An Alternate Approach to Hospital Cost Control: the Rochester Project

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THE ADMINISTRATION'S FIRST SALVO in the war on the nation's health care costs was the Hospital Cost Containment Act of 1977 (Senate 1391 and House of Representatives 6575). This war fulfills a commitment President Carter made during his campaign. This paper does not present an analysis of this bill, but rather raises some questions about the methods of State or Federal control of costs and describes a possible alternative, the Rochester MAXICAP Project.

The Problem

Despite the agreement in many quarters on the need to control health care costs in general (and hospital costs in particular), there seems to be no agreement on the method for effecting the necessary changes. The Secretary of the Department of Health, Education, and Welfare has generated considerable controversy by proposing the Hospital Cost Containment Act, but even the proposal's strongest critics agree that efforts must be made to contain health care costs.

In 1950 health care expenditures accounted for 4.6 percent of the gross national product (GNP). By 1976 that proportion had nearly doubled—reaching 8.6 percent. Hospital costs as a percentage of health care costs rose between 1950 and 1976 from about 30 percent to nearly 40 percent. In terms of the GNP, the proportion devoted to hospital care went from 1.7 percent to 3.2 percent—nearly a twofold increase—in an even shorter period, 1960–75 (*1*). The causes of this rise in hospital prices and expenditures have been described in many places and need not be reiterated here (*2–6*).

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The watershed of this chain of events was the passage of the Social Security Amendments of 1965, creating Medicare and Medicaid, amendments which, upon subsequent modifications, have been followed by a proliferation of rules and a concomitant expansion of the regulatory domain at both the Federal and State levels. Perhaps the most transparent illustration of the extensiveness of prolix and overlapping regulations is the datum in a recent report of the Hospital Association of New York State indicating that no less than 164 distinct regulatory agencies have some jurisdiction over hospitals in the State (*7*). Many of the regulations these agencies issue have the effect of controlling costs, but others result in increased costs.

The latest governmental efforts at containing hospital costs have been in the areas of prospective payment and prospective revenue, or cost "caps." The two most salient issues concerning cost "caps" on revenue are (*a*) How effective is this method for controlling hospital costs? (*b*) How equitable is this method in meeting the disparate hospital care needs of citizens in different geographic areas? An examination of the situation in New York State is of more than parochial interest to all Americans in view of the proposed national Hospital Cost Containment Act and the experience the State has had with both issues.

New York State's Experience

Per capita spending for health care in New York State is the highest in the country—40 percent higher than the national average. Among the major factors contributing to the State's financial difficulties has been its Medicaid program, which costs $3 billion annually. This sum is 23 percent of all the Medicaid monies spent in the entire United States, although only 8.5 percent of the U.S. population live in New York (*8*).

In an effort to ease governmental budgets, New York State has pursued three kinds of efforts to cut costs in its Medicaid program: (*a*) it has attempted to eliminate "unnecessary payments" through utilization review and rigorous efforts to discover fraud and abuse (*2,9*); (*b*) having reexamined its earlier liberal interpretations of "medical indigency" and covered services, it has cut back on both the eligibility and benefits that the Federal Government permits but does not require of States; (*c*) it has proposed that Medicaid reimbursement rates for outpatient and emergency services be frozen through 1979 at 1975 levels and has granted only modest increases in Medicaid inpatient reimbursement rates. The rising hospital costs in the private sector, however, threatened to widen the gulf between Medicaid care and the care provided to those who could afford to pay at rates that were neither frozen at 1975 levels nor held to minimal increases. The State's response was to attempt to set ceilings for Blue Cross hospital reimbursement by coupling them with Medicaid rates. But because Blue Cross accounts for more than twice as many total hospital days as does Medicaid, the exercise of leverage over the health care system by controlling the major source of nongovernmental financing of hospital care has greatly magnified the financial difficulties of hospitals.

Under the formula for Medicaid reimbursement in New York, the State pays $1, the county $1, and the Federal Government $2, for a total of $4. Yet, because of the coupling mechanism and the unequal proportions of health care costs paid by Blue Cross and Medicaid, eight additional Blue Cross dollars will be denied under the regulation that stops the $4 of Medicaid spending. To save the State $1, the health care institutions of the State are denied $12. Thus, reducing the State Medicaid budget by $20 million results in reducing the annual income of the hospitals of the State by $240 million. (These calculations were presented in a letter dated February 24, 1977, from George A. Allen, president of the Hospital Association of New York State (HANYS), which was addressed to the chief executive officers of all HANYS member institutions). Although, obviously, the State's actions were prompted by its general fiscal crisis, they have placed the acute general hospitals, and particularly the teaching hospitals, in a difficult situation.

