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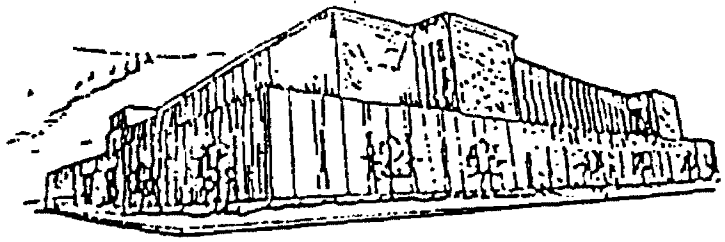

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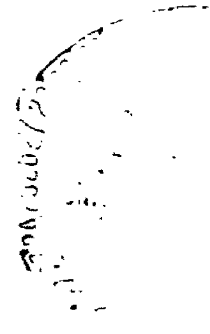

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BOREN AMENDMENT IMPLICATIONS IN DEVELOPING MEDICAID HOSPITAL REIMBURSEMENT POLICY

by

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B.S., Montana State University, 1979

Presented in partial fulfillment of the requirements

for the degree of

Master of Public Administration

The University of Montana

1994

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December 1, 1994
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CHAPTER I

INTRODUCTION

The Boren Amendment to the Social Security Act, approved in 1980, fundamentally changed the way state Medicaid agencies operate. A state Medicaid agency can no longer set reimbursement rates for institutional providers such as nursing facilities and hospitals without taking into account their reasonable costs. This is a radical departure from how these facilities have been reimbursed historically. This chapter describes the Medicaid program, the Boren Amendment, and the research questions addressed in this study.

The Medicaid Program

Medicaid is a jointly funded federal/state program which provides reimbursement for medical care for low-income persons who are aged, blind, disabled, or members of families with dependent children. Each state has the option of whether it wishes to participate in a Medicaid program. However, if it chooses to participate, a state must comply with federal Medicaid laws and regulations. Currently, every state but Arizona operates a Medicaid program.

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(Arizona operates a program that is similar to Medicaid under a federal demonstration waiver.)

Medicaid operates in much the same way that a health insurance company does except that the premiums are paid by federal and state taxes. In Montana, approximately $.71 of every $1.00 spent on the program is supplied by the federal government. The other $.29 is appropriated from the state general fund by the legislature.[1] Montana's Medicaid program is administered by the Medicaid Services Division of the Department of Social and Rehabilitation Services.

Each biennium the state legislature must decide whether to continue to fund the Medicaid program and, if so, approve an appropriation for the next two years. Medicaid is one of the three major components of the state general fund budget in Montana. For the first time in 1994, Medicaid expenditures are more than those of state institutions, ranking second only to education. The projected budget for Medicaid in this biennium (state fiscal years 1994 and 1995) is $635,481,485. $177,940,950 of this will be spent on the inpatient hospital program.[2] Because this appropriation for inpatient hospital services is so large, Medicaid must take particular care to administer the program in compliance with the Boren Amendment. A court order to pay hospitals more than has been allocated for their services would have devastating results on the state's ability to balance its

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overall budget and might result in a special session of the legislature being called.

Traditionally, the Medicaid appropriation has been based on the number and cost of services offered and the number of people served by the program. The state has been able to determine reimbursement and coverage policy within broad federal guidelines. For example, the state must cover certain services such as hospital and physician services and certain broad categories of people such as pregnant women and children if it chooses to participate in the Medicaid program. The state must also ensure that the services that it covers are adequate to meet the needs of the majority of the people covered under Medicaid. Thus, if Medicaid recipients see a physician five times a year on average, it is not sufficient to have a Medicaid program which will only pay for three physician visits annually.[3]

States traditionally have been given great latitude by the federal government in setting reimbursement rates for medical providers. Reimbursement policies have reflected the condition of the state economy. Payment rates have been increased in times of prosperity and have been frozen or decreased during lean years. The Health Care Financing Authority (HCFA), the agency that oversees the Medicaid programs for the federal government, has routinely approved whatever the state proposed to pay for medical services as long as the state Medicaid agency stated in its state plan

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that it complied with procedural requirements. (The state plan outlines services a state proposes to cover, any limits on the coverage, and how the services will be reimbursed.) HCFA's review of state plan amendments has been cursory at best. They have not looked at the state's methodology for determining itself to be in compliance.[4]

Recent court decisions in other states, however, are playing an increasingly important role in funding issues. Many of these decisions are the result of litigation over the Boren Amendment.

The Boren Amendment

Title XIX of the Social Security Act is the federal legislation authorizing the Medicaid program. The Boren Amendment is a 1980 amendment to Title XIX of that Act. It was originally part of an attempt to contain skyrocketing costs in nursing facilities and hospitals. The Boren Amendment, which is codified at 42 U.S.C. 1396(a)a(13)(A), provides states greater flexibility in developing Medicaid inpatient hospital rate-setting systems. States are now free to develop prospective payment systems without obtaining a "waiver" from HCFA of federal Medicaid regulations on cost based reimbursement. Nevertheless, the amendment also contains the caveat that rates be adequate to meet the needs of providers and recipients. Under the amendment:

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> A state plan for medical assistance must provide for payment...of the hospital, nursing home and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the state) and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs which the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality... (Emphasis added to identify the terms that have been most important in litigation.)

The Boren Amendment has become an increasingly important test of the adequacy of Medicaid reimbursement policies for nursing facilities and hospitals. Over the past decade state Medicaid programs have been required to prove the sufficiency of their rates in numerous court cases. States can no longer count on HCFA approval of a state plan amendment as prima facie evidence of Boren compliance. The Colorado 10th Circuit Court in AMISUB (PSL) v. State of Colorado Department of Social Services not only found that HCFA approval carried no weight, it also declared that each state has a responsibility to make periodic public showing of the methodology and data used to assure the adequacy of hospital and nursing home rates. A statement of assurance, no matter how well founded, is no longer enough.[5]

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Statement of the Problem

Montana Medicaid revised its methodology for hospital reimbursement in state fiscal year 1994. An October 7, 1992 letter from Julia E. Robinson, Director of the Montana Department of Social and Rehabilitation Services, to members of the legislature outlined the reasons that revisions were needed and asked for their support in the upcoming legislative session. The major reasons for revising the reimbursement methodology were to provide for more equitable alignment of Medicaid payments and hospital costs and to allow the state to comply with Boren Amendment requirements.[6] This revision was the first major change to the prospective payment system since its inception in 1987. It was also the first update to the system since Boren Amendment litigation has begun to figure so prominently in determining reimbursement levels in several other states.

Because of the dollars involved and the state's current precarious financial condition, it is imperative that recent Boren court decisions be taken into account to minimize the risk of losing a lawsuit if one should be filed over this new reimbursement system. The state's desire to control rising medical costs will need to be tempered by the reality that courts have found state budgetary ills to be secondary to the need to ensure that hospital providers receive rates that are reasonable and adequate to meet the costs of efficiently and economically operated facilities.

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Accordingly, the purpose of this paper is threefold. To determine the efficacy of the new reimbursement system, a study was undertaken to: 1) independently evaluate the history of the Boren Amendment and recent court findings in relationship to other states' compliance with it; 2) assess the recommendations made to the Department of Social and Rehabilitation Services by Abt Associates Inc. who had been hired to design the new hospital reimbursement system; and 3) offer suggestions for how Montana Medicaid might fashion its hospital reimbursement system to minimize the risk of losing a lawsuit. The author used this study as the basis for her recommendations to her superiors in the Department of Social and Rehabilitation Services as to whether the "new" reimbursement system would withstand a legal challenge based on previous Boren Amendment lawsuits.

Methodology

The source material for this paper includes court decisions and literature about the Amendment. The paper also relies on materials presented at a conference sponsored by the American Public Welfare Association on the Boren Amendment held in December 1991. Presenters at the conference included state officials such as assistant attorney generals and Medicaid directors, as well as representatives from consulting firms who specialize in the area of Medicaid systems and policy analysis.

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Organization of the Paper

Chapter 1 provides an overview of the problem addressed by the paper. Chapter 2 provides an overview of the legislative history of the Boren Amendment. Chapter 3 examines various court decisions which are shaping current reimbursement policies. It distinguishes those judicial findings that are based on procedural issues from those based on substantive policy issues. Finally, Chapter 4 presents recommendations regarding the design of the newly adopted hospital reimbursement system and how the state might reduce the risk of lawsuit.

