TO: Chris Jennings

FROM: Rich Deem

SUBJECT: Potential announcement for Vice President Gore

Per our discussion on possible announcements that Vice President Gore could make at our Grassroots Conference next week, I honestly believe that he should announce that HCFA has the authority and will correct the projection errors that, if left uncorrected will **ROB** physicians of $3 billion. Attached is a background document.

Supportive Arguments

1) HCFA clearly erred and should not renege on its previous commitment to correct projection errors. VP can announce that he will hold govt. to higher standard—fair and honest.
2) We have indications that Dems. and Reps. believe that HCFA should be required to correct the projection error. I also think that we can get key Republicans to say that HCFA has the authority to fix this and remove part of the SGR problem from the current BBA 97 fix legislation.
3) There is a strong case that fixing the projection error is not a scoring issue because CBO doesn't plug in projected updates in their spending estimates.
4) The SGR piece could be part of a bigger discussion about strengthening Medicare the effects of the BBA and the need to spend more money on seniors and stop the cut the provider game to cover up inadequate financing schemes.

On the PBR front: the VP could get good news coverage if he decided to attack the insurance industry for spending $100 m for its campaign of lies and distortions to block passage of meaningful patient protections. The media loves a fight and the insurance industry is an inviting target. Key points could include: the politics of greed vs. need---how many services could be provided with the money spent to block legislation----no more Jimmy Adams---quad amputee due to ER restrictions---compensation of insurance executives-----passed on bipartisan basis in over forty states----see Geo. W. Bush comments in recent Nat'l Journal---its time for leadership on the issue not silence.---contrast avg. citizen with Members of Congress who can go to Bethesda Naval without any managed care hassles. The targets of opportunity on PBR and insurers are endless.

Excerpts from letter of March 4, 1999, to Harriet S. Rabb, JD, HHS General Counsel, from Michael L. Ile, JD, AMA General Counsel, regarding use of accurate data in Medicare's sustainable growth rate

On behalf of the American Medical Association (AMA), I am writing to express our grave concern regarding the failure of the Health Care Financing Administration (HCFA) to revise the obviously flawed estimates used to establish the 1998 and 1999 Sustainable Growth Rate (SGR). By its action, HCFA has violated the statute authorizing the application of the SGR, and its continued use of erroneous estimates can only be seen as an act of bad faith on the part of the Agency and the Department. **Deliberate use of SGR estimates that are based on knowingly flawed projections --even after actual data have become available-- is arbitrary and capricious.** At a time when physicians are feeling increasingly burdened by Medicare's overwhelming regulatory requirements, the Department seriously should rethink and correct regulatory actions that inflict baseless economic penalties on each and every physician who tries to fulfill the goal of providing quality medical care services for elderly and disabled patients.

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Medicare's SGR system was established by the Balanced Budget Act of 1997 to limit growth in Medicare expenditures for physician services provided to beneficiaries enrolled in the fee-for-service (FFS) program. The Secretary of Health and Human Services is directed to calculate a target rate of spending growth for each year. Updates in the Medicare physician fee schedule depend on whether actual spending growth exceeds or falls short of the target amount. The Secretary is required pursuant to Section 1848(f) to calculate the SGR each year based on four Factors:

1. ...the Secretary's estimate of the weighted average percentage increase in the fees ... for all physicians' services...;

2. ...the Secretary's estimate of the percentage change ... in the average number of individuals enrolled under this part (other than Medicare + Choice plan enrollees) from the previous fiscal year...;

3. ...the Secretary's estimate of the projected percentage growth in real gross domestic product per capita...; and

4. ...the Secretary's estimate of the percentage change ... in expenditures for all physicians' services in the fiscal year ... which will result from changes in law and regulations....

*****

An SGR of 1.5% for fiscal year 1998 was published on October 31, 1997. This final notice (signed by HCFA Deputy Administrator Nancy-Ann DeParle on October 27, 1997 and HHS Secretary Donna E. Shalala on October 28, 1997) was characterized as "an interpretive rule" and notice and comment procedure was waived. In addressing Factors 2 and 3, the final notice makes the following statements:

- "Differences between projected and actual enrollment will be adjusted for in subsequent years."

- "Differences between projected and actual real gross domestic product per capita growth will be adjusted for in subsequent years."