Perhaps the most highly publicized of the other elements in the State's plan to control hospital costs is the reduction of hospital beds. In his State of Health message of February 17, 1977, Governor H. L. Carey reported that there were 79,028 acute care beds in the State, either in existence, under construction, or approved for construction, and he announced his intention to reduce this number by more than 11,000 by 1980. This announcement is particularly ironic because the State, which has had Certificate of Need legislation since 1964, had earlier approved the building of many of the beds it now proposes to close. However, recent events in New York State suggest that in an election year a proposal to eliminate beds is a highly volatile issue. In the fall of 1977, after a 4-year review of obstetrical beds in the Rochester region, the Finger Lakes Health Systems Agency (FLHSA) recommended the elimination of five obstetrical units. Nevertheless, Governor Carey stated during visits to the region during the next few months that two of the units would not be closed, and shortly thereafter the State Office of Health Systems Management announced that for at least another 18 months none of those beds would be closed because the "personal factor" had not received proper weight in the State's deliberations (*10*).

A proposal for a regionalized, more rational system of health services is not new. Indeed, such a system was recommended by the Committee on the Costs of Medical Care that was established in 1927 (*11*). And 30 years ago the Hill-Burton Act encouraged regional planning for hospital construction. However, the rapid expansion of hospitals and their rivalry (which is, after all, consonant with the notion of free enterprise) eviscerated the implementation of that plan. Attempts to regionalize hospital planning were made again by enacting the Regional Medical Program in 1965 and the Comprehensive Health Planning Program in 1966, but the effect of these programs was barely perceptible. And the National Health Planning and Resources Development Act of 1974 (Public Law 93–641) was yet another attempt to establish a mechanism for regionalization of hospital facilities. Because operating funds for hospitals orginate from multiple public and private third parties, as well as from patients who pay out of pocket, it is difficult—if not impossible—to implement coherent regionalization policies until the payment mechanism is coordinated to support this principle (*12*).

Determining the efficacy of hospital cost containment programs is admittedly difficult, but the evidence to date seems to indicate that prospective reimbursement as practiced in New York State since 1970 did not achieve, especially in its early years, the reduction in the rate of increase of hospital expenditures that had been hoped for (2). One of the principal reasons for the failure of the formula system, upon which the prospective reimbursement mechanism is based, it that "it favors the hospital that started the program with low rates of occupancy and fat in its operations, since subsequent rates of increase are automatically figured on these intial swollen base costs, and since nothing in the process brings an automatic inquiry into the efficiency of a hospital's specific departmental operations, as [is the case] with budget review. Conversely, the hospital that entered the program at an unusually high level of occupancy and with economical operations is automatically penalized because its initial base per diem rate was relatively low. Should its occupancy rate fall to average levels, moreover, its position becomes even more difficult. Because the system makes [little] provision for automatic volume adjustments (either up or down), hospitals have yet another incentive to build up patient day volumes of perhaps dubious necessity" (*13*). Thus, the current system offers fiscal incentives to have many patients who do not require a great deal of care.

MAXICAP Project

Two questions arise from consideration of the hospital payment systems in New York and other States:

1. How can hospital planning and payment functions be directly linked for cost effectiveness and equity?

2. How can Federal and State policies provide the flexibility needed to involve local communities in the payment and planning processes?

A project under development in the Rochester region of New York, in which a somewhat different approach is taken to the linkage of payment and planning, may provide some answers to these questions. This region consists of the nine counties that form the boundaries of the Finger Lakes Health Systems Agency, namely, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates. Extending from Lake Ontario in the north to the Pennsylvania border in the south, the nine counties have a total population of approximately 1.2 million.

The project, called "MAXICAP," is designed to demonstrate the effect of having a single community budget for hospitals across an entire region. (When the term "MAXICAP" is capitalized, it refers to the entire project. When written with both upper and lower case letters ("Maxicap"), it refers to the community spending limit.) Named in part to indicate the notion of maximum allowable revenues and expenses, MAXICAP is an approach to prospective hospital payment that identifies the "total sum of dollars which a community is willing to spend during any given period on hospital care" (*14*). The project was inspired by some aspects of the prospective reimbursement system developed in the early 1970s by Blue Cross of Rhode Island, the Rhode Island State Budget Office, and the Hospital Association of Rhode Island (*15–16*). Although the underlying concept of MAXICAP is relatively simple, the methods of implementation are rather complex.