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CHAPTER 2

LEGISLATIVE HISTORY OF THE BOREN AMENDMENT

Attempts at Cost Containment Leading up to Boren

In 1965 Congress enacted the Medicare and Medicaid programs making health care available to a large segment of the population. Many of the recipients of these programs had never before had an external payment source for their health care and consequently had not routinely sought health care services. This previously unmet need coupled with a retroactive cost based system of reimbursement led to a rapid rise in the cost of health care. According to the American Public Welfare Association, Federal Medicare and Medicaid outlays for hospital care increased at an annual rate of 17 percent from 1968 to 1978.[7] In 1969, the federal government paid the hospital industry $7.7 billion. By 1979, the amount had grown to $33.1 billion. The amount spent for hospital care during the 1970s also increased as a proportion of total health care expenditures, from approximately 30 percent in 1970 to almost 40 percent by 1977. During this same time period, the cost of an average day of hospitalization increased tenfold. The number of community hospital beds increased as well, by 100,000 from

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1970 to 1975. This increase in beds brought the national bed-to-population ratio to 4.4 beds per 1000 persons, which is at least 0.4 beds/1000 population more than many health planners recommend.

To address this rapid rise in cost and the proliferation of beds, Congress tried unsuccessfully to control the cost of health care in the 1970s by employing a variety of cost containment programs. The best known of these was the certificate of need (CON) program. The CON program was designed to contain both operating and capital costs by limiting the number of beds and the amount of specialized equipment that hospitals were allowed to have. Expansions in these areas were subject to statewide and regional health planning and approval processes. These review processes proved to be very political in nature. Hospitals successfully argued that they must have more beds and/or equipment to compete in a changing healthcare environment. Planning boards, which were often appointed by the governor, did not want to be seen as stifling economic development and so requests were granted. As a whole, the program was generally ineffective and hospitals continued to operate at significantly less than full occupancy.[8]

Another cost containment plan was the Voluntary Effort which was begun by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals in December 1977. The program was introduced to

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preempt President Carter's 1977 initiatives to regulate health care cost increases which would have imposed two new types of capital controls: a nationwide dollar limit on new capital expenditures and standards for the number of hospital beds and their rate of occupancy. The program sought to "voluntarily" contain costs so that the yearly growth of hospital expenditures would decline 4% over three years. The Voluntary Effort was credited with saving $1.48 billion in hospital expenditures in 1978. In 1979, however, the rate of expenditure grew dramatically and the Voluntary Effort was discredited as a viable cost containment measure.[9] In the years since, hospital expenditures have continued to grow at a rate which exceeds the Consumer Price Index and other inflationary measures. It is unclear whether this is due to poor management of hospitals, technology advances, an excess of beds/equipment to meet patient demand, or a combination of all of these factors.

While Congress tried unsuccessfully to enact national health care reform and a uniform cost reporting system for hospitals, nursing facilities and physicians in the 1970s, Medicaid and Medicare continued to reimburse 90% of hospital costs on a retrospective reasonable cost basis. This type of reimbursement methodology is known in economic terms as a cost-plus system. This cost-plus system failed to provide incentives to hospitals to reduce expenses. With few

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exceptions, whatever a hospital chose to spend was considered a reasonable cost of doing business and these costs were passed on to Medicaid and Medicare. According to testimony by Senator Lloyd Bentsen of Texas in the Senate Finance Committee in June 1976, the system was inherently inflationary. He described the problem with cost reimbursement this way: "The problem with our past attempts to limit costs is that we have attempted only to further refine the current system without facing up to its basic structural inadequacy." [10]

During this decade of failed attempts at cost containment, one initiative did show some promise. Amendments to the Social Security Act in 1968 and 1972 allowed states to obtain waivers from HCFA to conduct demonstration projects applying alternative payment methodologies in their Medicaid programs.[11] The success of these early demonstrations along with continued medical inflation became the impetus of what is now referred to as the Boren Amendment. When it was first passed in 1980, this amendment applied only to nursing facilities. In 1981 it was modified to include hospitals as well.

The Boren Amendment provides states greater flexibility in developing Medicaid inpatient hospital rate-setting systems. States are now free to develop prospective payment systems without obtaining a "waiver" from the federal government of federal Medicaid regulations on cost based

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reimbursement. Nevertheless, the amendment also contains the caveat that rates be adequate to meet the needs of providers and recipients.

A close reading of the Boren amendment reveals three basic requirements. A state must provide assurance in its state plan that its reimbursement:

> 1) is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities;
> 2) is reasonable and adequate to ensure that Medicaid recipients will have reasonable access to inpatient hospital services of adequate quality; and
> 3) takes into account the situation of hospitals that serve a disproportionate number of low income patients with special needs.[12]

The language of this amendment has become the focal point of repeated litigation between state Medicaid programs and Medicaid service providers. Since 1980, twenty states have instituted prospective payment systems for hospital reimbursement rather than continuing their old cost-plus systems of payment.[13] These prospective systems seek to provide incentives for efficiency and cost containment. The majority of these prospective payment systems, including Montana's system, have paid claims based on diagnosis related groups (DRGs). Each inpatient stay is classified into a "group" based on the patient's diagnosis and the procedures performed during hospitalization. Payment is then assigned based on the expected cost for the typical case in that DRG. This amount is paid regardless of whether

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the cost to the hospital for providing care is more or less than the reimbursement. This type of system provides an incentive to hospitals to provide care in the most economical manner possible. On any single case, if a hospital can provide care for less than what they are reimbursed, they are allowed to keep the profit. On the other hand, a hospital may also lose money if the cost of care exceeds reimbursement.

Soon after the passage of the Boren Amendment, which encouraged the utilization of alternative payment systems, states began to be sued by institutional providers for inadequate payment. Recognizing that the Boren Amendment was initiated as a cost containment program which allowed flexibility in establishing reimbursement methodologies, courts initially upheld state payment rates. More recently, however, courts have looked more closely at the adequacy of reimbursement. They have drawn a distinction between Boren's procedural and substantive requirements. Several states have lost major decisions in recent years based on both requirements.

As a result of these lawsuits, or the threat of such a lawsuit, the Boren Amendment has become a major consideration in determining Medicaid reimbursement. Adverse decisions in Boren Amendment cases have had large fiscal implications. In other instances the threat of lawsuits has led states to reach agreement with provider

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associations on reimbursement levels before a court challenge is brought.[14]

While not every state which has been sued has lost a Boren Amendment challenge, the courts have defined the issue in a manner which has reduced state discretion in determining reimbursement rates. Understanding the requirements of the Boren Amendment, as they have been defined by the courts, is a necessary first step in setting reimbursement rates and protecting Montana against a lawsuit. Several court cases and their implications will be reviewed in the next chapter.

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CHAPTER 3

BOREN'S PROCEDURAL AND SUBSTANTIVE REQUIREMENTS

Establishing Jurisdiction

The Supreme Court has debated for years the general question of whether there is a private right to bring a lawsuit to enforce a generally worded federal law that does not explicitly grant such a right. States have in the past contended that courts had no jurisdiction in deciding Boren Amendment disputes because the Social Security Act only gives actual Medicaid recipients the standing to sue.[15] Three recent court decisions have rejected this argument.

Colorado Health Care Association v. Colorado Department of Social Services was decided by the U.S. Court of Appeals for the Tenth Circuit in 1988. The court ruled that based on the Medicaid patients' and Medicaid providers' "parallel interests with respect to Medicaid funding and reimbursement," Medicaid providers had standing to challenge the state Medicaid plan.[16]

The second case establishing federal jurisdiction is Folden v. Washington State Department of Social and Health Services, et al., 744 F.Supp. 1507, 1532 (W.D. Wash. 1990). The Western District Court found that section 1331 under 28

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U.S.C. does not preclude federal jurisdiction over a case where the providers seek relief under the Boren Amendment.[17]

On June 14, 1990, the U.S. Supreme Court further affirmed the providers right to sue in federal court in Wilder v. Virginia Hospital Association. In this 5 to 4 decision, the Court determined that health care providers could sue state governments in federal court for inadequate reimbursement for services to Medicaid beneficiaries. The Court agreed with the Virginia Hospital Association's contention that Section 1983 of 42 U.S.C. provided for federal court review, stating that: "There can be little doubt that health care providers are the intended beneficiaries of the Boren amendment."[18] The Court went on to find that the standards of the Boren Amendment were binding on the states. Not only must states go through the process of making findings and assurances, they must also actually implement reasonable and adequate rates.[19]

The dissenting justices in Wilder contended that, if providers could sue states, the courts would contradict the intent of Congress to give states flexibility to develop methods and standards of ratesetting subject to the review of the Secretary of Health and Human Services. Chief Justice Rehnquist asserted that suits brought in the future "will inevitably seek the substitution of a rate system preferred by the provider for the rate system chosen by the State." Accordingly, a State will be prevented by a court

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from actually implementing the requirements of the Boren Amendment, to develop a rate system that the State believes is adequate.[20]

Nevertheless, with the right to sue state Medicaid programs in federal court firmly established by the Wilder decision, courts are increasingly in the business of setting, or at least voiding, state Medicaid reimbursement policy. These court decisions on the Boren Amendment have been categorized into two major areas, procedural and substantive requirements.

