.

25-3-513. Rules and regulations. The council, after consulting with the state health planning agency and the areawide health planning agencies, shall adopt rules and regulations necessary to implement this part 5. Such regulations shall be promulgated and published according to the requirements of section 24-4-103, C.R.S. 1973.

25-3-514. Injunction. The department may seek to enjoin the construction or modification of a hospital or health care facility for which a certificate of public necessity has not been issued as required by this part 5.

25-3-515. Withholding of license and funds - when. The department shall not license or allocate any funds to a newly constructed hospital or health care facility or to a hospital or health care facility that has modified its facilities if a certificate of public necessity has not been first obtained as required by this part 5.

25-3-516. Violation - penalty. Any person who constructs or modifies a hospital or health care facility without first having obtained a certificate of public necessity, as required by this part 5, is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than five hundred dollars.

25-3-517. Exclusion. (1) (a) For which has been submitted in good faith the preliminary plan as required by departmental rules and regulations pursuant to section 25-1-107 (1) (l) by or on behalf of a health care facility or health maintenance organization prior to May 30, 1973, and which has commenced construction no later than July 1, 1976, and completed construction no later than July 1, 1977; except that the council may grant an extension for projects excluded by this paragraph (a) upon good cause shown;

(b) Operated by religious groups relying solely on spiritual means through prayer for healing.

25-3-518. Transfer of certificate. A certificate of public necessity or any right obtained pursuant to any such certificate may be sold, assigned, leased, or otherwise transferred only upon approval of the council. Such approval shall be secured in accordance with the procedures established for application for such certificate.

25-3-519. Effect of part 5. (1) Nothing in this part 5 shall preclude consideration of the availability of health care facilities, services, or equipment in a state planning and management region contiguous to the state planning and management region in which the proposed certificate of public necessity will be utilized.

(2) Nothing in this part 5 shall prevent compliance with federal requirements made to effect implementation of Public Law 93-641 in the state of Colorado.

APPENDIX III

A GLOSSARY OF TERMS COMMONLY USED IN A DISCUSSION ON HEALTH CARE COSTS*

abuse: improper or excessive use of program benefits, resources or services by either providers or consumers. Abuse can occur, intentionally or unintentionally, when services are used which are excessive or unnecessary; which are not the appropriate treatment for the patient's condition; when cheaper treatment would be as effective; or when billing or charging does not conform to requirements. It should be distinguished from *fraud*, in which deliberate deceit is used by providers or consumers to obtain payment for services which were not actually delivered or received, or to claim program eligibility. Abuse is not necessarily either intentional or illegal.

actual charge: the amount a physician or other practitioner actually bills a patient for a particular medical service or procedure. The actual *charge* may differ from the *customary, prevailing*, and/or *reasonable charges* under *Medicare* and other insurance programs.

admission certification: a form of medical care review in which an assessment is made of the medical *necessity* of a *patient's admission* to a hospital or other inpatient institution. Admission certification seeks to assure that patients requiring a hospital level of care, and only such patients, are admitted to the hospital without unnecessary delay and with proper planning of the hospital stay. *Lengths of stay* appropriate for the patient's admitting *diagnosis* are usually assigned and certified, and payment by any program requiring certification for the assigned stay is assured. Certification can be done before (*preadmission*) or shortly after (*concurrent*) admission.

allied health personnel: specially trained and *licensed* (when necessary) health workers other than *physicians, dentists, podiatrists* and *nurses*. The term has no constant or agreed upon detailed meaning: sometimes being used synonymously with *para-medical personnel;* sometimes meaning all health workers who perform tasks which must otherwise be performed by a physician; and sometimes referring to health workers who do not usually engage in independent practice.

allowable charge: generic term referring to the maximum fee that a *third party* will use in reimbursing a *provider* for a given service. An allowable charge may not be the same as either a *reasonable, customary* or *prevailing charge* as the terms are used under the *Medicare* program.

* These terms and expressions were extracted from A Discursive Dictionary of Health Care, prepared for the use of the Subcommittee on Health and Environment of the U.S. House of Representatives Committee on Interstate and Foreign Commerce (February, 1976). These materials were distributed at "A Conference on Controlling Medicaid Costs", August 2-3, 1976, in Denver, sponsored by the National Conference of State Legislatures.

allowable costs: items or elements of an institution's costs which are reimbursable under a payment formula. Both *Medicare* and *Medicaid* reimburse hospitals on the basis of certain costs, but do not allow reimbursement for all costs. Allowable costs may exclude, for example, uncovered services, luxury accommodations, costs which are not *reasonable*, expenditures which are unnecessary in the efficient delivery of health services to persons covered under the program in question (it would not be allowable to reimburse costs under Medicare involved in providing services to newborn infants), or depreciation on a capital expenditure which was disapproved by a health planning agency. See also *section 223* and *1122*.

alternatives to long-term institutional care: the whole range of health, nutritional, housing and social services designed to keep persons, particularly the aged, disabled and retarded, out of institutions like *skilled nursing facilities* which provide care on a long-term basis. The goal is to provide the range of services necessary to allow the person to continue to function in the home environment. Alternatives to long-term care include day-care centers, foster homes or *homemaker services*.

ambulatory care: all types of health services which are provided on an *outpatient* basis, in contrast to services provided in the home or to persons who are *inpatients*. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his home to receive services and has departed the same day.

assignment: an agreement in which a *patient* assigns to another party, usually a *provider*, the right to receive payment from a *third-party* for the service the patient has received. Assignment is used instead of a patient paying directly for the service and then receiving reimbursement from public or private insurance programs. In *Medicare*, if a physician accepts assignment from the patient, he must agree to accept the program payment as payment in full (except for specific *coinsurance*, *copayment* and *deductible* amounts required of the patient). Assignment, then, protects the patient against liability for charges which the Medicare program will not recognize as *reasonable*. Under some *national health insurance* proposals physicians must agree to assignment for all of their patients or none of them; under Medicare, physicians may choose assignment for some of their patients but not others, and may do so on a claim by claim basis for some services but not others.

bad debts: the amount of *income* lost to a provider because of failure of patients to pay amounts owed. The impact of the loss of revenue from bad debts may be partially offset for *proprietary* institutions by the fact that income tax is not payable on income not received. They may also be recovered by increasing *charges* to paying patients by a proportional amount. Some *cost-based reimbursement* programs reimburse certain bad debts (see *reasonable cost*).

Blue Cross Association (BCA): the national non-profit organization to which the 70 *Blue Cross plans* in the United States voluntarily belong. BCA administers programs of *licensure* and approval for Blue Cross plans, provides specific services related to the writing and administering of health care benefits across the country, and represents the Blue Cross plans in national affairs. Under contract with the *Social Security Administration* (SSA), BCA is *intermediary* in the *Medicare* program for 77 percent of the *participating providers* (90 percent of the participating *hospitals*, 50 percent of the participating *skilled nursing facilities*, and 76 percent of the participating *home health agencies*).
Plan.