In considering Factor 4, the final notice also addressed "fee changes associated with implementation of the 1998 physician fee schedule."

*****

Three months after the statutorily set latest publication date, HCFA and HHS published the fiscal year 1999 SGR on November 2, 1998 as a "notice with comment period." (For fiscal years starting in 1999, Section 1848(f)(1) calls for publication to "occur by not later than August 1 before each fiscal year.") This notice could have been used as the vehicle to rectify the previous projection errors, but it was not. Under the heading "Factor Four – Percentage Increase in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in Fiscal Year 1999 Compared With Fiscal Year 1998," the notice addresses the failure to make the promised adjustments:

*****

> We do not believe that the Congress, in enacting the SGR, contemplated such significant variances between estimates made at different points in time. Therefore, we are considering whether we should "adjust" the SGR or the update for a year, to take into account more recent estimates, when the subsequent year's update is determined. Such an adjustment for estimate differences would assure that the update is related to actual performance. However, we have concerns about how this could best be accomplished, if at all, under current law. Therefore, we invite comments specifically with regard to how an adjustment could be effected consistent with the law and we will respond in a future notice.

*****

## HCFA HAS THE AUTHORITY AND THE RESPONSIBILITY TO UPDATE THE ESTIMATED FACTORS IN THE SGR TO REFLECT ACTUAL DATA

### Authority

The statutory basis for the SGR system was a recommendation from the Physician Payment Review Commission (PPRC), a congressional advisory body. In developing and making its recommendation, the PPRC clearly envisioned a process that allowed for corrections. In particular, the PPRC's 1996 Report to Congress stated:

> "Any revision to the Volume Performance Standard system should annually correct for any projection errors in the target growth rate from prior years. ...This limitation [projection errors] could be readily addressed by incorporating an adjustment into the sustainable growth rate that corrects for previous errors in the projection."

HCFA noted in its publication of the 1999 SGR that "the establishment of the SGR for any year involves the use of projected values for Medicare beneficiary fee-for-service enrollment and the real gross domestic product per capita." Based on the implications of projected values, HCFA also noted "concern" that "there will be differences compared to later estimates of some of the components of the SGR" even after their "best efforts to make estimates at the time the SGR is established."

We share this concern. Experience already has confirmed that even the worst case scenario presented in the 1999 SGR publication actually was an underestimation. ("A projection difference of only 1 percentage point would affect roughly $400 million in spending under the physician fee schedule.") Where we disagree strongly with HCFA is in its newly found interpretation that such variances were not imagined by Congress and that corrections may not be made under current law. Consistent with the directions from the PPRC and particularly in consideration of the cumulative effect of the SGR, there is no reason why corrections in the pertinent update factor cannot be made in succeeding years to account for previous inaccurate estimates.

The variances between actual numbers and estimated projections are created as a direct result of regulatory action. **The authority to make adjustments to address these variances is provided in Factor Four. This Factor is an adjustment factor to reflect "changes in law and regulations."**

Under the Medicare program, directions for and changes in the process for setting program payments are addressed through the regulatory process. Section 1871 of the Social Security Act, reads (in part):

> (a)(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.
>
> (2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

The SGR requirement is a substantive legal standard governing the payment for services, and its promulgation, even as a "final notice" and as a "final notice with comment period," clearly has the weight of regulation. In waiving the applicability of a notice and comment procedure for the 1998 SGR, HCFA refers to the final notice as a "rule" and both the 1998 and 1999 notices speak to the regulatory nature of the SGR determination through the inclusion of a section addressing the government's responsibility to present a "regulatory impact statement."

Implementation of the SGR is a regulatory action that must be accounted for in the application of Factor Four. In setting the 1998 SGR, Factor Four was used to account for "fee changes associated with implementation of the 1998 physician fee schedule." In considering the 1999 SGR, the implementation of the fee schedule in 1999 also was addressed in setting Factor Four. Clearly, the SGR is an integral component of the physician fee schedule and HCFA already has established the precedent to use this Factor to account for implications associated with implementing the payment schedule.

In publishing the 1999 SGR, HCFA weighed the issue of corrections for projection errors:

> "We are considering whether we should "adjust" the SGR or the update for a year, to take into account more recent estimates, when the subsequent year's update is determined. Such an adjustment for estimate differences would assure that the update is related to actual performance. However, we have concerns about how this could best be accomplished, if at all, under current law.

