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HEALTH POLICY BULLETIN

FOCUS: FEDERAL BUDGET REVIEW

Over the next five years hospitals will lose about $13.7 billion in Medicare inpatient payments; physicians, outpatient departments and centers, hospital-based specialists, and others will lose about $15.8 billion. Hospital DRG rates increase in January 1991 by 3.3 percent rather than 5.3 percent, a move that saves $1.1 billion. In 1992, however, the increase will be the hospital market basket index minus 1.6 points, and in 1993, the index minus 1.55 points; in 1994–95, the increase will be the full rate of inflation. Savings are projected at $11.8 billion from FY 1991 through FY 1995. The plan to go to 100 percent of hospital capital expenses in 1991 for Medicare patients was scrapped; instead, capital payments stay at 85 percent in FY 1991, then rise to 90 percent in FY 1992 and are folded into the prospective payment system in 1993.

The disproportionate share adjustment has been changed to give inner-city hospitals having 100-plus beds and a combined Medicaid and SSI patient volume of 15 percent and up an increase of $60 million in FY 1991, $115 million in FY 1992, and $395 million in FY 1995. The cost over five years is estimated at $1 billion. Another $1 billion is scheduled to be plugged into rural hospitals through 1995 to offset the difference between urban and rural payment rates. A DRG rate hike of 4.6 percent in FY 1991 still will leave rural hospitals significantly behind urban hospitals in their rate of payment for the same services, but more favorable hospital market basket index adjustments will lead to the gradual elimination of the differential and make rural hospital payment rates equal to urban rates. Michigan hospitals will continue to benefit from the regional cost basis for DRG payments (85 percent national and 15 percent regional) through September 1993. Payment policies for graduate medical education were continued. The slowdown from one year to two in implementing the new area wage index may hurt some Michigan hospitals.

Hospital outpatient departments keep their capital payments at 85 percent of costs in FY 1991 and 90 percent in FY 1992; they lose on payments for outpatient operating costs, which were cut 5.8 percent for the current fiscal year and $1.5 billion over the next five years.

Except for primary care services, physician fees are frozen, a move that will save $320 million in FY 1991. The cost of 245 "overpriced" procedures will be reduced by about 15 percent. Radiologists lose 9.5 percent, while fee reductions for anesthesiologists range from 7 to 15 percent; pathologists lose 7 percent. These moves are expected to save $3.8 billion from FY 1991 through FY 1995. All physicians get a 2 percent fee increase in 1992.

Most economists think further deficit reduction packages are likely since the Omnibus Budget Reconciliation Act of 1990 does not do enough to reduce the federal deficit, and despite the hoopla about spending and deficit reduction plans through FY 1995, the act is not binding on succeeding Congresses. Future budget battles undoubtedly will bring changes, and a prime candidate for reducing federal expenditures continues to be health care.

FOCUS: REQUIRED READING FOR HOSPITAL MANAGERS

Strategic Choices for America's Hospitals: Managing Change in Turbulent Times, by Stephen M. Shortell, Ellen M. Morrison, and Bernard Friedman, published in 1990, qualifies as required reading for every hospital executive. The book is divided into three sections: Change and adaptation in the hospital industry, managing change and adaptation, and ensuring hospital success. This review will focus on the need for new policy-making initiatives.

Shortell and his colleagues make six key assumptions about the delivery of health care in this decade: Cost containment pressures will continue; value will be an increasing concern; cost-saving technology will receive much greater emphasis; government and private programs will be developed to provide financial support for health care services for the elderly, the poor, and the uninsured; substance abuse, homicides, and accidents will increase; and economic and professional conflict among health care professionals will increase within the delivery system. Four key elements for hospitals' future success need to be developed: Continuum of care, systemlike behavior, hospital-physician partnerships, and strategic leadership for board members, executives, and health care professionals.

Using the assumptions and the key elements to provide the underpinnings, the authors devise a scenario for public policy making that takes account of the tendency in the hospital industry to develop systems and that recognizes that no matter what the national issues are, health care is delivered at a local level. The writers suggest that to make policy that can be implemented on all levels a new forum or steering committee is needed that contains representation from all sectors (suggested members include the American Association for Retired People, the General Accounting Office, the American

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College of Health Care Executives, and representatives from the major trade and professional groups, legislative staff, the major hospital systems and alliances, and labor, business, and consumer groups).