Blue Cross plan: a nonprofit, tax-exempt health service *prepayment* organization providing coverage for health care and related services. The individual plans should be distinguished from their national association, the *Blue Cross Association*. Historically, the plans were largely the creation of the hospital industry, and designed to provide hospitals with a stable source of revenues, although formal association between the Blue Cross and American Hospital Associations ended in 1972. A Blue Cross plan must be a nonprofit community service organization with a governing body with a membership including a majority of public representatives. Most plans are regulated by State *insurance commissioners* under special enabling legislation. Plans are exempt from Federal income taxes, and, in most States, from State taxes (both property and premium). Unlike most private insurance companies, the plans usually provide *service* rather than *indemnity benefits*, and often pay hospitals on the basis of *reasonable costs* rather than *charges*. There are 70 plans in the United States.
Plan.

capital depreciation: the decline in value of *capital* assets (assets of a permanent or fixed nature, goods and plant) over time with use. The rate and amount of depreciation is calculated by a variety of different methods (e.g., straight line, sum of the digits, declining balance) which often give quite different results. Reimbursement of health services usually includes an amount intended to be equivalent to the capital depreciation experienced by the provider of the services in conjunction with their provision.

capital expenditure review (CER): review of proposed *capital* expenditures of hospitals and/or other health facilities to determine the *need* for, and *appropriateness* of, the proposed expenditures. The review is done by a designated *regulatory* agency such as a *State health planning and development agency* and has a sanction attached which prevents (see *certificate-of-need*) or discourages (see *section 1122*) unneeded expenditures.

carrier: a commercial health *insurer*, a government agency, or a *Blue Cross* or *Blue Shield* plan which *underwrites* or administers programs that pay for health services. Under the *Medicare Part B (Supplemental Medical Insurance) Program* and the *Federal Employees Health Benefits Program*, carriers are agencies and organizations with which the program contracts for administration of various functions, including payment of *claims*. See also *intermediary* and *third party*.

categorically needy: persons who are both members of certain categories of groups eligible to receive public assistance, and economically needy. As used in *Medicaid*, this means a person who is aged, blind, disabled, or a member of a family with children under 18 (or 21, if in school) where one parent is absent, incapacitated or unemployed and, in addition, meets specified *income* and *resources* requirements which vary by State. In general, categorically needy individuals are persons receiving cash assistance under the AFDC or *SSI* programs. A State must cover all recipients of AFDC payments under Medicaid; however, it is provided certain options (based, in large measure, on its coverage levels under the old

Federal/State welfare programs) in determining the extent of coverage for persons receiving Federal SSI and/or State *supplementary SSI payments*. In addition, a State may cover additional specified groups, such as foster children, as categorically needy. A State may restrict its Medicaid coverage to this group or may cover additional persons who meet the categorical requirements as *medically needy*.

categorically related: in the *Medicaid* program, the requirements (other than *income* and *resources*) which an individual must meet in order to be eligible for Medicaid benefits; also individuals who meet these requirements. Specifically, any individual eligible for Medicaid must fall into one of the four main categories of people who are eligible for welfare cash payments. He must be "aged", "blind", or "disabled" (as defined under the *Supplemental Security Income Program*, title XVI of the Social Security Act) or a member of a family with dependent children where one parent is absent, incapacitated, or unemployed (as defined under the Aid to Families with Dependent Children Program, title IV of the Social Security Act). After the determination is made that an individual is categorically related, then income and resources tests are applied to determine if the individual is poor enough to be eligible for assistance (*categorically needy*). As a result of this requirement, single persons and childless couples who are not aged, blind, or disabled and male-headed families in States which do not cover such groups under their AFDC programs cannot receive Medicaid coverage no matter how poor they are.

certificate-of-need or necessity: a certificate issued by a governmental body to an individual or organization proposing to construct or modify a *health facility*, or offer a new or different health *service*, which recognizes that such facility or service when available will be *needed* by those for whom it is intended. Where a certificate is required (for instance for all proposals which will involve more than a minimum *capital* investment or change *bed* capacity), it is a condition of *licensure* of the facility or service, and is intended to control expansion of facilities and services in the public interest by preventing excessive or duplicative development of facilities and services. An example of *capital expenditure review*, certificate of need for construction of new *hospitals* is a requirement of law in 23 States and the District of Columbia. Under the National Health Planning and Resources Development Act of 1974, P.L. 93-641, all States are required to have the *State health planning and development agency* (designated pursuant to the law) administer a State certificate of need program, which must apply to all new *institutional health services* proposed to be offered or developed in the State. The *health systems agencies* (local planning bodies under P.L. 93-641) are required to make recommendations to the State agencies regarding proposed new institutional health services within their areas.

concurrent review: review of the medical *necessity* of *hospital* or other health facility *admissions* upon or within a short period following an admission and the periodic review of services provided during the course of *treatment*. The initial review usually assigns an appropriate *length of stay* to the admission (using *diagnosis* specific *criteria*) which may also be reassessed periodically. Where concurrent review is required, payment for unneeded hospitalizations or services is usually denied. HEW recently issued *utilization review rules* which would have required concurrent review (defined as review within one working day of admission) of all *Medicare* and *Medicaid* cases after July 1, 1975. Admissions which were found unnecessary would not have been reimbursed under either Medicare or Medicaid beyond three days after this finding. As a result of suit by the AMA against implementation of certain portions of these regulations, particularly the concurrent review requirement, implementation of the requirements was enjoined by temporary injunction. HEW is rewriting the regulations. Under the enjoined regulations, review was to be conducted by a physician member or by a qualified nonphysician member of the committee or group assigned the utilization review responsibility in each hospital. Such individual was to be appropriately trained and qualified to perform the assigned review functions, and the review was to use criteria selected or developed by the hospital *utilization review committee* or group. Concurrent review should be contrasted with a retrospective *medical audit*, which is done for *quality* purposes and does not relate to payment, and *claims review*, which occurs after the hospitalization is over.

copayment: a type of *cost sharing* whereby *insured* or covered persons pay a specified flat amount per unit of service or unit of time (e.g., $2 per visit, $10 per inpatient hospital day), their *insurer* paying the rest of the cost. The copayment is incurred at the time the service is used. The amount paid does not vary with the cost of the service (unlike *coinsurance*, which is payment of some percentage of the cost).

cost-related or cost-based reimbursement: one method of payment of medical care programs by *third parties*, typically *Blue Cross* plans or government agencies, for services delivered to patients. In cost-related systems, the amount of the payment is based on the *costs* to the provider of delivering the service. The actual payment may be based on any one of several different formulae, such as full cost, full cost plus an additional percentage, *allowable costs*, or a fraction of costs. Other reimbursement schemes are based on the *charges* for the services delivered, or on budgeted or anticipated costs for a future time period (*prospective reimbursement*). *Medicare*, *Medicaid*, and some *Blue Cross* plans reimburse hospitals on the basis of costs; most private insurance plans pay charges.

costs: expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see *actual*, *allowable*, *direct*, *indirect*, *life*, *marginal* and *opportunity costs*). *Charges*, the price of a service or amount billed an individual or third party, may or may not be the same as, or based on, costs. Hospitals often charge more for a given service than it actually costs in order to recoup losses from providing other services where costs exceed feasible charges. Despite the terminology, cost control programs are often directed to controlling increases in charges rather than in real costs.

cost sharing: provisions of a health *insurance policy* which require the *insured* or otherwise covered individual to pay some portion of his covered medical expenses. Several forms of cost-sharing are employed, particularly *deductibles, coinsurance* and *copayments.* A deductible is a set amount which a person must pay before any payment of *benefits* occurs. A copayment is usually a fixed amount to be paid with each service. Coinsurance is payment of a set portion of the cost of each service. Cost-sharing does not refer to or include the amounts paid in *premiums* for the *coverage.* The amount of the premium is directly related to the benefits provided and hence reflects the amount of cost-sharing required. For a given set of benefits, premiums increase as cost-sharing requirements decrease. In addition to being used to reduce premiums, cost sharing is used to control *utilization* of covered services, for example, by requiring a large copayment for a service which is likely to be overused.

coverage: the guarantee against specific *losses* provided under the terms of an *insurance policy.* Frequently used interchangeably with *benefits* or protection. The extent of the insurance afforded by a policy. Often used to mean insurance or an insurance contract.

credentialing: the recognition of *professional* or technical competence. The credentialing process may include *registration, certification, licensure,* professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of *health manpower* by controlling entrance into *practice,* and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the *quality* of personnel by providing *standards* for evaluating competence, and defining the scope of functions and how personnel may be used.

customary charge: generally, the amount which a physician normally or usually *charges* the majority of his patients. Under *Medicare,* it is the median charge used by a particular physician for a specified type of service during the calendar year preceding the *fiscal year* in which a *claim* is processed. There is therefore, an average delay of a year and a half in recognizing any increase in actual charges. Customary charges in addition to *actual* and *prevailing charges* are taken into account in determining *reasonable charges* under Medicare.

deductible: the amount of loss or expense that must be incurred by an *insured* or otherwise covered individual before an *insurer* will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g. \$100 per calendar year, *benefit period,* or *spell of illness.* Deductibles in existing policies are generally of two types: (1) static deductibles which are fixed dollar amounts, and (2) dynamic deductibles which are adjusted from time to time to reflect increasing medical prices. A third type of deductible is proposed in some *national health insurance* plans: a *sliding scale deductible,* in which the deductible is related to *income* and increases as income increases.