**We agree that the update must relate to actual performance. Not only does HCFA have the authority to do so, it has the obligation to do so.**

*****

TO: CHRIS JENN

TO BE PUBLISHED IN FY 2000 SEE NOTICE

for a given year is based on projected values, updates may be either lower or higher than they would have been if we had used later data. Thus, we initially considered revising estimates of the factors used in setting the SGR when later data had become available. However, as we indicated in the notice with comment period published in the **Federal Register** (63 FR 59188) on November 2, 1998, we had concerns about whether we had the statutory authority to make these revisions under current law and invited comments regarding how an adjustment could be made consistent with the law. The comments we received and our response are discussed below.

Comment: The American Medical Association and numerous physician organizations suggested that congressional intent should be interpreted to authorize adjustments for projection error. These commenters also suggested a number of different approaches for making such adjustments. The various approaches suggested rely on later data.

Response: We do not believe that we have the authority to make adjustments based on Congressional intent because the statutory language clearly requires that estimated values be used for computing the SGR and there is no provision for revising the estimates to reflect later data. Our actions are controlled by the clear statutory language.

Thus, we will not be able to make adjustments to the SGR based on later data.

However, the Administration's legislative package for fiscal year 2000, released in February 1999, contains a legislative proposal to adjust the SGR if later data are different from earlier estimates, as well as to address issues relating to the instability of the SGR discussed below. The changes proposed are all budget neutral. If Congress enacts this proposal for fiscal year 2000, we would revise the SGR for fiscal year 2000 as appropriate.

**V. Technical Problems With the Sustainable Growth Rate System**

We have begun to forecast the SGR for future years, and it appears that there is some instability in the SGR system. In the long-term, updates could oscillate between the maximum increase and decrease adjustments due to the use of mismatched time periods and the lag between measurement periods. The solution would be technical and would involve the matching of time periods for the SGR calculation, the actual versus target measurement, and the update adjustment. As discussed above the Administration has submitted a legislative proposal to the Congress that will address these factors and result in less oscillation in the physician fee schedule update.

# FAX COVER SHEET

## OFFICE OF LEGISLATION

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Number of Pages:_____ Date: _____

| To: | From: |
|---|---|
| Devora | IRA BURNEY |
| Fax: 690 7600 | Fax: 202-690-8168 or 205-5157 |
| Phone: _____ | Phone: _____ |

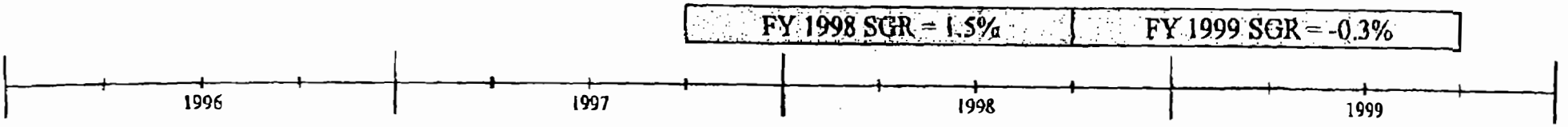
REMARKS:_____


**HEALTH CARE FINANCING ADMINISTRATION**
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

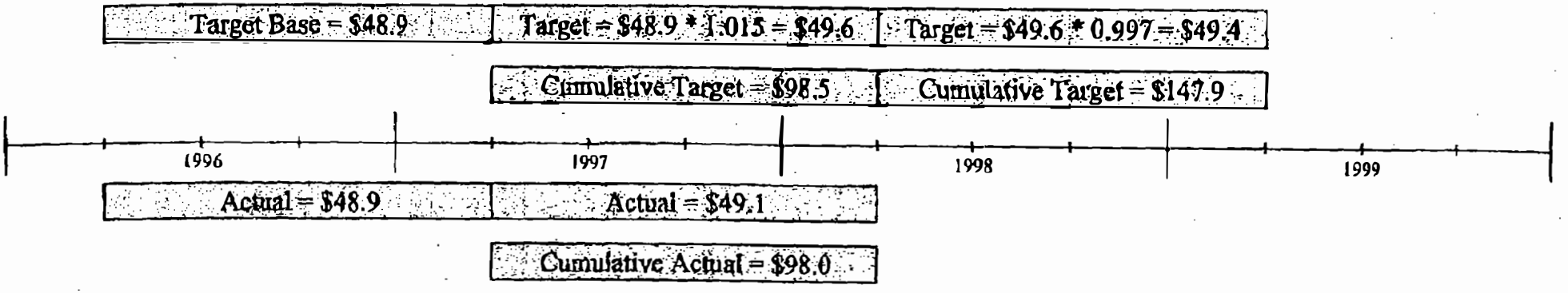
# CURRENT SUSTAINABLE GROWTH RATE CALCULATION