The Rochester region's experience both with prospective reimbursement and regional hospital planning led to the selection in 1976 of the MAXICAP project as one of seven Social Security Administration experiments in prospective reimbursement to be funded under Section 222 of Public Law 92–603. The contract for the demonstration project was awarded to the Blue Cross Association and the Hospital Association of New York State.

The Rochester area had a long record of hospital planning, dating back to the year 1939, when the Rochester Hospital Council was formed. The Commonwealth Fund provided support for the formation of the Council of Rochester Regional Hospitals in 1946, and these two councils merged in 1951 to form the Rochester Regional Hospital Council (*17*). This experience with regional planning contributed to the New York State Health Planning Law of 1964 and also was considered in the evolution of the Federal health planning laws.

The substantial success that metropolitan Rochester has had in limiting its bed supply demonstrates the effectiveness of the Rochester Regional Hospital Council in health planning. The region's 3.65 bed-per-1,000-population ratio is significantly lower than New York State's ratio of 4.66 beds and the national ratio of 4.40 beds (*18*) and is well below the target of 4.0 beds recently set in a study by the Department of Health, Education, and Welfare (*19*). Hospital cost control in the Rochester region was brought about principally by controlling the number of beds in the region. This effort has historically received strong support from area industry (such as the Eastman Kodak Company and the Xerox Corporation) payers of a large proportion of hospital costs in the region. Initially, much of the impetus for such containment came from Marion B. Folsom, a Rochester resident who had been treasurer of Eastman Kodak before becoming Secretary of Health, Education, and Welfare during the Eisenhower administration (*20*). In 1960, shortly after returning from DHEW, Folsom was asked to serve as chairman of the allocation committee of a fund drive to finance the construction of new hospital beds. Largely at his instigation, a study was done which indicated that "fewer additional general hospital beds were needed than had been estimated" (*21*). In addition to recommending a slight decrease in the bed-to-population ratio, the study recommended more appropriate allocation of patients. The effects of implementing those recommendations are still apparent today; Rochester has a lower ratio of general hospital beds per 1,000 population and a higher ratio of nursing home beds and health-related facility beds per 1,000 population 65 years and older than the average for the State (*22*).

Another element affecting hospital costs is the somewhat atypical insurance arrangement that is dominant throughout the FLHSA region. Six of the nine counties in the region are in one Blue Cross-Blue Shield plan, which establishes community rates for nearly all group contracts. The effect of this community rating, as opposed to the more generally used experience rating, is that groups that have experienced high morbidity rates are not discriminated against. "This means that everyone with equal coverage pays the same premium, irrespective of *known* differences in their likelhood of illness and their liability of incurring medical care expenditures, of whatever magnitude" (*23*). Because of the historical support of Blue Cross by regional industry leaders and because Blue Cross is also the fiscal intermediary for Medicare Part A services in the Rochester region, it is estimated that 85 percent of the population in these six counties is covered by the combined Blue Cross mechanism—the highest percentage of regional coverage in the nation (*24*).

One of the difficulties in efficiently allocating hospital resources has been that each institution is a separate, relatively autonomous entity. Another drawback is that more often than not, there is little coordination between the planning of capital expenditures and the payment of hospital operating costs, in spite of the fact that planning bodies such as health systems agencies were intended to effect such coordination. Thus, a recent study assessing the effectiveness of New York's Cost Control Act concluded that the act has had less than an optimal effect because "Hospitals retain unfettered freedom to effect savings or to limit the increase in costs in any way they see fit" (*25*).

However, the issue becomes very different when a regional body is looking at appropriate hospital facilities and services for the entire population within its boundaries, rather than at the independence and solvency of each hospital. In an effort to directly address these difficulties, the authors of the MAXICAP proposal have articulated three questions that summarize their approach: "(*1*) What is the maximum amount the community is willing to spend on hospital care? (*2*) What goods and services should be purchased with this amount of funds? (*3*) How should the money be disbursed to the participating hospitals?" (*14*).

We offer a necessarily truncated synopsis of the general concepts that have been proposed to implement the MAXICAP program in the Rochester region. The MAXICAP demonstration project represents a voluntary attempt by "hospitals, third party payors, planners, consumers, and governmental agencies to develop a prospective hospital payment system" that will be acceptable to all parties to the project (*26*). The feasibility of the entire project rests on the collective integration of three distinct functions: formulating a community hospital plan; developing a Maxicap; aligning the community hospital plan with the aggregate of individual hospital plans, and aligning actual hospital operating costs with the Maxicap (*14*).