Early and Periodic Screening Diagnosis and Treatment Program (EPSDT): a program mandated by law as part of the *Medicaid* program. The law (section 1905(a)(4)(B) of the Social Security Act) requires that by July 1, 1969, all States have in effect a program for eligible children under age 21 "to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in *regulations* of the Secretary."

Issuance of regulations implementing the program was delayed until November, 1971, and States were allowed to phase in their programs by age groups until July 1, 1973. By law (section 403(g) of the Social Security Act), States which do not have a program in effect in any fiscal quarter after June 30, 1974, for all children in families receiving AFDC payments are subject to a financial penalty. The State programs are not just to pay for services but also to have an active outreach component to inform eligible persons of the benefits available to them, actively to bring them into care so that they can be screened, and, if necessary, to assist them in obtaining appropriate treatment. EPSDT should properly refer only to programs which have all of these elements.

extended care facility (ECF): previously used in *Medicare* to mean a *skilled nursing facility* which qualified for participation in Medicare. In 1972, the law was amended to use the more generic term skilled nursing facility for both Medicare and *Medicaid*. Medicare coverage is limited to 100 days of post hospital *extended care services* during any *spell of illness;* thus Medicare coverage in a skilled nursing facility is limited in duration, must follow a hospital stay, and must be for services related to the cause of the hospital stay. These conditions do not apply to skilled nursing facility benefits under Medicaid. Thus, the continued use of the term "extended care facility benefits" is a kind of shorthand to refer to the benefit limitations on skilled nursing facility care under Medicare.

extended care services: as used in *Medicare*, services in a *skilled nursing facility* provided for a limited duration (up to 100 days during a *spell of illness*) after a hospital stay, and for the same condition as the hospital stay was for. As defined under Medicare, the following items and services furnished to an *inpatient* of a skilled nursing facility are included: *nursing care* provided or supervised by a *registered professional nurse;* bed and board associated with the nursing care; *physical, occupational,* or *speech therapy* furnished by the skilled nursing facility or by others under arrangements with the facility; medical social services; such *drugs, biologicals, supplies,* appliances and *equipment* as are ordinarily used in care and treatment in the skilled nursing facility; medical services provided by an *intern* or *resident* of a hospital with which the facility has a transfer agreement; and other services as are necessary to the *health* of the patients.

fee for service: method of *charging* whereby a physician or other practitioner bills for each *encounter* or service rendered. This is the usual method of billing by the majority of the country's physicians. Under a fee for service payment system, expenditures increase not only if the fees themselves increase but also if more units of service are charged for, or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita or *prepayment* systems, where the payment is not changed with

the number of services actually used or if none are used. While the fee-for-service system is now generally limited to physicians, dentists, podiatrists and optometrists, a number of other practitioners, such as *physician assistants*, have sought reimbursement on a fee for service basis.

fee schedule: a listing of accepted *charges* or established allowances for specified medical or dental procedures. It usually represents either a physician's or *third party's* standard or maximum charges for the listed procedures.

first-dollar coverage: *coverage* under an *insurance* policy which begins with the first dollar of expense incurred by the *insured* for the covered benefits. Such coverage, therefore, has no *deductibles* although it may have *copayments* or *coinsurance.*

fiscal agent or intermediary: a contractor that processes and pays *provider claims* on behalf of a State *Medicaid* agency. Fiscal agents are rarely *at risk*, but rather serve as an *administrative* unit for the State, handling the payment of bills. Fiscal agents may be insurance companies, management firms, or other private contractors. Medicaid fiscal agents are sometimes also *Medicare carriers* or *intermediaries*.

fraud: intentional misrepresentation by either *providers* or *consumers* to obtain services, obtain payment for services, or claim program eligibility. Fraud may include the receipt of services which are obtained through deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received. Fraud is illegal and carries a penalty when proven. See also *abuse*.

generic equivalents: drug products with the same active chemical ingredients sold under the same *generic name* but often with different *brand names*. Generic equivalents are often assumed to be, but are not necessarily, *therapeutic equivalents*. The term has such inconsistent meaning that it must be used with care or avoided.

generic name: the *established*, official, or non-proprietary, name by which a drug is known as an isolated substance, irrespective of its manufacturer. Each drug is *licensed* under a generic name, and also may be given a *brand name* by its manufacturer. The generic name is assigned by the United States Adopted Names Council (USAN), a private group of representatives of the American Medical Association, American Pharmaceutical Association, United States Pharmacopeia and Food and Drug Administration, plus one public member. There have been recent attempts to encourage *physicians* to *prescribe* drugs by generic names whenever possible instead of by brand names. This is said to allow considerable cost savings. Considerable controversy has arisen over whether drugs sold by generic name are in fact *therapeutically equivalent* to their brand-name counterparts. In some cases two versions of the same drug, manufactured by the same or different manufacturers, may not, usually for reasons of *bioavailability*, be therapeutically equivalent. Advocates of generic prescribing question whether such differences are universal or always significant. See also *Maximum Allowable Cost Program* and *antisubstitution*.

health maintenance organization (HMO): an entity with four essential attributes:

(1) an organized system for providing health care in a geographic area, which entity accepts the responsibility to provide or otherwise assure the delivery of

(2) an agreed upon set of *basic* and *supplemental health* maintenance and treatment *services* to

(3) a voluntarily enrolled group of persons, and

(4) for which services the HMO is reimbursed through a predetermined, fixed, periodic *prepayment* made by or on behalf of each person or family unit *enrolled* in the HMO without regard to the amounts of actual services provided. (From the report of the Committee on Interstate and Foreign Commerce on the HMO Act of 1973, P.L. 93-222, in which the term is legally defined, section 1301 of the *PHS Act*.) The HMO is responsible for providing most health and medical care services required by enrolled individuals or *families*. These services are specified in the contract between the HMO and the enrollees. The HMO must employ or contract with health care providers who undertake a continuing responsibility to provide services to its enrollees. The prototype HMO is the Kaiser-Permanente system, a *prepaid group practice* located on the West Coast. However, *medical foundations* sponsored by groups of physicians are included under the definition. HMOs are of public policy interest because the prototypes appear to have demonstrated the potential for providing high *quality* medical services for less money than the rest of the medical system. Specifically, rates of hospitalization and surgery are considerably less in HMOs than occurs in the system outside such prepaid groups, although some feel that earlier care, *skimping* or *skimming* may be better explanations.

health service area: a geographic area appropriate for the effective *planning* and development of health services. Section 1511 of the *PHS Act* requires that health service areas be delineated throughout the United States. The governors of the various States designate the areas using requirements specified in the law respecting geography, political boundaries, population, *health resources* and coordination with areas defined for other purposes.

health systems agency (HSA): a *health planning* and resources development agency designated under the terms of the National Health Planning and Resources Development Act of 1974, P.L. 93-641. P.L. 93-641 requires the designation of an HSA in each of the *health service areas* in the United States. HSAs are to be nonprofit private corporations, public regional planning bodies, or single units of local government, and are charged with performing the health planning and resources development functions listed in section 1513 of the *PHS* Act. The legal structure, size, composition and operation of HSAs are specified in section 1512 of the Act. HSA functions include preparation of a *health system plan* (HSP) and an *annual implementation plan* (AIP), the issuance of grants and contracts, the review and approval or disapproval of proposed uses of a wide range of Federal funds in the agency's health service area, and review of proposed new and existing *institutional health services* and making of recommendations respecting them to *State health planning and development agencies*. HSAs will replace existing *areawide CHP agencies* but with expanded duties and powers.

health system plan (HSP): a long range health plan prepared by a *health systems agency* for its *health service area* specifying the health *goals* considered appropriate by the agency for the area. The HSPs are to be prepared after consideration of national guidelines issued by HEW and study of the characteristics, resources and special needs of the health service area. Section 1513 of the PHS Act requires and specifies the nature of an HSP.