## The Balanced Budget Act of 1997 Provision

**SGR calculated on a FISCAL YEAR basis:**

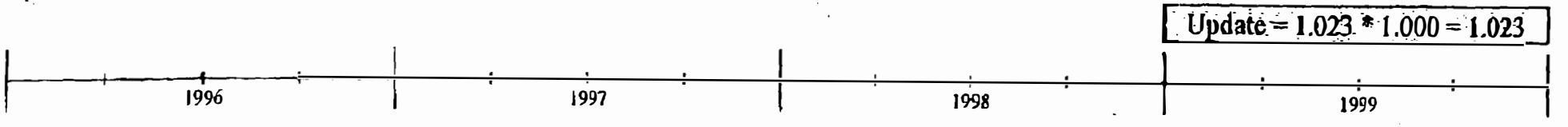



**Performance adjustment calculated on a YE 3/31 basis:**




**Conversion factor updated on a CALENDAR YEAR basis:**

Update = (1 + MEI) * (1 + performance adjustment)



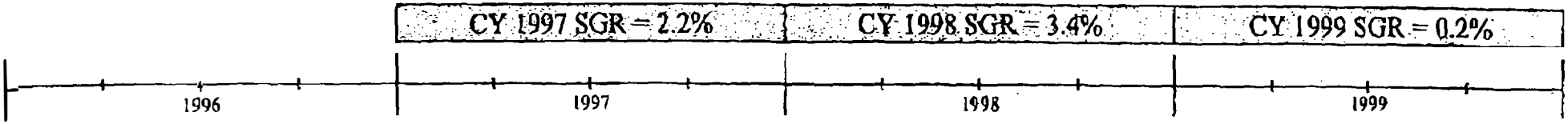

$$\text{CY 1999 Performance Adjustment} = \frac{\$147.9 - \$98.0}{\$49.1 * 1.015} = 0.0\%$$

Note: Dollar figures are in billions. Figures are for allowed charges, before application of deductible and coinsurance. Figures are for services covered for measurement of performance, not services subject to performance adjustment.

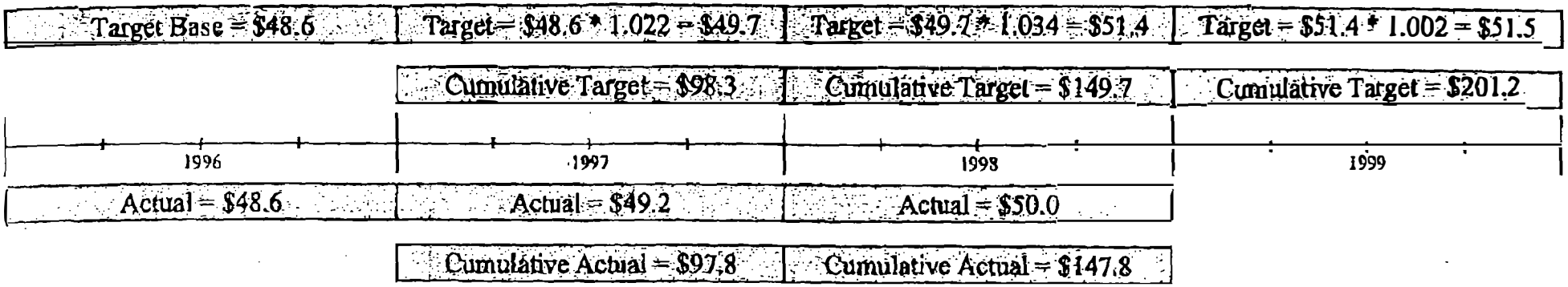
# REVISED SUSTA NABLE GROWTH RA' 'E CALCULA' 'ION