Developing a community hospital plan. The Finger Lakes Health Systems Agency will develop a community hospital plan that will describe what the hospital system in each of the three subareas ought to look like in 5 years, depending on the Maxicap dollar limits established for each subarea. It will deal with the number of hospital beds (or other units of service) of various types that ought to be available in aggregate in each subarea. It will also deal with other desired characteristics, for example, 80 percent of the subarea's population should be within 30 minutes' driving time of a hospital.

Subsequently, the hospitals in the FLHSA region will be responsible for formulation of a hospital service plan that will include (*a*) long-range actions for a 5-year period (for example, by year 5, hospital A will close its pediatric unit of 8 beds); (*b*) short-range objectives for a 1-year period (for example, by the end of next year the bed-per-1,000-population ratio in the northern subarea will be X per 1,000);

and (*c*) short-range actions (for example, by the end of next year, hospital D will reduce its obstetrics bed capacity by 13).

The community hospital plan and the hospital service plan are intended to be components of the health systems plan and the annual implementation plan that the FLHSA is required to develop under Public Law 93–641. Final approval of the integration of the community hospital plan and the hospital service plan rests with the FLHSA. The precise method by which the community hospital plan will be incorporated into the State medical facilities plan has not been determined yet. However, even though the community hospital plan has not been fully articulated, the component elements and mechanisms for developing it have been proposed to hospital administrators throughout the region.

Developing a Maxicap. The aggregate dollar amount (a limit on both revenues and expenses) to be spent on acute hospital care for the entire region will be decided by a "community body" that is yet to be designated. Although the specific composition of this group has not been decided, its membership will be somewhat similar to that of the project policy group, which includes providers, third-party payors, health planners, industry and union representatives, and consumers. The Maxicap will be calculated for each year, and there will also be projections for a period of 5 years. Since the cap will be divided into three subareas, one anticipated difficulty is in determining the subarea in which services that cannot be assigned to every subarea, such as a burn-care unit or a kidney transplant program, will be established.

Melding the Maxicap and the community hospital plan. Hospital service plans, which are not to be confused with Health Systems plans, will be developed at the subarea level. The hospital service plan will "indicate the type and number of services to be provided by specific hospitals and the agreed upon cost at which these services will be provided." The regional-subarea hospital service plans will "indicate the type and number of services to be provided by each of the hospitals in the region or a given subarea and the agreed upon cost at which these services will be developed." Any disagreements between the hospital service plans relating to their respective shares in the Regional-Subarea Hospital Service Plan will have to be negotiated before the package is submitted to the Finger Lakes Health Systems Agency. "When added together the individual Hospital Service Plans will equal the Regional-Subarea Hospital Service Plans, both in terms of type and number of services to be provided, and in terms of agreed upon costs" (*26*). The hospital service plan must be coordinated with the community hospital plan, and both must function within the constraints of the Maxicap. Determination of the congruence of the respective hospital service plans with the community hospital plan will be made by the Finger Lakes Health Systems Agency. A mediation mechanism is being planned, in the event that any of the individual hospitals is unable to prepare a hospital service plan.

There are obvious advantages to this type of a regional, population-based plan for hospital services, particularly since there is a relatively fixed prospective budget with which to perform the services. For one thing, because it is assumed that the budget will always be less than the combined institutions would desire, there is an inherent constraint in the system. A further advantage is that allocation of dollars and services can also be made with appropriate sensitivity to the demographic characteristics and economic factors impinging on the consumers. The principle of regional decision making as an integral aspect of the MAXICAP program is of crucial interest in the evolution of a national health insurance program. A program in which decisions are made and priorities set in relatively small regions is vastly superior to one in which a single plan with inflexible norms is established for areas as large and diverse as, for example, New York State. In his third annual State of the Health message on February 15, 1978, Governor Carey suggested that we are moving "toward a uniform reimbursement mechanism," although he did not describe in detail how such a mechanism would be structured. The regional mechanism outlined in the MAXICAP project would seem to ensure a high degree of responsiveness to local needs and demands. One hopes that it would also guarantee greater sensitivity to the entire range of consumers and their respective needs than has been evident in the usual reimbursement system. Because of the enormous disparity in health care delivery systems and the variations in health care problems throughout this country—both among and within regions—the development of mechanisms that will be sensitive to the needs of the respective regions seems essential.