Defining Procedural and Substantive Requirements

Procedurally, courts have concluded that states must conduct "findings" in determining their payment rates. States must do a study to determine reasonable hospital costs. Failure to do so can result in invalidation of the payment rate regardless of the actual adequacy of the rates. States must also have an adequate ratesetting appeals process (and providers must take advantage of that process if it exists before going to court).

Substantive compliance with Boren requires actually paying rates that are adequate and reasonable to meet the needs of efficiently and economically operated providers. The majority of substantive cases thus far have been decided on the definition of what is an adequate/reasonable rate and an efficient/economic provider. A few courts have also

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addressed the access and quality issue and the disproportionate share provisions of the Boren Amendment.

Procedural Issues - State Findings and Assurances

Under the Boren Amendment, states must make findings at least annually and whenever they modify their Medicaid plans to assure that the requirements of the Amendment have been met.[21] A finding is a statement that summarizes the facts that the state Medicaid agency has taken into account in submitting its assurances.

The precedent-setting case in procedural compliance is AMISUB (PSL) v. State of Colorado Department of Social Services. Decided in 1989, the 10th Circuit Court found that while the state is "free to create its own method for arriving at the required findings," a state may not fail to make such findings because it lacks administrative resources or because such findings represent an administrative burden to the state.[22]

In deciding this case the court indicated that its first inquiry was whether the state was in procedural compliance with the law. Specifically, it found that in order to comply with the procedural requirements of Boren, a state must have a "bona fide finding process" which identifies and determines the following three components: "1) efficiently and economically operated hospitals; 2) the costs that must be incurred by such hospitals; and 3)

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payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals." [23] In other words there must be an adequate factual basis, supported by objective evidence, behind a state's findings and assurances to HCFA that its rates are adequate.[24]

In Nebraska Health Care Association v. Dunning, the 8th Circuit Court of Appeals found that:

> The state's submission of its new plan was simply not accompanied by any information even purporting to meet the requirements of the [Boren Amendment] federal regulation. This fact, without more, is sufficient to invalidate HCFA's purported approval of [the state Medicaid plan amendment]. There was no factual basis for the assurances Nebraska submitted to HCFA, and HCFA's approval, being based on unsupported assurances, is without legal effect.[25]

In Temple University v. White, the 3rd Circuit Court of Appeals, disturbed that no special studies, findings, or investigations were conducted by Pennsylvania, concluded that "...without knowledge of hospital costs, [the State] could not have known what an efficient and economical hospital operation would entail, let alone what payment rates would be reasonable and adequate to meet the hospital's costs and assure reasonable access to hospital care." [26]

Other courts have found the lack of special studies to support findings to be problematic as well. In ruling against the state in Kansas Health Care Association v. Kansas DSRS, the Federal District Court concluded: "the

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state has not conducted any studies to determine the actual costs of 'efficiently and economically operated' facilities in order to determine whether the rates, as set, would cover those costs."[27]

In Lapeer County Medical Care Facility v. State of Michigan, 765 F.Supp. 1291, at 1299 (W.D. Mich. 1991) the district court found that the state had failed to submit objective data to support their assertions that the new rates were reasonable and adequate, "Nor have defendants submitted even an iota of evidence that they have conducted any objective economic analysis to support their argument that plaintiffs are currently operating inefficiently and uneconomically, or to determine the effect of the reductions on the quality of care plaintiffs will be able to provide."[28]

In these decisions, and others, it is clear that courts are placing great emphasis on whether state assurances are supported by adequate findings. The second procedural area that courts are looking at are the states' internal mechanisms for appealing ratesetting determinations.

State Appeal Mechanisms

States are required to have, in compliance with federal regulations at 42 CFR 447.253 (c), "an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative

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review, with respect to such issues as the agency determines appropriate, of payment rates." States have established a wide variety of appeals mechanisms in response to this regulation. This is an area of compliance with Boren that remains largely untested. There are, however, a few courts that have ruled on whether a state's procedures are adequate or whether providers have adequately exhausted their state administrative remedies in the context of the Boren Amendment.

In St. Michael Hospital v. Thompson,[29] the Western District Court in Wisconsin abstained from ruling on a Boren Amendment case based on an application of the Burford doctrine.[30] The Burford doctrine is a 1943 Supreme Court decision requiring that a federal court must decline to interfere with state administrative agency orders or proceedings for which there are difficult questions of state law bearing on substantial policy questions or where federal review would disrupt state efforts to establish a coherent policy. In contrast, the 4th Circuit Court of Appeals in Virginia Hospital Association v. Baliles ruled that the Burford doctrine did not apply to a Boren Amendment action brought by a group of hospitals since the state's administrative appeals process did not authorize appeals by class representatives.[31]

Other court cases have addressed whether the state appeal process is adequate to redress specific alleged

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violations of the Boren Amendment. The East District Court in Mary Washington Hospital v. Fisher ruled that Virginia's appeals process, which did not allow a hospital to appeal on the basis that its costs are higher than the costs of its peer group, "is unreasonably and arbitrarily narrow." The court ordered the state to develop a new appeals procedure, but indicated that it would not dictate either the type of appeals procedure which should be adopted or the issues that should be appealable. The court did suggest that the state consider issues such as whether a hospital's costs are higher than its peer group for reasons beyond its control.[32]

In Connecticut Hospital Association v. O'Neill, a magistrate judge for the Connecticut District Court dismissed the plaintiff's action for failure to state a cause for which relief could be granted. The court upheld the state's payment system, concluding that "the Connecticut state plan adopts the Medicare reasonable cost principles which provide the highest rates allowable under federal law. Thus, the State's finding of compliance with the Boren Amendment cannot be reasonably questioned."[33]

The court also noted that the state provided for administrative review of the reimbursement rate on a hospital by hospital basis only. Under such circumstances, the court said that federal law precluded an overall change in the reimbursement rate that would affect all hospitals.[34] The failure of hospitals to take advantage of the state's

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adjustment and rebasing provisions strongly influenced this decision.[35]

As is demonstrated by the variety of opinions in these "procedural" cases, the courts appear comfortable in determining whether a specific state appeals procedure is adequate in a particular situation and whether states have made adequate findings and assurances. The next cases deal with more problematic "substantive" court decisions.

Substantive Issues - Rate Setting and Rate Adjustment

Even when a state's findings and assurances and administrative appeals process are found procedurally acceptable under the Boren Amendment, the courts have looked further to see whether the payment rates themselves are substantively adequate. The primary focus in cases decided on substantive grounds has been whether the rates are adequate to meet the "costs that must be incurred" by "efficiently and economically operated" providers. Court cases which have set the standards for defining those terms will be examined below. A few courts have also addressed the "access to" and "quality of care" issues and the "disproportionate share" provisions of the Amendment. These cases will be examined later in this chapter.

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Defining "Efficiently and Economically Operated" Facilities

"Costs that must be incurred" by an "efficiently and economically operated" facility are terms which play prominently in Boren Amendment litigation. Neither the federal government nor individual states have defined what these terms mean. Most states have tried to rely on an implicit definition, i.e., if you can operate at a certain level you must be efficient and economic. Unfortunately for the states who have used this line of reasoning, courts have not been willing to accept these implicit definitions.