Hill-Burton: legislation, and the programs operated under that legislation, for Federal support of construction and *modernization* of hospitals and other *health facilities*, beginning with P.L. 79-725, the Hospital Survey and Construction Act of 1946. The original law, which has been amended frequently, provided for surveying State *needs*, developing plans for construction of hospitals and public health centers, and assisting in constructing and equipping them. Until the late 1960s, most of the amendments expanded the program in dollar amounts and scope. More recently, the administration has attempted to terminate the program while the Congress has sought to restructure it toward support of *outpatient* facilities, facilities to serve areas deficient in health services, and training facilities for health and allied health professions. Under P.L. 93-641, the National Health Planning and Resources Development Act of 1974, the Hill-Burton program will be administered by the *State health planning and development agency*. The purpose of the existing Hill-Burton programs was modified by P.L. 93-641 to allow assistance in the form of grants, loans or loan guarantees for the following purposes only: modernization of health facilities; construction of outpatient health facilities; construction of inpatient facilities in areas which have experienced recent rapid population growth; and conversion of existing medical facilities for the provision of new health services.

home health care: health services rendered to an individual as *needed* in the home. Such services are provided to aged, disabled, or sick or convalescent individuals who do not need institutional care. The services may be provided by a *visiting nurse association* (VNA), *home health agency*, hospital or other organized community group. They may be quite specialized or comprehensive (nursing services, speech, physical, occupational and rehabilitation therapy, homemaker services, and social services). Under *Medicare*, such services must be provided by a home health agency. Under *Medicaid*, States may, but do not have to, restrict coverage of home health care to services provided by *home health agencies*.

intermediary: a public or private agency or organization selected by *providers* of health care which enters into an agreement with the Secretary of HEW under the *Hospital Insurance Program* (Part A) of *Medicare*, to pay *claims* and perform other functions for the Secretary with respect to such providers. Usually, but not necessarily, a *Blue Cross plan* or private insurance company. See also *carrier* and *fiscal agent*.

Intermediate care facility (ICF): an institution recognized under the *Medicaid* program which is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a *hospital* or *skilled nursing facility* is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. Public institutions for care of the *mentally retarded* or people with related conditions are also included. The distinction between "health-related care and services" and "room and board" has often proven difficult to make but is important because ICFs are subject to quite different *regulation* and coverage than institutions which do not provide health-related care and services. An ICF/MR is an ICF which cares solely or particularly for the mentally retarded.

Kerr-Mills: popular name for the Social Security Amendments of 1960 which expanded and modified the Federal government's existing responsibility for assisting the States in paying for medical care for the aged poor. The Act liberalized Federal sharing in *vendor payments* for medical care under the Federal/State old-age cash assistance program. It also created a new public assistance category—Medical Assistance for the Aged (MAA). The *medically indigent* eligible for assistance under this program were persons age 65 or over whose *incomes* were high enough that they were not eligible for Old Age Assistance but who needed help in meeting the costs of their medical care. The Federal share of medical payments ranged between 50 and 80 percent depending on the per capita income of the States with no limitation on the maximum amount of payment. The Social Security Amendments of 1965 established the *Medicaid* program, which substituted a single program of Federal assistance for medical vendor payments under the categorical cash assistance and MAA programs. The concept of medical indigency was extended to needy disabled, blind, and dependent children and their families. In July, 1970, Federal sharing in vendor payments became available only under Medicaid.

length of stay (LOS): the length of an *inpatient's* stay in a hospital or other *health facility*. It is one measure of use of health facilities, reported as an average number of days spent in a facility per *admission* or discharge. It is calculated as follows: total number of days in the facility for all discharges and *deaths* occurring during a period divided by the number of discharges and deaths during the same period. In *concurrent review* an appropriate length of stay may be assigned each patient upon admission. Average lengths of stay vary and are measured for people with various ages, specific diagnoses, or sources of payment.

license: a permission granted to an individual or organization by competent authority, usually public, to engage in a *practice*, occupation or activity otherwise unlawful. Licensure is the process by which the license is granted. Since a license is needed to begin lawful practice, it is usually granted on the basis of examination and/or proof of education rather then measures of performance. License when given is usually permanent but may be conditioned on annual payment of a fee, proof of *continuing education*, or proof of

competence. Common grounds for revocation of a license include incompetence, commission of a crime (whether or not related to the licensed practice) or moral turpitude. Possession of a medical license from one State may (*reciprocity*) or may not suffice to obtain a license from another. There is no national licensure system for health *professionals*, although requirements are often so nearly standardized as to constitute a national system; see *national boards* and *Federation Licensing Examination.*

Life Safety Code: a fire safety code prepared by the National Fire Protection Association. The provisions of this Code (NFPA, 21st edition, 1967) relating to hospitals and nursing facilities must (except in instances where a waiver is granted) be met by facilities certified for participation under *Medicare* and *Medicaid.* The Secretary of HEW may accept a State's fire and safety code, in lieu of the 1967 edition of the Life Safety Code, if he finds that it is imposed by law and will provide adequate protection for *inpatients* of nursing facilities. The code is based on the Southern Standard Building Code which contains optimum (not minimum) standards.

long-term care: health and/or personal care services required by persons who are chronically ill, aged, disabled, or retarded, in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in *nursing homes*, homes for the retarded and mental hospitals. *Ambulatory services*, like *home health care*, which also can be provided on a long-term basis, are seen as *alternatives to long-term institutional care.*

management: the organization and control of human activity directed toward specific ends. See *administration* for further discussion of these two closely related terms. Different kinds of management are sometimes described: e.g. by exception, in which only exceptions from defined *policy* are reported and acted on; and by *objective*, in which clearly stated objectives are used to guide the management process.

management information system: a system (frequently automated or computer based) which produces the necessary information in proper form and at appropriate intervals for the *management* of a program or other activity. The system should measure program progress toward *objectives* and report costs and problems needing attention. Special efforts have been made in the *Medicaid* program to develop information systems for each State program.

Medicaid (Title XIX): a Federally-aided, State operated and administered program which provides medical *benefits* for certain low-income persons in need of health and medical care. The program, authorized by title XIX of the Social Security Act, is basically for the *poor.* It does not cover all of the poor, however, but only persons who are members of one of the categories of people who can be covered under the welfare cash payment programs—the aged, the blind, the disabled, and members of families with dependent children where one parent is absent, incapacitated or unemployed. Under certain circumstances States may provide Medicaid coverage for children under 21 who are not *categorically related.* Subject to broad Federal guidelines, States determine the benefits covered, *program eligibility*, rates of payment for *providers*, and methods of administering the program. Medicaid is estimated to provide services to some 25 million people, with Federal-State expenditures of approximately $12.5 billion in *fiscal year* 1975.

Medicaid mill: a health program which serves, solely or primarily, *Medicaid* beneficiaries, typically on an *ambulatory* basis. The mills originated in the ghettos of New York City and are still found primarily in urban slums with few other medical *services*. They are usually organized on a for *profit* basis, characterized by their great productivity, and frequently accused of a variety of *abuses* (such as *ping-ponging* and *family ganging*).