Some of the data used is estimated

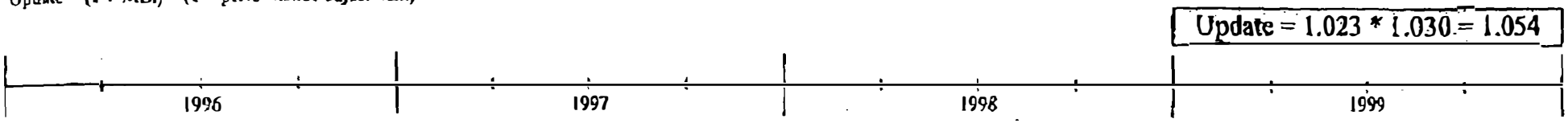
**SGR calculated on a CALENDAR YEAR basis:**




**Performance adjustmeot calculated on a CALENDAR YEAR basis:**




**Conversion factor updated on a CALENDAR YEAR basis:**
**Update = (1 + MEI) * (1 + performance adjustment)**




$$\text{CY 1999 Performance Adjustment} = \frac{\$201.2 - \$147.8}{\$50.0 * 1.002} \approx 6.6\% \text{ (3.0\% maximum)}$$

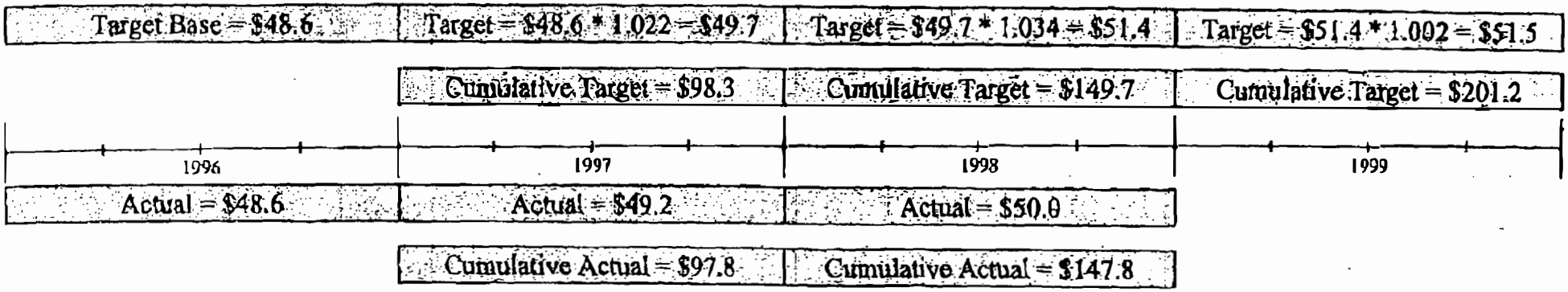
Note: Dollar figures are in billions. Figures are for allowed charges, before application of deductible and coinsurance. Figures are for services covered for measurement of performance, not services subject to performance adjustment.