The scenario has three fundamental aspects: (1) Fiscal and clinical accountability for care provided to geographically based populations, (2) overall allocation of resources based on a particular population's health needs with internal allocation based upon provider performance, and (3) negotiations among provider, purchaser, and consumer groups about what services will be delivered at what price.

Fiscal accountability is accomplished by *capping health care expenditures*. The steering committee would recommend a package of basic benefits to the federal government, which would mandate them. Benefits could vary by geographical area because of the health status of the area and its epidemiological and demographic characteristics as well as the provider resources available. Every health care benefit would be costed out, including additional or optional benefits that employers might want to offer and individuals might want to purchase.

A global budget composed of dollars from the federal and state governments, private insurers, and employers for health care services and a separate budget for capital needs would be established. The global budget would be tied to expected patient outcomes and health status. Funds would be allocated to health promotion and accountability regions (HPARs), geographic entities that would be responsible for fiscal and clinical accountability. The HPARs would be composed of representatives from the major purchasers, labor, consumer groups, and health care executives and professionals and would be created by the federal government with the advice of the steering committee. Both purchasers and providers would have to participate in HPARs to receive Medicare reimbursement. The HPAR technical resource staff would rate the population for its health needs, and insurers and health care plans would be allowed to charge more to people who represent poor health risks than those rated as lower risks. Data collected by the regional staffs on outcomes, patient satisfaction, quality of care, health status, and finances would be reported to the public every year.

The scenario calls for local systems to have great autonomy to organize and deliver services. Competitive market forces would ensure the punishment of the inefficient, who would have to absorb their losses. Efficient provider systems could keep as much as 75 percent of the surplus they generate, with the remainder going to the HPAR; part of the HPAR share could be used to create a reinsurance pool to cover people who are uninsured, to meet possible higher levels of utilization resulting from population shifts among the HPARs, and/or to meet needs created by a natural disaster. Fiscal and clinical accountability would be tied together.

The third element in the scenario, negotiation, would decide who is responsible for what. The researchers postulate that some providers will choose to specialize in particular populations like the elderly or the indigent. Since the dollars are allocated on the basis of each group's health status, uncompensated care and cost-shifting would vanish.

Five advantages are to be gained from this scenario. First, public and private payers would gain predictable, stable relationships with providers through the negotiating structures, and both would be forced to work together to assess health needs and develop a lump-sum budget that relates needs to resources. Second, the budget is a comprehensive health care budget with dollars allocated along the total continuum of health care rather than to specific segments. Third, the dollars received by a region depend upon the performance of its providers; tying dollars to performance contains costs while providing quality care. Fourth, social responsibilities and free enterprise are combined; a basic level of care becomes available to all Americans, the risk rating of populations provides flexibility and assures that no group will be without services because they are undesirable customers, and the existence of health systems able to serve large geographic areas promotes efficiency. Finally, the budget cap imposes a discipline that forces the delivery of cost-effective care.

What are the disadvantages? The HPARs would be new geopolitical regions; transcending the boundaries of state health planning and welfare agencies could be extremely difficult. The HPARs would be bodies with tremendous clout that the authors feel should depend heavily on expertise rather than political allegiances. (It is hard, however, to find experts in health care who are also political eunuchs.) Assessing the health needs of populations and measuring patient outcomes are very unscientific activities right now. A two-tier system definitely would exist, but the presence of a minimum package would give everyone guaranteed access to basic benefits.

The authors feel that the HPAR proposal is workable because it takes advantage of the trend toward system building that exists in the hospital industry. Health care systems would be pushed farther in the direction of developing systems for reporting performance data that would meet concerns about the relationship of price and quality of care. Effective economic partnerships among hospitals, physicians, and other health professionals are needed. Finally, they point out that it does not matter if readers disagree with them because the scenario accounts adequately for the trends that have developed and will continue to develop over the next decade in the making of health care policy in the United States.

—Frances L. Faverman, Editor