Medical Assistance Program: the health care program for the *poor* authorized by title XIX of the Social Security Act, known as *Medicaid*.

medical audit: detailed retrospective review and evaluation of selected *medical records* by qualified *professional* staff. Medical audits are used in some *hospitals*, *group practices*, and occasionally in private, independent practices for evaluating professional performance by comparing it with accepted *criteria*, *standards* and current professional judgment. A medical audit is usually concerned with the care of a given *illness* and is undertaken to identify deficiencies in that care in anticipation of educational programs to improve it.

medical care evaluation studies (MCE studies): retrospective medical care review in which an in-depth assessment of the *quality* and/or nature of the use of selected health services or programs is made. Restudy of an MCE study assesses the *effectiveness* of corrective actions taken to correct deficiencies identified in the original study, but does not necessarily repeat or replicate the original study. *Utilization review* requirements under *Medicare* and *Medicaid* require *utilization review committees* in hospitals and skilled nursing facilities to have at least one such study in progress at all times. Such studies are also required by the *PSRO* program.

medical indigency: the condition of having insufficient *income* to pay for adequate medical care without depriving oneself or *dependents* of food, clothing, shelter, and other essentials of living. Medical indigency may occur when a self-supporting individual, able under ordinary conditions to provide basic maintenance for himself and his *family*, is, in time of catastrophic illness, unable to finance the total cost of medical care. See also *medically indigent*, *spend down*, and *medically needy*.

medically indigent: a person who is too impoverished to meet his medical expenses. It may refer to either persons whose *income* is low enough that they can pay for their basic living costs but not their routine medical care, or alternately, to persons with generally adequate income who suddenly face catastrophically large medical bills. See also *medical indigency*, *medically needy* and *spend down*.

medically needy: in the *Medicaid* program, persons who have enough *income* and *resources* to pay for their basic living expenses (and so do not need welfare) but not enough to pay for their medical care. Medicaid law requires that the standard for income used by a State to determine if someone is medically needy cannot exceed 133 percent of the maximum amount paid to a family of similar size under the welfare program for families with dependent children (AFDC). In order to be eligible as medically needy, people must

fall into one of the categories of people who are covered under the welfare cash assistance programs; i.e., be aged, blind, disabled, or members of families with dependent children where one parent is absent, incapacitated or unemployed. They receive benefits if their income after deducting medical expenses (see *spend down*) is low enough to meet the eligibility standard. Thirty-two States now provide Medicaid coverage to the medically needy.

medically underserved area: a geographic location (i.e., an urban or rural area) which has insufficient *health resources* (manpower and/or facilities) to meet the medical *needs* of the resident population. *Physician shortage area* applies to a medically underserved area which is particularly short of physicians. Such areas are also sometimes defined by measuring the *health status* of the resident population rather than the supply of resources, an area with an unhealthy population being considered underserved. The term is defined and used several places in the *PHS Act* in order to give priority to such areas for Federal assistance.

medical review: review, required by *Medicaid*, by a team composed of physicians and other appropriate health and social service personnel of the condition and need for care, including a medical evaluation, of each *inpatient* in a *long-term care facility*. By law, the team must review the: care being provided in the facilities; adequacy of the services available in the facilities to meet the current health *needs* and promote the maximum physical well-being of the patients; *necessity* and desirability of the continued placement of such patients in the facilities; and feasibility of meeting their health care needs through alternate institutional or noninstitutional services. Medical review differs from *utilization review* in that it requires evaluation of each individual patient and an analysis of the *appropriateness* of his specific treatment in a given institution, whereas utilization review is often done on a sample basis, with special attention to certain procedures, conditions or *lengths of stay*.

Medical Services Administration (MSA): the bureau which *administers* the *Medicaid* program at the Federal level. It is part of the *Social and Rehabilitation Service*, which administers most of the welfare programs within the Department of Health, Education, and Welfare. It is an organization of approximately 200 people in Washington's central office and 100 people in the ten HEW regional offices. Direct administration of Medicaid programs is carried out by the States.

Medicare (Title XVIII): a nationwide health insurance program for people aged 65 and over, for persons eligible for social security disability payments for over two years, and for certain workers and their dependents who need kidney transplantation or dialysis. Health insurance protection is available to *insured* persons without regard to *income*. Monies from *payroll taxes* and *premiums* from *beneficiaries* are deposited in special *trust funds* for use in meeting the expenses incurred by the insured. The program was enacted July 30, 1965, as title XVIII—Health Insurance for the Aged—of the Social Security Act, and became effective on July 1, 1966. It consists of two separate but coordinated programs: *hospital insurance* (Part A), and *supplementary medical insurance* (Part B).

nursing homes: generally, a wide range of institutions, other than hospitals, which provide various levels of maintenance and personal or *nursing care* to people who are unable to care for themselves and who may have health problems which range from minimal to very serious. The term includes free standing institutions, or identifiable components of other *health facilities* which provide nursing care and related services, personal care, and residential care. Nursing homes include *skilled nursing facilities, intermediate care facilities,* and *extended care facilities* but not *boarding homes.*

open-ended programs: in the Federal *budget,* entitlement programs for which eligibility requirements are determined by law, e.g., *Medicaid.* Actual *obligations* and resultant *outlays* are limited only by the number of eligible persons who apply for *benefits* and the actual benefits received.

optional services: services which may be provided or covered by a health program or *provider* and, if provided, will be paid for in addition to any *required services* which must be offered. In addition to the required services under *Medicaid,* if States elect to include any of the optional services in their programs, matching funds under *title XIX* are available. The optional services States may offer are the following: *prescribed drugs* (covered by 50 out of 53 States and jurisdictions); clinic services (offered by 41); *dental* services (41); eyeglasses (38); private duty *nursing* (21); *skilled nursing facility services* for individuals under 21 (42); care for patients under 21 in psychiatric hospitals (25); *intermediate care facility* services (49); prosthetic *devices* (43); *physical therapy* and related services (35); other *diagnostic, screening, preventive* and *rehabilitation* services (25); *optometrists'* services (37); *podiatrists'* services (39); *chiropractors'* services (27); care for persons 65 or older in institutions for *mental diseases* (41); and care for patients 65 or older in tuberculosis institutions (31). States may also offer any "medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their *practice* as defined by State law" that is not specifically excluded from coverage by title XIX (the exclusions are: care or services for inmates of public nonmedical institutions; *inpatient* services in a mental institution for individuals over 20 and under 65; and services for persons under 65 in a tuberculosis institution).

outpatient medical facility: a facility designed to provide a limited or full spectrum of *health* and medical services (including health education and maintenance, *preventive* services, *diagnosis, treatment,* and *rehabilitation*) to individuals who do not require hospitalization or institutionalization (*outpatients*).

ownership disclosure: disclosure by a health program of all ownership interests in the program. By law, each *skilled nursing facility* participating in *Medicare* and *Medicaid* must supply ownership information to the State survey agency and each *intermediate care facility* must supply such information to the State licensing agency. Full and complete information must be supplied on the identity of: each person having (directly or indirectly) an ownership interest of ten percent or more in such facility; in the case of a facility organized as a corporation, each officer and director of the corporation; and in case the facility is organized as a partnership, each partner. Any changes which affect the accuracy of this information must be promptly reported.

participation (participating): a *physician* participates in an *insurance* plan when he agrees to accept the plan's preestablished fee or *reasonable charge* as the maximum amount which can be collected for services rendered. A non-participating physician may charge more than the insurance program's maximum allowable amount for a particular service. The patient is then liable for the excess above the allowed amount. This system was developed in the private sector as a method of providing the *insured* with specific health care services at no *out-of-pocket* costs. The term is used more loosely in *Medicare* and *Medicaid* to mean any physician who accepts reimbursement from either program. Approximately half of Medicare claims are paid to physicians who participate by accepting *assignment.* Any physician accepting Medicaid payments must accept them as payment in full. A hospital or other health program is called a participating *provider* when it meets the various requirements of, and accepts reimbursement from, a public or private health insurance program.

peer review: generally, the evaluation by *practicing physicians* or other *professionals* of the *effectiveness* and *efficiency* of services ordered or performed by other practicing physicians or other members of the profession whose work is being reviewed (peers). Frequently refers to the activities of the *Professional Standards Review Organizations* (PSRO) which in 1972 were required by P.L. 92-603 to review services provided under the *Medicare, Medicaid,* and *Maternal and Child Health* programs. Local PSROs, which receive Federal guidance and funding from HEW, are staffed by local physicians, osteopaths, and non-physicians. Their duties include the establishment of *criteria, norms* and *standards* for *diagnosis* and *treatment* of *diseases* encountered in the local PSRO jurisdiction, and review of services that are inconsistent with the established norms, e.g., hospital stays longer than the normal *length of stay.* The norms may be *input, process,* or *outcome measures.* Peer review has been advocated as the only possible form of *quality control* for medical services because it is said that only a physician's professional peers can judge his work. It has been criticized as having inherent conflict of interest, since, it is said, a physician will not properly judge those who will judge him, and also as not adequately reflecting *patient* objectives and points of view.