Although it is too early to tell if such an elaborate mechanism as Maxicap can be made to work effectively, the progress that the project policy group has made in evolving plans for its implementation has been remarkable. However, there are still several difficulties inherent in the project. A cap on increases in hospital expenditures does not necessarily mean that reductions will come in the most appropriate places. In discussing the impact of a scheme similar to MAXICAP, Feldstein and Goddeeris argued that if the cap is set too low, "The poor and the aged, for example, might find it more difficult to get basic medical care, while other groups are provided services of questionable value" (*4*). Additionally, because of the vested interests of the various parties in the MAXICAP experiment, many compromises must be made among the participating institutions. And general acceptance of the MAXICAP project by the physicians practicing throughout the region is essential. Undoubtedly the process of negotiation will be fascinating to observe. Since each of the hospitals and communities throughout the region will have to engage in tradeoffs, certainly negotiations will be difficult.

There are repeated assertions that MAXICAP is a community plan. However, a word of clarification is in order. The MAXICAP project is not a community plan in the sense that it is being formulated principally by consumers and public officials. Rather the policies and methodology of the project are being developed by a project policy group composed of:

6 representatives of Rochester community hospitals
1 representative of a statewide hospital advisory group
2 representatives of Blue Cross plans
1 representative of the State of New York Department of Health
1 representative of the State of New York Department of Social Services
1 representative of the Social Security Administration
2 representatives of consumers (both executives)

This group is assisted by technical staff from the Blue Cross Association of America, Hospital Association of New York State, Finger Lakes Health Systems Agency, Rochester Hospital Service Corporation (which is the regional Blue Cross Association), and the Rochester Regional Hospital Association. The project has been attacked in some quarters for its relative lack of consumer involvement. Yet, in spite of the homogeneous composition of the parties to the proposal, all seem to be keenly aware that unless the cost-containment issues are resolved regionally in a fashion that is genuinely beneficial to the larger community, the New York State Department of Health will likely play an even greater role in these matters. In a message to the Monroe County Medical Society, the president of the Rochester Blue Cross observed that the MAXICAP project is "not the only federally-funded experimental attempt to arrive at a better method of reimbursing hospitals, but it is unique in its reliance on the community to voluntarily implement a new system. The government, in effect is asking Rochester to demonstrate that a community is capable of making the necessary adjustments by itself. . . . We hope we can count on your support and participation in your hospital's part of this effort to retain local control" (*27*).

The widely heralded Department of Health, Education, and Welfare proposals in the Hospital Cost Containment Act of 1977 are designed to reduce the rate of growth of total hospital revenues through the "GNP deflator" mechanism (*28*). We believe, however, that in spite of the many elaborate provisions of the Administration's CAP proposal, it will at best only be slightly more effective than recent efforts in New York State, because it is based on a prospective payment system that funds each and every existing hospital irrespective of the appropriateness of the services they deliver. Recently, Dan Rostenkowski, chairman of the House Ways and Mean Subcommittee on Health, presented a bill known as the "Voluntary Effort" (sponsored by the American Medical Association, the American Hospital Association, and the Federation of American Hospitals) that proposes to contain hospital costs with minimal government regulation (*29*). The introduction of this bill raises doubt as to the likelihood of passage of the Hospital Cost Containment Act. Our intention is not to present the MAXICAP approach as the best of all possible reimbursement systems. The Rochester project represents merely one step toward the objective of hospital cost containment. And, admittedly many obstacles must be surmounted before the MAXICAP program can be implemented. However, the project offers a mechanism for achieving a more effective and more equitable system of control than that currently being advocated at the Federal level.

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SYNOPSIS

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The rapid escalation in health care costs has demonstrated a need to control costs in general and hospital costs in particular. In New York State, efforts at control have followed one of several paths, including reduction of Medicaid program expenditures, elimination of hospital beds, and prospective reimbursement of hospital costs. Although some success has been achieved in each of these areas, hospital costs containment has not been as successful as had been hoped.

A new project called MAXICAP, being developed in the Rochester region, seeks to link payment with regional hospital planning. MAXICAP represents a voluntary attempt by hospitals, third party payers, planners, consumers, and governmental agencies to devise a prospective hospital payment system. Under this system community hospital plans in the Rochester region would be integrated and a cap imposed on both revenues and expenses for acute hospital care. The principal advantage of the MAXICAP is that it offers a mechanism for linking hospital planning with payment functions on a regional basis. The principal disadvantage is that the success of the MAXICAP depends upon the voluntary cooperation of the vast majority of the acute care hospitals in the area—hospitals that may be scattered throughout a relatively large region.