The Western District Court in Multicare Medical Center v. State of Washington (1991) concluded that Washington's attempt to implicitly define reasonable costs was impermissible. Washington defined economic and efficient providers as those facilities who had their costs met by a reimbursement plan that capped base rates at the 50th percentile of operating expenses and froze capital costs at the base year level. The plaintiffs successfully convinced the judge that because only 3 percent of the providers were getting their full costs met under this reimbursement scheme it was not equitable.[36] The court concluded that:

> Based on the rate setting alone, there is no objective benchmark of an efficiently and economically operated facility by which the State could judge the adequacy of its payment rates, and hence no reasonably principled basis on which the State could make its finding that the rates were reasonable and adequate to meet the costs that must be incurred by economically and efficiently operated facilities...While the identification and determination of economically and efficiently

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> operated hospitals may be implicit in the rate setting methodology, the State cannot base its findings as to the reasonableness and adequacy of its payment rates on the rate setting alone. This would result in circular reasoning.[37]

In Michigan Hospital Association v. Babcock, the Western District Court said that the state failed to show that they went through the process of deciding what was an economically and efficiently operated hospital. Furthermore, the court found that it is "hard to give credence to the idea that only 14 of 182 hospitals and only hospitals with high indigent volume are efficiently and economically operated."[38]

While these opinions do not offer firm insight as to how low is too low for reimbursement levels, they do suggest that courts will be uneasy if some minimal threshold percentage of provider costs is not met, particularly in the absence of analysis justifying the low percentage. Phyllis Thompson, a partner with the firm of Covington and Burling who represented Washington in the Multicare case, observed that: "The courts do seem to be in some sort of 50% rule of thumb. That is, if you can show that you are meeting allowable costs for 50% of providers, then you have some basis for being comfortable." In preparing to defend the state, she found some historical basis to the 50% standard. This standard was proposed by HCFA at one time as a benchmark for approval of a state plan. If 50% of the facilities were reimbursed their costs, then there would be

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limited scrutiny of the plan. If the 50% test was not met, then HCFA would look much harder. Although this standard was never formally adopted, she states that there: "are vestiges of it around in the minds of lots of people... I think that you will have a difficult road to hoe if you can't at least meet that 50% test."[39]

Defining "Costs That Must be Incurred"

In defining "costs that must be incurred," the state of Washington attempted to pay a percentage of marginal or variable costs rather than fixed costs. The court in Multicare Medical Center rejected this argument finding that "...the uncontroverted evidence at trial establishes that all hospitals, including economically and efficiently operated hospitals, must incur fixed costs in treating Medicaid patients...."[40] The court went on to say that "...representatives from several hospitals with stable Medicaid population levels testified that they would not have to acquire as many beds and as much equipment if they did not treat Medicaid patients. Medicaid patients, like other patients, use the fixed assets of hospitals."[41]

Budgetary Considerations

Several states have attempted to use budget neutrality as a justification for setting rates restrictively, with limited success. In AMISUB, the 10th Circuit Court of

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Appeals nullified Colorado's budget neutrality factor adjustment which reduced DRG rates by 46%. They found it significant that the Director of Colorado Medicaid "admitted at trial that he had no data that shows that the actual payment rates being made to Colorado hospitals under the new DRG system will reimburse any Medicaid provider's reasonable costs."[42] The court found it unreasonable that hospitals, even though they were efficient and economical, would not be compensated for their costs. Significantly, however, the court also said the law does not require actual reimbursements for all costs, only those that are a result of efficient operation.[43]

A year earlier, the same court in Colorado Health Care Association v. Colorado Department of Social Services permitted the elimination of an incentive allowance for nursing homes with costs below its 90th percentile payment ceiling. The court made it clear that states may consider budgetary constraints, stating that: "to terminate or affect one [program] component, even if only for reasons of budgetary considerations, does not automatically produce a non-compliant payment." An important factor in this decision was that the state "considered some forty different options for cutting program costs...[and analyzed] savings in Medicaid and General Fund appropriations, client and provider impact, comments on immediate and long-term

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implications, and potential for success in implementation."[44]

In Michigan Hospital Association v. Babcock (1990) the Western District Court considered whether an update factor that was driven by budgetary factors, and for which there were no findings of reasonableness and adequacy of rates, is permissible under the Boren Amendment. In invalidating Michigan's state plan amendment, the court emphasized that "...the State's witness...stated that the recent update of 0.5% was based solely on budget considerations. Budget constraints can be considered in determining Medicaid rates, but cannot be the sole factor considered."[45]

The Eastern District Court in Temple University V. White found Pennsylvania's budget neutrality factor which reduced rates by 14% across-the-board impermissible. "...The evidence makes very clear that the 'budget neutrality' adjustment, like other features of the [state plan] is entirely budget-driven. It is simply a mechanism for keeping total medical assistance costs within the Welfare Department budget." The court further elaborated that: "moreover, the across-the-board approach--applying the adjustment equally to all hospitals and all groups without regard to their relative level of efficiency or other pertinent circumstances--is utterly inconsistent with the notion of rewarding efficiency."[46]

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LaPeer County Medical Care Facility v. State of Michigan, decided in 1991 by the Western District Court, probably best summarizes how courts are viewing budget reductions:

> ... the objective findings necessary to support the assurances, which must be submitted to the Secretary at some point, have to be completed prior to implementation [of the reductions]. If such is not required, health care providers and medicaid beneficiaries would be subject to unreasonable reductions and inadequate reimbursement rates at any time the state determines that cost-saving measures were necessary. Such liberty would severely undermine the assurances mandated by federal law.[47]

In weighing the public interest in issuing the preliminary injunction against a 30% reduction in reimbursement to 23 Michigan county nursing facilities, the court asserted in this case that the benefits of the reductions were "far outweighed" by their attendant costs.

> There is no question that the State of Michigan is in a budget crisis and that the legislature has responded with a law that requires all state citizens to make sacrifices. However, sacrifice is one thing. Creating conditions that are short sighted, not shown to be cost effective, and potentially life threatening is another.[48]

Thus, while courts have ruled that state budgetary considerations may be taken into account, any reductions to reimbursement must still be supported by objective evidence. Budgetary considerations cannot be the sole factor in determining reimbursement.

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Hospital Peer Groups

Some states band hospitals into peer groups, based on specific characteristics or statistical analysis, for purposes of calculating rates appropriate for similarly situated facilities. Courts have generally found this to be acceptable, as long as these peer groups were not assembled arbitrarily.[49]

The Eastern District Court found in Temple University v. White, that Pennsylvania's peer grouping system which classified hospitals into seven groups based on 13 variables concerning teaching, Medicaid volume, environment, and cost was arbitrary and not permissible. The court found using groups which ranged from group one, with highest cost factors, to group seven, with lowest cost factors, created perverse incentives for hospitals to increase costs to enter more highly compensated peer groups. The court elaborated: "...this difficulty is exacerbated by the fact that hospitals are assigned to groups, not because their scores on the ranking test were comparable, but simply in order to achieve seven groups of equal size."[50]

In Multicare Medical Care the Western District Court considered whether the four peer groups Washington used in setting rates were permissible. The court affirmed that these peer groups (consisting of essential rural, nonessential rural and non-teaching urban, teaching hospitals, and other specialty hospitals) were permissible

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to use in rate setting even though they did not consider other factors such as wage differentials. The court granted the state broad discretion in setting peer groups particularly when the state conducted an analysis examining different peer group options.[51]

Mary Washington Hospital v. Fisher (1985) also looked at the issue of peer groups. Here the court decided that a Virginia ratesetting task force's utilization of number of beds and whether a hospital was urban or rural were adequate proxies for case-mix and other cost variations. "The Task Force started with a significantly longer list of possible factors that might be used in establishing the peer groups ... [and t]he list was narrowed down to the two criteria ultimately chosen..." The court concluded that "...relatively imprecise groupings or classifications are almost unavoidable ... and imprecisions may certainly be justified by the difficulty of developing a more precise system."[52]

It appears that peer grouping methodologies which are supported by objective analysis will be acceptable to the courts. Groupings that are unsupported and arbitrary or that group very different providers together, however, will be examined closely. Courts will not hesitate to invalidate the latter types of grouping methodology.[53]

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Adequacy of the Update Factor

Some state payment methodologies use an update factor to adjust base year costs annually to account for inflation and other factors that affect the costs which must be incurred by an economically and efficiently operated facility. These states must decide which cost increases will be incorporated into the update factor to ensure that they result in reasonable and adequate rates. Several update factors have been used by different states, including the Consumer Price Index (CPI) and the Medicare Prospective Payment Update Factor (MPUF). As discussed in the next three cases, court decisions have varied regarding the adequacy of these factors.[54]

The state of Washington used the MPUF for updating its rates against the advice of its consultant, Peat Marwick, who helped them design their reimbursement system. Peat Marwick had raised questions about the "political football nature" of this particular update factor which is established by Congress in the context of a budget reconciliation act.[55] MPUF was questionable in their minds because it is not based on actual inflation factors, it is a number established primarily to balance the budget. The Western District Court in Multicare Medical Center confirmed Peat Marwick's warning when it rejected Washington's reliance on this inflation factor. According to the Court: "The use of MPUF...was driven solely by the State's desire