ping-ponging: the practice of passing a *patient* from one *physician* to another in a health program for unnecessary cursory examinations so that the program can charge the patient's *third-party* for a physician *visit* to each physician. The practice and term originated and is most common in *Medicaid mills.*

prepaid group practice: an arrangement where a formal association of three or more physicians provides a defined set of services to persons over a specified time period in return for a fixed periodic *prepayment* made in advance of the use of service.

prepaid health plan (PHP): generically, a contract between an *insurer* and a *subscriber* or group of subscribers whereby the PHP provides a specified set of health *benefits* in return for a periodic *premium.* The term now usually means organizational entities in California which provide services to Medi-Cal (the name for California's *Medicaid* program) beneficiaries under contract with the State of

California.* In the latter instance, provision was made under the Medi-Cal Reform Program of 1971 for Medi-Cal administrators to contract with groups of medical providers to supply specified services on a prepaid, per capita basis. These entities have been the subject of much controversy regarding the *cost* and *quality* of their services, see *skimping*.

prevailing charge: a *charge* which falls within the range of charges most frequently used in a *locality* for a particular medical *service* or procedure. The top of this range establishes an over-all limitation on the charges which a *carrier*, which considers prevailing charges in reimbursement, will accept as *reasonable* for a given service, without adequate special justification. Current *Medicare rules* state that the limit of an area's prevailing charge is to be the 75th percentile of the *customary charges* for a given service by the *physicians* in a given area. For example, if customary charges for an appendectomy in a locality were distributed so that 10 percent of the services were rendered by physicians whose customary charge was $150, 40 percent by physicians who charged $200, 40 percent who charged $250, and 10 percent who charged $300 or more, then the prevailing charge would be $250, since this is the level that, under Medicare regulations, would cover at least 75 percent of the cases.

preventive medicine: care which has the aim of preventing *disease* or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive *medicine* developed subsequent to bacteriology, and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. With increasing knowledge of nutritional, malignant and other *chronic diseases*, the scope of preventive medicine has been extended. It is now operatively assumed that most if not all problems are preventable at some stage of their development. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of our environment and our relations with it through such things as avoidance of hazardous substances, modified diet, and *family planning*. In particular, the promotion of health through altering behavior, especially by health education, is gaining prominence as a component of preventive care.

primary care: basic or general health care which emphasizes the point when the *patient* first seeks assistance from the medical care system and the care of the simpler and more common *illnesses*. The primary care *provider* usually also assumes ongoing responsibility for the patient in both *health* maintenance and *therapy* of illness. It is comprehensive in the sense that it takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral or social. The appropriate use of *consultants* and community resources is an important part of effective primary care. Such care is generally provided by *physicians*, but is increasingly provided by other personnel such as family *nurse practitioners*.

primary payer: denotes *insurer* obligated to pay *losses* prior to any liability of other, secondary insurers. Under current law, *Medicare* is a primary payer with respect to *Medicaid*; for a person eligible under both programs, Medicaid pays only for *benefits* not covered under Medicare, or after Medicare benefits are exhausted.

prior authorization: requirement imposed by a *third party*, under some systems of *utilization review*, that a *provider* must justify before a *peer review* committee, insurance company representative, or State agent the *need* for delivering a particular *service* to a *patient* before actually providing the service in order to receive reimbursement. Generally, prior authorization is required for non-emergency services which are expensive (involving a hospital stay, *preadmission certification*, for example) or particularly likely to be overused or *abused* (many State *Medicaid* programs require prior authorization of all *dental* services, for instance).

Professional Standards Review Organization (PSRO): a physician-sponsored organization charged with comprehensive and on-going review of *services* provided under the *Medicare*, *Medicaid* and *Maternal and Child Health* programs. The purpose of this review is to determine for purposes of reimbursement under these programs whether services are: medically *necessary;* provided in accordance with professional *criteria*, *norms* and *standards;* and, in the case of institutional services, rendered in an *appropriate* setting. The requirement for the establishment of PSROs was added by the Social Security Amendments of 1972, P.L. 92-603, to the Social Security Act as part B of title XI. PSRO areas have been designated throughout the country and organizations in many of these areas are at various stages of implementing the required review functions.

profile: a longitudinal or cross-sectional aggregation of medical care data. *Patient* profiles list all of the *services* provided to a particular patient during a specified period of time. *Physician*, hospital, or population profiles are statistical summaries of the pattern of *practice* of an individual physician, a specific hospital, or the medical experience of a specific population. Diagnostic profiles are a subcategory of physician, hospital, or population profiles with regard to a specific condition or *diagnosis*.

profit: the gain made by the sale of a good or *service* after deducting the value of the labor, materials, rents, interest on *capital* and other expenses involved in the production of the good or service. Economists define profit as return to (or on) capital investment, and distinguish normal (competitive) and excessive (more than competitive) profit. Profit in the sense of a profit-making or *proprietary* institution is present when any of the net earnings of the institution inure to the benefit of any individual. . .

prospective reimbursement: any method of paying *hospitals* or other health programs in which amounts or rates of payment are established in advance for the coming year and the programs are paid these amounts regardless of the costs they actually incur. These systems of reimbursement are designed to introduce a degree of constraint on *charge* or *cost* increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved *efficiency* by sharing savings with institutions that perform at lower than anticipated costs. Prospective reimbursement contrasts with the method of payment presently used under *Medicare* and *Medicaid* where institutions are reimbursed for actual expenses incurred, i.e., on a *retrospective* basis. See also *section 222*.

provider: an individual or institution which gives medical care. In *Medicare*, an institutional provider is a *hospital*, *skilled nursing facility*, *home health agency*, or certain providers of outpatient *physical therapy services*. These providers receive *cost-related reimbursement*. Other Medicare providers, paid on a *charge* basis, are called *suppliers*. Individual providers include individuals who *practice* independently of institutional providers. The term must sometimes be distinguished from *consumer*, for instance when requiring consumer representation in a health program. For these purposes P.L. 93-641 defines the term for individuals as follows (section 1531(3) of the PHS Act):

(3) The term "provider of health care" means an individual—

(A) who is a direct provider of health care (including a *physician*, *dentist*, *nurse*, *podiatrist*, or *physician assistant*) in that the individual's primary current activity is the provision of health care to individuals or the *administration* of facilities or institutions (including hospitals, *long-term care facilities*, *outpatient facilities* and *health maintenance organizations*) in which such care is provided and, when required by State law, the individual has received *professional* training in the provision of such care or in such administration and is *licensed* or *certified* for such provision or administration; or

(B) who is an indirect provider of health care in that the individual—

(i) holds a *fiduciary* position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual *income* from any one or combination of the following:

(I) fees or other compensation for research into or instruction in the provision of health care.

(II) entities engaged in the provision of health care or in such research or instruction.

(III) producing or supplying *drugs* or other articles for individuals or entities for use in the provision of, research into or instruction in the provision of health care.

(IV) entities engaged in producing drugs or such other articles.