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to meet budgetary targets. There was no factual basis to support DSHS's choice of the MPUF as the retrospective and prospective inflation factor in its payment methodology."[56]

In direct contrast to this case, the District Court in Connecticut Hospital Association v. O'Neill (1991) upheld the use of the MPUF. They found it acceptable because it is a component of the Medicare methodology.[57]

Virginia uses the Consumer Price Index (CPI) which is an average of the inflation rate in many areas, not just hospital costs, as its update factor. While the Eastern District Court expressed concern about the use of the CPI in Mary Washington Hospital, it concluded that no harm was demonstrated at the current time: "[the State's] vague promise [that it will be flexible in updating its rates]...supports the Court's instinct that the potential future adequacy of Virginia's rates under the current system is not now a properly justiciable issue."[58]

Disproportionate Share Hospitals

The Boren Amendment requires that states take into account the situation of hospitals which serve a disproportionate number of low income patients in setting reimbursement rates. Congress clarified this intent in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203). States may calculate the required additional payments to disproportionate share hospitals by adopting Medicare's

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formula for such allowances or by adopting their own formulas based on a "minimum specified additional payment (or increased percentage amount) and for an increase in such payment amount (or percentage payment) in proportion to the percentage by which the hospital's utilization rate...exceeds one standard deviation above the mean."

Only two cases, both from Pennsylvania, have addressed this disproportionate share requirement of the Boren Amendment. In West Virginia University Hospitals the Third Circuit Court ruled that Pennsylvania's reimbursement methodology which took into account the costs of disproportionate share hospitals in the state, but not out of state, was impermissible.[59] Pennsylvania Medicaid was obligated to recognize and reimburse their portion of the costs incurred by West Virginia University Hospitals because Pennsylvania cases contributed to the number of low income patients served there.

In Temple University the Eastern District Court found that the disproportionate share allowance "...misses the mark by so wide a margin as to be inconsistent with the intent of Congress." The court was concerned with the proportionality of the disproportionate share adjustments to the actual increased costs of facilities that qualify for them. The court noted that:

> ...by specifying either the Medicare system or an alternative system devised by the States [to address the disproportionate share requirement], Congress seems to have contemplated that the

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> State's plan would produce comparable results. The 2.5% override provided by the Pennsylvania Plan is only about 1/10 the amount which would be payable under the Medicare analysis (2.5% versus 20.93%).[60]

Access to Care

States have argued that the one area that has yet to be considered in Boren litigation, access to health care services, should be the benchmark of whether a state is providing adequate reimbursement. In this view, if providers continue to admit Medicaid recipients, reimbursement rates must be adequate. So far, the courts have declined to find that access to care is a valid measure of adequacy of reimbursement and thus Boren compliance.

While the Third Circuit Court agreed with the state of Pennsylvania that no recipients were being denied access because of payment in the Temple University case, they concluded that it is inevitable that access will be affected in the future if the payment system remains in place.[61] In the only comment related to Medicaid client access to services in Multicare Medical Center, the Western District Court stated that "there has been no evidence presented to indicate that the Medicaid reimbursement rates presently in place have adversely affected reasonable access to Washington hospitals as of the present."[62]

As demonstrated by the review of the court findings in Boren Amendment litigation in this chapter, courts have

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become increasingly more explicit and prescriptive in their interpretations of what is required to comply with the Amendment. In the final chapter of this paper, Montana's system for hospital reimbursement will be examined and recommendations will be made regarding how to reduce both the risk of lawsuits and of losing such lawsuits, if filed.

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CHAPTER 4

RECOMMENDATIONS FOR MONTANA

Montana Medicaid contracted with Abt Associates Inc. (hereafter referred to as Abt) in 1992 to evaluate and recommend revisions to its hospital reimbursement system. A comprehensive description of the Abt recommendations is included in Appendix A. Montana adopted the majority of these recommendations and implemented a new reimbursement system for hospitals October 1, 1993. The eight revisions to the old system which are summarized below have particular relevance in potential Boren Amendment litigation:

1. Re-base the reimbursement system every five years.
2. Update the DRG grouper and the DRG weights every three years.
3. Update the inflation factor annually using the TEFRA rate established by HCFA.
4. Update outlier and catastrophic case thresholds annually using a Montana-specific inflation rate.
5. Exempt the twenty smallest hospitals from the DRG system.
6. Create different DRG weights and a separate catastrophic case pool for the seven largest referral hospitals.
7. Establish stop-loss provisions for mid-size hospitals.
8. Include payment for capital, medical education, and malpractice costs in the out-of-state hospital rates.[63]

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Because the new hospital reimbursement system has been in place less than one year, the assurances HCFA requires the state to submit to comply with the Boren Amendment have not yet been made. This chapter will, therefore, focus on how the state Medicaid program proposes to implement the Abt recommendations. These recommendations will be examined in greater detail to determine how Montana might fare under either a procedural or substantive Boren Amendment challenge.

Procedural Compliance

Montana Medicaid must submit annual assurances about the adequacy of hospital reimbursement to HCFA in order to comply with Boren Amendment requirements. The Abt Associates Inc. study will be the basis for the next five years for these assurances. This study was an in-depth look at all aspects of the reimbursement system for hospitals. The study included: the technical aspects of the rates, including how individual hospitals will fare under the new system; the fiscal intermediary's job performance (this is the firm that processes and pays claims for Medicaid); the utilization review process; and input from providers through personal interviews and surveys and a representative provider committee who provided comment/criticism over the course of the study.

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The findings and assurances that will be made in fiscal year 1994, due to the depth of this study, should not pose a problem. Clearly the state has engaged in a process of conducting the economic analysis necessary to determine that its payment rates are adequate.

The ability to make these assurances in coming years, however, will depend on the state's compliance with the study recommendations. These include: re-basing the system every five years through an extensive analysis such as the one just conducted; updating the DRG grouper and weights every three years; updating the DRG base rate for inflation annually using the Tax Equity and Fiscal Responsibility Act (TEFRA) update that is established annually by HCFA as the upper payment limit for hospitals not subject to prospective payment systems; and updating thresholds for outlier and catastrophic cases annually using a Montana-specific charge inflation factor.[64]

Requests for contracts to re-base the system and update the version of the DRG grouper utilized are not currently budgeted. Provisions will need to be made to either acquire legislative approval and funding in coming years or re-allocate existing contract funds to these projects by the Medicaid program. Traditionally, the legislature has been reluctant to fund such projects. Proposals to re-base hospital rates and update the DRG grouper were turned down in 1989 and 1991.

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Authority to annually update DRG weights using TEFRA limits, and outlier and catastrophic payments using Montana specific charge information, was included in the Medicaid budget approved by the 1993 legislature. According to Kathleen Martin, former program manager of the hospital program in the Medicaid Division, these update factors will be used barring unforeseen reductions in the program by the legislature.[65]

The other area which is subject to "procedural" litigation is whether the state's appeal procedure for ratesetting is adequate. Montana does allow appeals based on facility specific computations such as the add-on factor for capital. The state will also allow a facility to appeal whether it should be placed within a particular peer grouping for rate setting whenever the system is re-based. There is, however, no appeal allowed for individual rates to be set outside of the peer group if an individual hospital contends that its costs are higher than those of its peer group for reasons beyond its control.[66]

Even though Montana limits the ability of hospitals to appeal, it appears that they will be in a strong position to defend their actions in the face of litigation. Two courts have upheld the use of peer groups in ratesetting.

In Mary Washington Hospital v. Fisher (1985) Virginia was ordered to develop a new appeals procedure by the Eastern District Court. The Court suggested that the state

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consider issues such as whether a hospital's costs are higher than its peer group for reasons beyond its control as a factor which can be appealed.[67] The same Court upheld, however, the use of peer groupings which are developed after analysis, concluding the "...relatively imprecise grouping or classifications are almost unavoidable...."[68] The 1991 Washington state Western District Court in Multicare Medical Center v. State of Washington also affirmed that peer groups were permissible to use in rate setting.[69]

Montana could enhance its ability to defend itself against a procedural challenge by allowing appeals on the basis that an individual hospital's costs are above those of its peer group for reasons beyond its control. The burden of proof in such a case would rest with the hospital.

Montana Medicaid appears to be well positioned to defend a Boren Amendment suit on procedural grounds, assuming it follows the Abt recommendations for studies and update factors. The final portion of this chapter will examine whether the state would fare as well in terms of challenges on substantive issues under Boren.

Substantive Compliance

The primary focus in cases decided on substantive grounds has been whether rates are adequate to meet the needs of efficiently and economically operated providers. Montana has significantly modified its old system, where all

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hospital providers were paid a state-wide DRG, to ensure that its rates are adequate. These revisions include: exempting the twenty smallest hospitals from the DRG system; creating different DRG weights for the seven largest referral hospitals; creating a catastrophic case pool for these same seven hospitals; setting new thresholds for outliers which will be updated annually; establishing stop-loss provisions for certain hospitals; updating and recalibrating the DRG grouper using Montana specific data; and changing the payment for out-of-state hospitals to include capital, medical education, and malpractice.[70] These changes will now be examined in the context of previous Boren Amendment litigation on substantive issues to determine how vulnerable the state might be if such a lawsuit is filed.

Hospital Peer Groups

Courts have generally found the practice of categorizing hospitals into peer groups based on specific characteristics or statistical analysis acceptable for calculating rates. Montana has established three such peer groups for payment purposes. This was done because the old system did not provide for an equitable alignment of Medicaid payments and hospital costs. Larger hospitals that served as referral centers were disadvantaged by the more intensive nature of the services required by many of their

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patients relative to patients admitted to other facilities. The smallest hospitals in very rural areas, on the other hand, were disadvantaged by the small volume of cases that they served.[71]

After extensive analysis of the 53 in-state hospitals and the out-of-state facilities located within 100 miles of the Montana border, Abt recommended three peer groups: small rural, large referral, and mid-sized hospitals (which include all other in-state general/acute care hospitals and out-of-state border hospitals). Differentiation between these three groups is based on a number of characteristics, including number of beds, size of metropolitan area where the facility is located, volume of program activity in the hospital, and evidence of in-referral from outlying areas.[72]

The twenty small hospitals that form the first peer group are located in counties designated by the Department of Agriculture as either an "8" or "9," meaning that they are "completely rural" or have "fewer than 2500 urban population."[73] These facilities have been exempted from the DRG system and are being reimbursed on a cost basis because they are small, rural, and vulnerable in regard to their ability to generate sufficient resources to maintain access to acute services for local beneficiaries. Maintaining such access was an objective that the Montana Medicaid program specified at the onset of the Abt study.[74]

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Payments to the two peer groups remaining under the DRG system, mid-sized and large referral hospitals, are further differentiated based on the weights given to certain DRGs, stop-loss policies, and payments for catastrophic cases. The first of these three differentiations, use of distinct DRGs and weights for the large institutions, is a way of providing more equity across hospitals without setting separate rates.[75] Under the previous system all hospitals were paid the same amount for a DRG. Because Montana was using version 4.0 of the Medicare grouper, the old system did not recognize the refinements in payments for expanded diagnoses categories that were built into more recent versions. The new system incorporates version 9.0 of the Medicare grouper which increases the number of DRGs from 473 to 492. After extensive analysis there was also evidence of large intensity differences (based both on length of stay and charges) across hospitals and within DRGs necessitating further splits. The concentration of difficult or nonstandard cases was extremely high in the seven large referral hospitals. The new system divides 28 additional DRGs to establish two different payment rates for the same diagnosis, resulting in a total of 520 DRG's.[76] In all but one case, these additional customized splits favored the larger referral institutions.[77]

Most, if not all, prospective payment systems contain an outlier policy. Very simply put, this is an escape

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clause for hospitals so that if they have an exceptional case that either takes substantially more days or financial resources to treat, they are not put at huge financial risk. Montana's old system had a very generous outlier policy. By 1991, over 22% of the hospital admissions were being paid as outliers even though this payment was supposed to cover only "exceptional" cases.[78] The new system handles these "exceptional" cases three ways: through outliers, stop-loss payments, and catastrophic case payments.

Standard outlier payments will be made to both large referral and mid-sized hospitals for stable DRGs. These payment thresholds will be updated annually using the state wide cost to charge ratio. Total outlier payments will be limited to approximately 5% of the inpatient hospital budget.[79] In addition to this outlier policy, stop-loss payment provisions will be made available to mid-size hospitals and a catastrophic payment policy will be available to the large referral hospitals.

This difference in payment policy for the different peer groups is based on the particular characteristics of the respective groups. Analysis demonstrated that mid-sized hospitals did not treat the most expensive cases. They truly were occurring only in the largest seven hospitals. Because DRGs are based on a law of average which does not address these extraordinary costs, the catastrophic policy was developed.[80] Under this policy, large referral

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hospitals will be reimbursed for catastrophic cases on a percentage of charges. The threshold for cases is $100,000 in 1994 and it will be inflated annually.

Mid-sized hospitals will receive a stop-loss payment based on the statewide cost to charge ratio for cases where the charges are less than 75% or greater than 400% of the DRG amount.[81] This policy is designed to cover the risk to these mid-size hospitals for DRGs for which there was an insufficient number of cases available to determine if the weights for the DRG were stable. Large referral hospitals were not included in the stop-loss provision because it was felt that they treated a large enough volume of cases to create stable, predictable average resource requirements.[82]

The use of peer grouping to set different payment rates would seem to be acceptable based on the decisions of the courts in two cases previously examined: the Multicare Medical Center case decided in Washington state and the Mary Washington Hospital v. Fisher case decided in Virginia. In both cases the courts upheld the use of peer grouping methodologies when these methodologies were based on analysis.

Defining "Costs Which Must be Incurred"

The Boren Amendment requires that state Medicaid programs pay the "costs that must be incurred" by an "efficiently and economically operated" facility.

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Differences in opinion between providers and state Medicaid programs about what these terms mean has been the basis of much of the litigation which has taken place over the past decade or so. Montana has sought to define these terms in the new reimbursement system.

Fiscal year 1991 is the base year used to set new rates. This year was chosen because it was the most current period for which Medicare cost reports were available for all facilities. (Medicare and Medicaid use the same cost report but they are audited and settled separately.) Unfortunately, the latest year that Medicaid settled cost reports were available was 1989. 1991, rather than 1989, was used because Abt. Associates Inc. believed that using data from the more current year, even though it was not yet audited, provided a greater chance that contemporary structural features of the hospital industry would be incorporated into the new ratesetting system.[83]

Abt performed a variety of tests to define reasonable costs for fiscal year 1991. Six separate estimates were created by assuming that the cost per discharge for each year between 1985 and 1991 was efficient. The discharge cost for each year was inflated by the TEFRA market basket update factors as published by HCFA to come up with six individual ratios of allowed versus actual costs. This ratio was then averaged. The average suggested that about 88% of expenses in 1991 were "reasonable". However, because

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the data for 1987 and 1988 were incomplete, they were thrown out. This resulted in a new estimate of the ratio of reasonable to allowed costs of 93.5% for 1991.[84] This ratio, which is considerably more generous to hospitals than the 88%, has been adopted by Montana Medicaid.

In addition to this efficiency test, Abt utilized another measure to confirm efficiency. This was the weighted 80th percentile standard. It was defined as "the cost per admission where 80% of the program discharges before 1991 were serviced in facilities having adjusted costs per discharge lower than the indicated amount." In simpler terms, 80% of the cases would have had their costs met by the payment rate in 1991. The resulting estimate of unreasonable cost (about $2 million) was consistent with the independent estimate that 6.5% of the costs were unreasonable using the methodology described above.[85]

Abt Associates Inc. recommended that Montana Medicaid use the 93.5% efficiency standard in setting its base rate in 1991. In their words:

> We believe that setting rates against an estimated reasonable cost threshold of 93.5% of observed allowed costs is generous, is attainable by all facilities in the state, and is justifiable to federal officials as an objective standard that will reinitialize a more controlled ratesetting methodology in years to come. . . .This efficiency standard is consistent with a conservative estimate of reasonable costs which is based upon the average of several estimates using the data that was available to us at this time.[86]

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This 1991 base rate is inflated by the TEFRA market basket rate for each year. This TEFRA inflation factor is the maximum inflator allowed by HCFA. Use of this factor as the maximum which can be paid by a state Medicaid agency has been upheld by two courts.