(iii) is a member of the immediate *family* of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

(iv) is engaged in issuing any policy or contract of individual or group health *insurance* or hospital or medical service benefits.

quality assurance: activities and programs intended to assure the *quality* of care in a defined medical setting or program. Such programs must include educational or other components intended to remedy identified deficiencies in quality, as well as the components necessary to identify such deficiencies (such as *peer* or *utilization review* components) and assess the program's own *effectiveness*. A program which identifies quality deficiencies and responds only with negative sanctions, such as denial of reimbursement, is not usually considered as a quality assurance program, although the latter may include use of such sanctions. Such programs are required of *HMOs* and other health programs assisted under authority of the *PHS Act* (e.g., section 1301(c)(8)).

reasonable charge: for any specific *service* covered under *Medicare*, the lower of the *customary charge* by a particular *physician* for that service and the *prevailing charge* by physicians in the geographic area for that service. Reimbursement is based on the lower of the *reasonable* and *actual charges*. For example, suppose the prevailing charge for a fistulectomy is $100 in a certain *locality*, i.e., this is the 75th percentile of the customary charges for that service by the physicians in that locality. Dr. A's actual charge is $75, although he customarily charges $80 for the procedure; Dr. B's actual charge is his customary charge of $85; Dr. C's is his customary charge of $125; Dr. D's is $100, although he customarily charges $80; and there are no special circumstances in any case. The reasonable charge for Dr. A would be $75 since the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and below the prevailing charge for the locality. The reasonable charge for Dr. B would be $85, because his customary charge is lower than the prevailing charge for that locality. The reasonable charge for Dr. C would be $100, the prevailing charge for his locality. The reasonable charge for Dr. D would be $80, because that is his customary charge which is lower than the actual charge in this particular case. His reasonable charge cannot exceed his customary charge in the absence of special circumstances, even though his actual charge of $100 is the same as the prevailing charge. Generically, the term is used for any charge payable by an *insurance* program which is determined in a similar, but not necessarily identical fashion.

reasonable cost: generally the amount which a *third party* using *cost-related reimbursement* will actually reimburse. Under *Medicare* reasonable costs are costs actually incurred in delivering health *services* excluding any part of such incurred costs found to be unnecessary for the *efficient* delivery of *needed* health services (see section 1861 of the Social Security Act). The law stipulates that, except for certain *deductible* and *coinsurance* amounts that must be paid by *beneficiaries*, payments to hospitals shall be made on the basis of the reasonable cost of providing the covered services. The Secretary of HEW has prescribed *rules* setting forth the method or methods to be used and the items to be included in determining the reasonable cost of covered care. The regulations require that costs be apportioned between Medicare beneficiaries and other hospital *patients* so that neither group subsidizes the costs of the other. The items or elements of cost, both *direct* and *indirect*, which the regulations specify as reimbursable are known as *allowable costs*. Such costs are reimbursable on the basis of a hospital's actual costs to the extent that they are reasonable and are related to patient care. Under certain conditions the following items may be included as allowable costs: *capital depreciation;* interest expenses; educational activities; research costs related to patient care; unrestricted grants, gifts and income from endowments; value of services of non-paid workers, compensation of owners; payments to related organizations; return on equity *capital* of *proprietary* providers; and the *inpatient* routine *nursing differential*. *Bad debts* may only be included to the extent institutions fail in good faith efforts to collect the debts. See also *section 223*.

retrospective reimbursement: payment to *providers* by a *third party carrier* for *costs* or *charges* actually incurred by *subscribers* in a previous time period. This is the method of payment used under *Medicare* and *Medicaid*.

section 222: a section of the Social Security Amendments of 1972, P.L. 92-603, which authorizes the Secretary of HEW to undertake, with respect to *Medicare*, studies, experiments or demonstration *projects* on: *prospective reimbursement* of *facilities*, ambulatory surgical centers (*surgicenters*), intermediate care and *homemaker services* (with respect to the *extended care benefit* under Medicare); elimination or reduction of the three-day prior hospitalization requirement for *admission* to a *skilled nursing facility;* determination of the most appropriate methods of reimbursing the services of *physicians' assistants* and *nurse practitioners;* provision of day care services to older persons eligible under Medicare and *Medicaid;* and possible means of making the services of *clinical psychologists* more generally available under Medicare and Medicaid. Studies, experiments and demonstration projects are now in progress in most of these areas.

section 223: a section of the Social Security Amendments of 1972, P.L. 92-603, which requires the Secretary to establish limits on overall *direct* or *indirect costs* which will be recognized as *reasonable* under *Medicare* for comparable *services* in comparable *facilities* in an area. The Secretary is also permitted to establish maximum acceptable costs in such facilities with respect to items or groups of services (for example, food or standby costs). The *beneficiary* is liable (except in the case of *emergency care*) for any amounts determined as excessive (except that he may not be charged for excessive amounts in a facility in which his admitting *physician* has a direct or indirect ownership interest). Under *rules* issued for this section, reimbursement for hospital *inpatient* routine service costs is limited, effective July 1, 1975, to a figure derived from the 80th percentile (plus 10 percent of the median) for each class of hospitals. Classification of hospitals is based on whether the hospital is located in a Standard Metropolitan Statistical Area (SMSA) or not, per capita *income* in the area, and hospital *bed* capacity. The total number of hospital classes is 32.

section 224: a section of the Social Security Amendments of 1972, P.L. 92-603, which places a limit for purposes of *Medicare* and *Medicaid* reimbursement on *charges* recognized as *reasonable*. The law recognizes as reasonable those charges which fall within the 75th percentile of all charges for a similar *service* in a *locality*. Increases in *physicians'* fees allowable for Medicare purposes are *indexed* to a factor which takes into account increased costs of *practice* and the increase in general earnings levels in an area. Under recently issued *regulations* the index factor for fiscal 1976 is 1.179.

section 1122: a section of the Social Security Act added by P.L. 92-603. The section provides that payments will not be made under *Medicare* or *Medicaid* with respect to certain disapproved *capital* expenditures determined to be inconsistent with State or local health plans. P.L. 93-641, the National Health Planning and Resources Development Act of 1974, requires States participating in the section 1122 program to have the new *State health planning and development agency* serve as the section 1122 agency for purposes of the required review.

skilled nursing facility (SNF): under *Medicare* and *Medicaid*, an institution (or a distinct part of an institution) which has in effect a transfer agreement with one or more *participating hospitals* and which:

is primarily engaged in providing skilled nursing care and related services for *patients* who require medical or *nursing care*, or *rehabilitation* services for the rehabilitation of *injured, disabled* or *sick* persons;

has formal policies, which are developed with the advice of a group of *professional* personnel, including one or more *physicians* and one or more *registered nurses*, to govern the skilled nursing care and related medical or other services it provides;

has a physician, a registered professional nurse or a medical staff responsible for the execution of such policies;

has a requirement that the health care of every patient be under the supervision of a physician, and provides for having a physician available to furnish *necessary* medical care in case of an emergency;

maintains *medical records* on all patients;

provides 24-hour nursing service and has at least one registered professional nurse employed full time. Effective October 30, 1972, the 1972 Amendments permit the Secretary of HEW, to the extent that this provision may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, to waive the requirement if he finds that certain conditions are met;

provides *appropriate* methods and procedures for the dispensing and administering of *drugs* and *biologicals*;

has in effect a *utilization review* plan which meets the requirements of the law;

in the case of an institution in any State in which State or applicable local law provides for the *licensing* of institutions of this nature, is licensed pursuant to such law, or is approved, by the agency of the State or *locality* responsible for licensing institutions of this nature, as meeting the *standards* established for such licensing;

has in effect an overall plan and *budget*, including an annual operating budget and a three-year *capital* expenditures plan;

effective July 1, 1973, supplies full and complete information to the Secretary as to the identity of each person having (directly or indirectly) an ownership interest of ten percent or more in the facility, in the case of a skilled nursing facility organized as a corporation, of each officer and director of the corporation, and in the case of a skilled nursing facility organized as a partnership, of each partner; and promptly reports any changes which would affect the current accuracy of the information so required to be supplied;

effective July 1, 1973, cooperates in an effective program that provides for a regular program of independent *medical review* of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

effective July 1, 1973, meets such provisions of the *Life Safety Code* as are applicable to *nursing homes*; except that the Secretary may waive, for such periods as he deems *appropriate*, specific pro-

visions of the Code that if rigidly applied would result in unreasonable hardship for a nursing home, but only if such waiver will not adversely affect the *health* and *safety* of the patients (except, the provisions of the Code will not apply in any State if the Secretary finds that in the State there is in effect a fire and safety code, imposed by State law, that adequately protects patients in nursing facilities); and

meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary. Effective October 30, 1972, the Secretary is prohibited from requiring, as a *condition of participation*, that a skilled nursing facility furnish medical social services to its patients. However, when these services are provided, it is expected that they conform to recognized standards (see section 1861 of the Social Security Act).

Social and Rehabilitation Service (SRS): the *administration* within HEW which manages welfare and related programs including *Medicaid*, which is the responsibility of SRS's *Medical Services Administration*. Since SRS is not under the direction of HEW's Assistant Secretary for Health, this means that Medicaid is administered separately from the Department's other health programs.

spend down: a method by which an individual establishes eligibility for a medical care program by reducing gross *income* through incurring medical expenses until net income (after medical expenses) becomes low enough to make him eligible for the program. The individual, in effect, spends income down to a specified eligibility standard by paying for medical care until his bills become high enough in relation to income to allow him to qualify under the program's *standard* of *need*, at which point the program *benefits* begin. The spend-down is the same as a *sliding scale deductible* related to the over-all income level of the individual. For example, if persons are eligible for program benefits if their income is $200/month or less, a person with a $300/month income would be covered after spending $100 *out-of-pocket* on medical care; a person with an income of $350 would not be eligible until he incurred medical expenses of $150. The term spend-down originated in the *Medicaid* program. An individual whose income makes him ineligible for welfare but is insufficient to pay for medical care, can become Medicaid-eligible as a *medically needy* individual by spending some income on medical care. Medicaid only covers an individual if aged, blind, disabled, or a member of a family where one parent is absent, incapacitated, or unemployed—that is, fitting one of the categories of individuals who are covered under the welfare cash payment programs.

standards: generally, a measure set by competent authority as the rule for measuring quantity or *quality*. Conformity with standards is usually a condition of *licensure, accreditation*, or payment for *services*. Standards may be defined in relation to: the actual or predicted effects of care; the performance or credentials of *professional* personnel; and the physical plant, governance and *administration* of *facilities* and programs. In the *PSRO* program, standards are professionally developed expressions of the range of acceptable variation from a *norm* or *criterion*. Thus, the criteria for care of a urinary tract infection might be a urinalysis and urine culture and the standard might require a urinalysis in 100 percent of cases and a urine culture only in previously untreated cases.

State cost commissions: State agencies assigned various health *services cost* and *charge regulation* or review responsibilities. The duties of a commission may include assuring that: total hospital costs are reasonably related to total services offered; aggregate rates bear a reasonable relationship to aggregate costs; and rates are applied equitably to preclude any possibility of discriminatory pricing among various services and patients of a hospital.

State health planning and development agency (SHPDA): section 1521 of the *PHS Act,* added by P.L. 93-641, requires the establishment of State health planning and development agencies in each State. As a replacement for existing *State CHP agencies,* SHPDAs will prepare an annual preliminary State health plan and the State medical facilities plan *(Hill-Burton).* The agency will also serve as the designated review agency for purposes of *section 1122* of the Social Security Act and administer a *certificate-of-need* program.

Statewide health coordinating council (SHCC): a State council of *providers* and *consumers* (who shall be in the majority) required by section 1524 of the *PHS Act,* added by P.L. 93-641. Each SHCC generally will supervise the work of the *State health planning and development agency,* and review and coordinate the plans and *budgets* of the State's *health systems agencies* (HSA). It will also annually prepare a State health plan from HSA plans and the preliminary plans of the State agency. The SHCC will also review applications for HSA planning and resource development assistance.

third-party payer: any organization, public or private, that pays or *insures* health or medical expenses on behalf of *beneficiaries* or recipients (e.g. *Blue Cross* and *Shield,* commercial insurance companies, *Medicare,* and *Medicaid*). The individual generally pays a *premium* for such coverage in all private and some public programs. The organization then pays bills on his behalf; such payments are called third party payments and are distinguished by the separation between the individual receiving the *service* (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party).

Title XVIII: the title of the Social Security Act which contains the principal legislative authority for the *Medicare* program, and therefore a common name for the program.

Title XIX: the title of the Social Security Act which contains the principal legislative authority for the *Medicaid* program, and therefore a common name for the program.

uniform cost accounting: the use of a common set of accounting definitions, procedures, terms, and methods for the accumulation and communication of quantitative data relating to the financial activities of several enterprises. The American Hospital Association, for example, encourages the use of its Chart of Accounts as a system which can be employed by *hospitals* in the United States.

usual, customary and reasonable plans (UCR): health *insurance* plans that pay a *physician's* full *charge* if: it does not exceed his usual charge; it does not exceed the amount customarily charged for the service by other physicians in the area (often defined as the 90 or 95 percentile of all charges in the community), or it is otherwise *reasonable*. In this context, usual and customary charges are similar, but not identical, to *customary* and *prevailing charges*, respectively, under *Medicare*. Most private health insurance plans, except for a few *Blue Shield plans*, use the UCR approach.

utilization: use. Utilization is commonly examined in terms of patterns or rates of use of a single *service* or type of service, e.g., *hospital* care, *physician visits*, *prescription drugs*. Measurement of utilization of all medical services in combination is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population *at risk* for a given period, e.g., number of *admissions* to hospital per 1,000 persons over 65 per year, or number of visits to a physician per person per year for *family planning* services.

utilization review (UR): evaluation of the *necessity, appropriateness* and *efficiency* of the use of medical *services*, procedures and *facilities*. In a hospital this includes review of the appropriateness of *admissions*, services ordered and provided, *length of stay*, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a *utilization review committee, PSRO, peer review* group, or public agency.

utilization review committee: a staff committee of an institution or a group outside the institution responsible for conducting *utilization review* activities for that institution. *Medicare* and *Medicaid* require as a *condition of participation* that *hospitals* have a utilization review committee in operation.

vendor: a *provider;* an institution, agency, organization or individual practitioner who provides health or medical *services*. *Vendor payments* are those payments which go directly to such institutions or providers from a *third party* program like *Medicaid*.

vendor payment: used in public assistance programs to distinguish those payments made directly to *vendors* of service from those cash income payments made directly to assistance recipients. The vendors, or providers of health services, are reimbursed directly by the program for services they provide to eligible recipients. Vendor payments are essentially the same as *service benefits* provided under health *insurance* and *prepayment* plans.

APPENDIX IV

Colorado Blue Cross-Blue Shield
Description of Membership Categories

The membership of Colorado Blue Cross-Blue Shield is grouped into the following major categories: Merit Rated Groups, Community Rated Groups, Non-Group, National Account and Miscellaneous Groups, Medicare Supplemental, and Federal Employees program.

Merit Rated Groups. This category consists of all local groups with an enrollment of 25 or more subscribers. Rates are determined independently for each group by utilizing a formula which considers the income and claims experience of that particular group in comparison with all other Merit Rated Groups. As of June 1, 1976, there were 905 groups, with a Blue Cross subscriber membership of 143,297 and a Blue Shield subscriber membership of 142,033. The Merit Rated category has the largest number of subscribers, as compared with the other categories underwritten by the Blues.

Community Rated Groups. This category consists of local groups with enrollment of 3 to 24 subscribers. The income and claims experience for this entire category of business is used, along with projection factors, to establish two sets of rates -- a high and a low -- applicable to all groups. The claims experience of the particular group determines whether it receives the set of high rates or the set of low rates.

As of May 31, 1976, there were 7,581 Community Rated groups with a Blue Cross subscriber membership of 42,887 and a Blue Shield membership of 42,710.

Non-group. This category consists of individual enrollees and those who have converted from group coverage. This group consists primarily of persons who are not eligible for group enrollment.

National Account and Miscellaneous Groups. This category consists of groups which are rated on a basis similar to that of the Merit Rated Groups, but the formula is modified by special agreements with the groups, other Blue Shield/Cross plans, and the National Association of Blue Shield Plans. These groups are not limited to Colorado residents and their rates are not entirely within the control of the Colorado Blue Shield, but they are subject to those other agreements and formulas which are being used.

Medicare Related Contracts. These plans supplement the coverage provided under Medicare. The so-called Medicare "carve-out" provides coverage in addition to Medicare which brings an individual's coverage up to the level of the coverage provided in a particular group. The Medicare Supplemental plan provides major medical coverage.