Charleston Memorial Hospital v.Conrad was decided in 1982 by the 4th Circuit Court of Appeals. The court specified that because the Boren Amendment was designed to lower payments from those required under Medicare retrospective reimbursement, state plans that continue to use Medicare reasonable cost principles pay the maximum permissible rates allowed by law.[87] This ruling that the Medicare ceiling is the maximum amount allowed by federal law was affirmed in 1983 in Alabama Hospital Association v. Beasley by the 11th Circuit Court.[88]

It is important to note that although 80% of the discharged cases in 1991 will have their costs covered under the new system of reimbursement, only 45% of the hospitals will recover their costs.[89] Phyllis Thompson, a partner in Covington and Burling which tried unsuccessfully to defend the state of Washington in the Multicare case, pointed out that she believes that it is important to show that a state can meet a "50% test" on reimbursement.[90] While the plaintiffs in a Boren suit would undoubtedly argue that it is not reasonable that only 45% of hospitals have their costs met, Montana has employed two tests to demonstrate

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efficiency. Because these standards result in 80% of the discharges being paid for, because there are "winners and losers" among both the large and mid-size hospitals, and because Montana uses TEFRA which is the highest inflation factor allowed, this should not be an insurmountable argument to overcome.

Disproportionate Share Hospitals

Montana's new system takes into account the capital, medical education, and malpractice costs of out-of-state hospitals in determining rates.[91] This change and the continued use of the federal definition to define disproportionate share hospitals puts the Montana Medicaid program in a very strong position to defend any challenge based on previous disproportionate share rulings.

Conclusion

The analysis presented above indicates that Montana Medicaid's reimbursement system should fare well in the event of Boren Amendment litigation in the immediate future. Montana will, however, continue to be subject to the same budgetary pressures that other states have faced in trying to control rising medical costs in the Medicaid program. The challenge in future years will be to devote enough resources, both in terms of payment to providers and administrative support for the payment system itself, to

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maintain the hospital reimbursement system so that it remains defensible. That chapter is yet to be written.

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APPENDIX A

Abt Recommendations for Improving the Montana Medicaid Hospital Reimbursement System

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1.0 Recommendations

1. The program should continue to reimburse hospitals on the basis of a DRG system that employs a statewide base rate, outlier provisions, exemptions for capital cost, outpatient and rehabilitation services, and certain other items that continue to be paid on a cost basis.

The basic tenets of the DRG approach to payment continue to be worthwhile in supporting efficiency and equity in payment to hospital providers. Data do not allow us to estimate what the impact of the current system has been on cost and payments, though the cost containment impacts of the DRG system can be presumed from available research evidence.[1] The DRG system makes hospitals accountable for choices they and physicians make about intensity of service and length of stay. There is no alternative payment methodology with a proven cost containment record to match that of the basic system which Montana has in place. The only possible exceptions would be an all payer, budget control approach (used in Maryland) or selective contracting (California). However, these kinds of systems, arguably more equitable or more effective in the containing cost, require extraordinary levels of resources to administer. For that reason we do not recommend such approaches as an option for consideration to the basic DRG program.

2. We recommend that the basic DRG system, or prospective fee approach to payment, be extended to capital, outpatient services, and other excluded costs and excluded providers as quickly as possible.

We do not recommend initiating any of this activity at this time. Other recommended improvements, noted below, need to be made first to rectify certain problems and inequities in the current system. But, we recommend that the state extend current legislation to provide for prospectivity in payment of the following services, at some fixed point in the future or against some phase-in schedule. Medicare is now moving to prospective payment for capital, with outpatient services soon to follow. With the pace of cost increases in both of these areas, the program must develop a design, a ratesetting approach, and an implementation plan in order to protect the fiscal integrity of the program and to put sensible cost containment policy into place. We include as appendices brief discussions of options that might be available to the program.

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[1]Coulam, R. and Gaumer, G., "A Critical Appraisal of the Literature on the Impacts of PPS," Health Care Financing Review, Annual Supplement, March 1992.

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3. Psychiatric services in acute facilities should continue to be paid under the DRG system, as modified, and the exemption should continue for qualifying freestanding facilities.

We recommend that the program take steps, and possibly legislative action, to better control the use of services and the associated payment levels for the psychiatric services that are covered by the program. This is not simply a ratesetting methodology issue. To improve equity to providers we recommend that refinements be made in FY 1993 in the psychiatric DRGs to take account of intensity differences in the treatment of children and adults and differences in severity that occur across types of hospitals. And, to improve efficiency for the program we recommend that future options be considered that include selection of a case management vendor who, under capitation, would have responsibility for all state funded psychiatric services and populations. Or, a future option could be considered that would put all psychiatric services covered by the program on a DRG basis with peer grouping for different types of facilities.

4. Rehabilitation services should be also be considered an area for future cost containment activity.

We do not believe that the current payment approach for rehabilitation services is inequitable to providers. But, we recommend that the program consider improving the efficiency of the payment approach; either by developing a statewide per diem rate for each of several levels of care, or by utilizing a set of DRG-like categories, one for each MDC which would be determined by the principal diagnosis.

5. Important changes need to be made immediately in the payment provisions used to pay hospital providers in other states.

We recommend that a capital/education/malpractice DRG rate add-on be established and paid to border facilities that serve the program's beneficiaries. We recommend that program staff enter into discussions with officials from other state programs so as to begin paying out-of-state providers on the basis of the methodology used by the Medicaid program in their respective states. If need be, a rate agreement could be negotiated that is different from, but grounded on, the payment approach used by these other states (for example, the program could be twice the rate paid by the hospital's own Medicaid program). We also recommend that the program investigate the possibility that some of the volume of referral services to hospitals in other states be appropriately serviced by Montana providers. The improvements in payment equity for large, referral hospitals which are detailed below should improve the financial attractiveness to

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Montana hospitals for treating the kinds of difficult cases that are often sent out of state. And, in a parallel activity, we recommend that Medicaid examine methods of educating, encouraging, or regulating the practice pattern of Montana referring physicians so as to achieve the most appropriate and efficient referral pattern for cases that are candidates for out-of-state referral.

6. We recommend that the improvements in the DRG system explicitly recognize the intensity differences for facilities that serve as referral centers within the state. We recommend that this be done by establishing a peer group of qualifying facilities and by establishing a set of qualifying DRGs. Those DRGs would have separate relative weights in the qualifying hospitals.

One of the potential limitations of DRG systems is that intensity or acuity tends to vary across patients within any particular DRG. On average, and over large numbers of cases, this within-DRG variation is equitably treated by DRG payment systems. However, if there are classes of facilities which treat patients who are systematically more severe than those treated in other places, then there is a persisting inequity in the system. This appears to have been the case in Montana, with a relatively small number of large urban hospitals and a much larger number of very small facilities dispersed across the state. Our analyses suggest that the concentration of certain kinds of cases is extremely high in the large referral hospitals and, anecdotal, persons and their physicians prefer to use these institutions for difficult and nonstandard cases. And, our analyses show that intensity is higher in those institutions for 29 such DRGs.

7. We recommend that the current system be modified to exclude certain rural hospitals from prospective payment and have them reimbursed for services to beneficiaries on the basis of incurred costs. We recommend that these facilities be designated as those that serve isolated, small rural populations, who would be disadvantaged in their access to acute services if hospitals failed to recover incurred costs. Small, isolated communities also do not permit hospital managers as many market opportunities for coping with inpatient volume variations and other efficiency-related factors that may lead to less than full cost recovery at the standard DRG rates.

We recommend that the state utilize the United States Department of Agriculture county classification system in

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order to identify rural counties throughout the state that are so sparsely populated as to make it a difficult marketplace to sustain a hospital, and a significant access problem to obtain acute services if the existing hospital were no longer operational. We recommend that the categories described by the USDA as "completely rural" with urban population centers of less than 2500 persons be considered qualification for this class of excluded facilities. There are 25 facilities in these counties in the state of Montana, five of which are already in the MAF program and are exempt from the Medicaid DRG system.

8. We recommend that the DRG system be implemented in FY 1993 with a modified version 9.0 HCFA grouper using weights derived from Montana data.

HCFA's Medicare version 9.0 grouper is the most popular and most current of the groupers being used by state Medicaid programs. The version 9.0 grouper, and the associated weights, improve the fairness of payment across patients and across hospitals. Payment can be much better aligned with cost of treatment due to the addition of a number of new DRGs and refinements to many others which we detail in our report. To provide the most equity to providers, weights should be developed from billed charges that are untrimmed, utilizing no variance reduction or smoothing techniques (such as geometric means, logarithms, robust weighting) that would "compress" the measured weights. As noted earlier, our recommendations include improving the grouper classifications further by creating more DRGs to provide for age splits (over, under 18) for the psychiatric DRGs, and for intensity splits for certain DRGs associated with higher intensity in the urban referral hospitals. A total of 520 DRGs are recommended, up from the 473 used in the current program.

9. We recommend that the methodology used for paying for services rendered to extraordinary cases be modified extensively in order to stem the primary source of uncontrolled program payments in the current methodology. Specifically, we would replace the separate cost outlier, day outlier, and stop loss methodologies with a catastrophic case payment policy, a new outlier payment policy, and a new stop loss payment methodology which applies only to certain DRGs.

For outliers, we recommend that thresholds for cost and day outliers each be set so that 5% of program payments would be paid under the outlier rule in either case. The actual outlier payment policy would pay the estimated incremental costs associated with the higher of the qualifying day or

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outlier amounts.

A catastrophic payment rule is being recommended as a new feature of the program. This provision would identify a threshold (a charge threshold equivalent to $120,000 in 1991 billed charges) which would allow providers to seek special supplemental payment. Qualifying cases successfully appealed to an adjudication body would be reimbursed, at maximum, costs as determined by billed charges multiplied by the statewide cost-to-charge ratio (SCCH).

We recommend eliminating the current stop loss provision for SCHs and newborn cases and replacing it with a stop loss arrangement aimed at those DRGs which have insufficient volumes of Montana data to generate "stable" DRG weights. This payment provision would not be available to the large, referral hospitals, which have sufficient volumes of cases to make the set of weights stable in the aggregate. For the "unstable" DRGs in qualifying facilities the stop loss provision would protect the state and the provider from abnormal or unanticipated patterns of cases in these DRGs. Payment would be determined by the level of billed charges for the case. If charges are between 75% and 400% of the DRG amount, then the DRG amount is the payment in full. For other cases, estimated cost would be paid using the statewide cost-to-charge ratio applied against charges.

10. We recommend that the standardized payment amount be rebased against estimated incurred costs in 1991, and that those costs be subjected to a reasonableness test, or an efficiency standard, in creating the pool of costs to be used for computing the new standardized payment amount.

The current system has not been rebased since inception, when the standardized amount was based on 1983 costs. Rebasing is essential since there are recommendations about new exclusion rules and new approaches for defining, and paying for extraordinary cases. We recommend that the most recent year of available data from submitted Medicare cost reports be used (1991) to reflect the most recent data on costs and on the distribution of cases across the industry. We further recommend that the cost base be subjected to a reasonableness test in the form of an efficiency standard which is based on analyses of reasonable cost increases using TEFRA update limitations. The indicated standard for efficient operations is consistent with the use of the weighted 80th percentile level of expenses per case (adjusted for casemix) as a reasonableness test on base year incurred costs, which yields a reasonable cost level that is about 93.5% of 1991 allowed inpatient costs.

The DRG standard rate for the 1991 base period which is

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consistent with this reasonableness standard and other aspects of the recommended payment methodology is $1,635. For setting the FY 1994 rate, the use of this rate base (plus the TEFRA updates) would extend the same TEFRA-based reasonableness standard to the period between the base year (1991) and the rate year (1994). An alternative assumption would be to not apply an implicit reasonableness test to the 1992-93 period. Instead, the 1994 rate would be based on recovery of 93.5% of allowed costs at the onset of the 1994 fiscal year. This rule would cause the 1991 base rate to be $1,665.

11. We recommend that the program utilize two update factors in order to adjust rates from year to year for changes in factors that affect the costs of providing services to recipients, but which are not under the control of hospital managers.

We recommend that the standard payment amount and the outlier per diem (for day outliers) be updated from year to year based on the TEFRA market basket index used by HCFA and published in the Federal Register.

We also recommend that the state develop an index of charge levels based on the ratio of casemix adjusted billed charges in the past year to casemix adjusted billed charges in 1991. This would be used to update the statewide reasonable cost to charge ratio (SCCH) by using the TEFRA increase to indicate reasonable costs. It would also be used to update the thresholds that are based on charge levels such as for cost outliers, for catastrophic cases, and for stop loss cases.

12. We recommend that the utilization review program be reestablished but focused on retrospective review of targeted diagnoses/procedures, profiling of hospitals and physicians, short stays, and problems identified through monitoring of practice patterns and claims reporting. Medicaid UR should increase attention to provider participation and education to help promote formative improvements in provider practice.

We recommend that Medicaid develop a flexible, focused, and interactive strategy for UR, with data analytic and clinical review components designed to accommodate, and respond to, changing patterns of health care delivery. A UR committee, including participants representing physicians and hospitals as well as Medicaid, should be established to advise the program on review priorities, provider education and sanctions, and follow-up for catastrophic and other unusual cases. Computer generated reports should be prepared by Medicaid, a review organization, or qualified third party as a basis for review, to inform the UR committee and Medicaid,

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and as a tool for provider education.

We also recommend that Montana exclude review of normal newborns, as several Medicaid DRG systems have done; provide statistical review of outliers, readmissions and transfers, with clinical follow-up as indicated; and review cases that pass the proposed catastrophic limit, or the threshold for unstable DRG charge-based payment. We further recommend that special approaches be developed, on the advice of the UR committee, for review of psychiatric and rehabilitation services. These approaches might include case management, service contracting, or other methods used by other states and adapted to Montana's health care delivery environment. Existing resources should be adequate to redirect and focus Medicaid UR to improve its cost effectiveness and efficiency.

13. We recommend that certain aspects of the program be retained in their current form, including: the transfer payment policy, disproportionate share rules, and definitions of allowed cost.

Our analyses indicate that these program features are adequate and appropriate methods, widely recognized as fair and equitable, and do not warrant change at this time.

14. We recommend that the program take steps to improve fiscal agency and operations in order to expedite the settlement of cost, to expedite the determination of eligibility, and to otherwise improve the appropriate cashflow to providers.

The hospital survey and interviews with providers were frequently consumed by reference to difficulties in getting paid promptly, and with expressions of concern about getting certain reports from the fiscal agent to list payment transactions. Complaints by providers and program officials were also common about the timeliness about certain volume reconciliation reports that are key to conducting the cost of settlement.

15. We recommend that the program take the following legislative and regulatory steps immediately: to provide a legislative basis to proceed with payment reform (by means of regulation); to adopt prospective payment approaches for capital costs as well as psychiatric, outpatient, and rehabilitation services; to provide opportunity for updating rates, the SCCH ratio, and other payment parameters without legislation; and to create other law or regulation that would be required to establish

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the hospital groups, exemptions and payment rules we recommend.

> To expedite implementation of a comprehensive, total system, as we propose, and to ensure its performance integrity (including routine maintenance, refinement and updates), the Medicaid program should initiate appropriate legislative and regulatory action immediately upon agreement about system parameters and features.

16. To help achieve better alignment of payments and costs of treatment, and to encourage appropriate referral behavior, we recommend that the large referral hospitals in the state be recognized as a peer group for purposes of the payment system. These facilities would separate DRG weights for a small set of DRGs, and would not utilize the stop-loss payment provision owing to their large volumes of cases.

> In order to make proper compensation for differences in intensity we recommend the establishment of a peer group representing the largest hospitals within the largest urban areas of the state, and to which to which physicians around the state commonly refer or transfer cases. A group of seven facilities is recommended, as determined by examining the largest (the size of facilities, number of beds); the fraction of admissions coming from other, more rural counties; the volume of program services and the corresponding "statistical stability" of the version 9.0 DRG weights, and the diversity of DRGs treated in these institutions. These facilities are:
>
> - Montana Deaconess (Great Falls)
> - St. Vincent's (Billings)
> - St. James (Butte)
> - Missoula Memorial (Missoula)
> - Columbus (Great Falls)
> - Billings Deaconess (Billings)
> - St. Patrick's (Missoula)

17. We recommend that the state make explicit provisions and plans to update, recalibrate, and improve system features as part of an overall program of maintenance for the system. This will require additional program staff.

> These activities include developing a plan for further improvements to the payment method (rehab, psych, out-of-state hospital negotiations, capital and DSH). Other maintenance activities include preparing the update factors, the SCCH, the various thresholds, and the standard payment amount (every year); revising the grouper and recalibrating the weights (probably every three years); and rebasing and computing capital payment amounts (every five or six years).

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The necessary monitoring activity and the annual preparation of update factors will require preparation of cost report and claims data and considerable analytic work. This data and analytic work has not been done before, contributing to the obsolescence of many program parameters, and resulting in inequities and loss of fiscal control. We strongly recommend that the program add a staff analyst position (or at least 75% of one full-time position) to do this work.

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