# 75%/33% WEIGHTS SUSTAINABLE GROWTH RATE CALCULATION

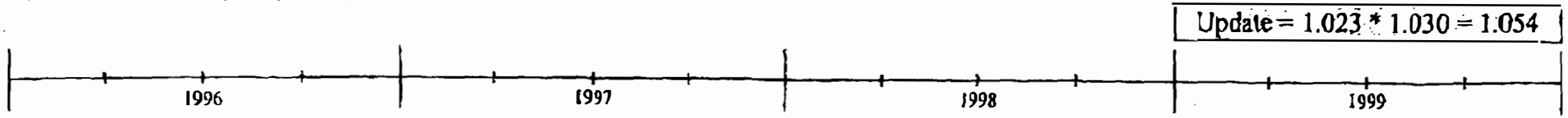
Some of the data used is estimated

**SGR calculated on a CALENDAR YEAR basis:**


**Performance adjustment calculated on a CALENDAR YEAR basis:**



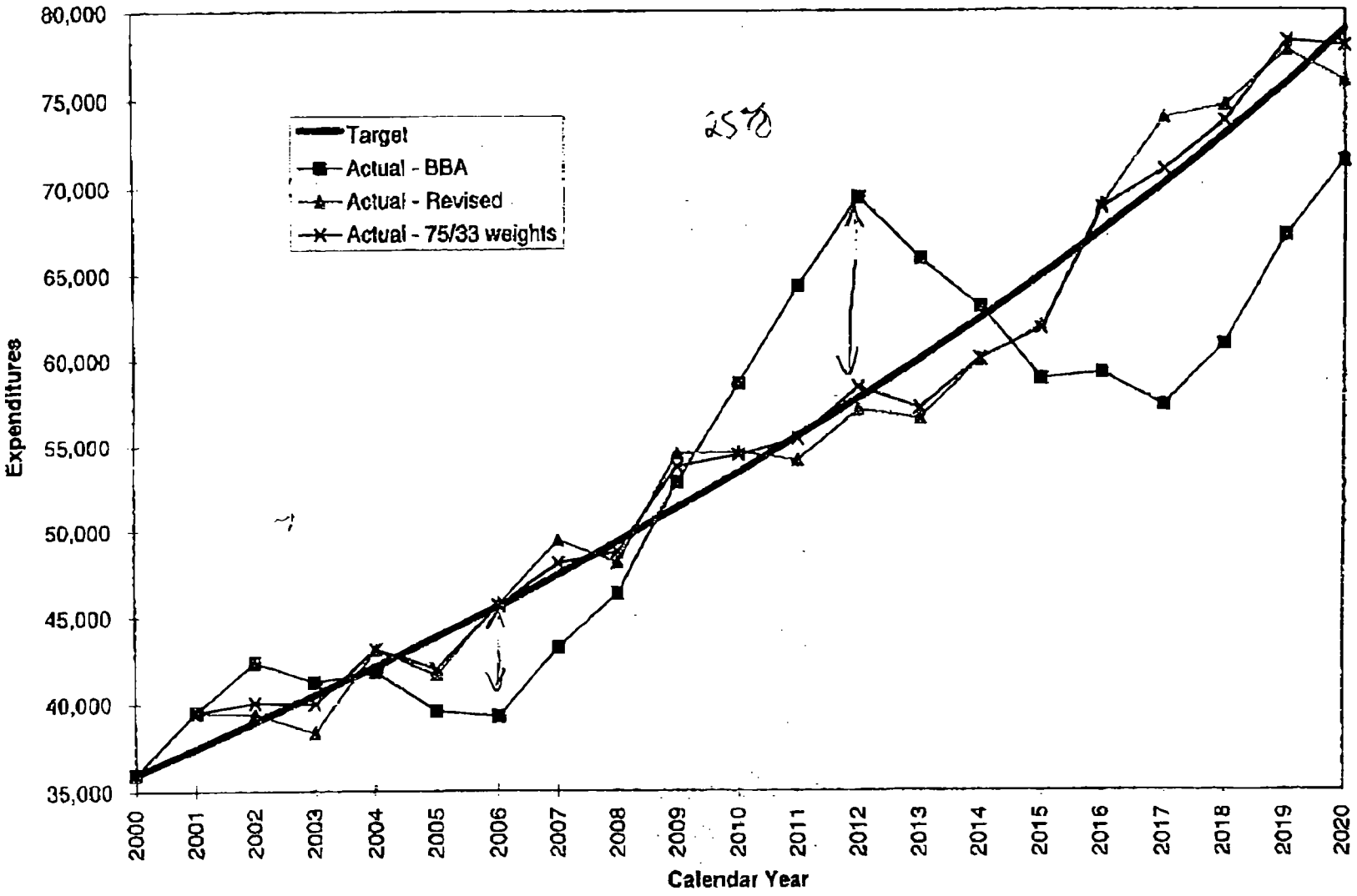

**Conversion factor updated on a CALENDAR YEAR basis:**
Update = (1 + MEI) * (1 + performance adjustment)




$$\text{CY 1999 Performance Adjustment} = (.75) * \frac{\$51.4 - \$50.0}{\$50.0} + (.33) * \frac{\$149.7 - \$147.8}{\$50.0 * 1.002} = 3.4\% \text{ (3.0\% maximum)}$$

Note: Dollar figures are in billions. Figures are for allowed charges, before application of deductible and coinsurance. Figures are for services covered for measurement of performance, not services subject to performance adjustment.

## Comparison of SGR systems



## Comparison of SGR Systems

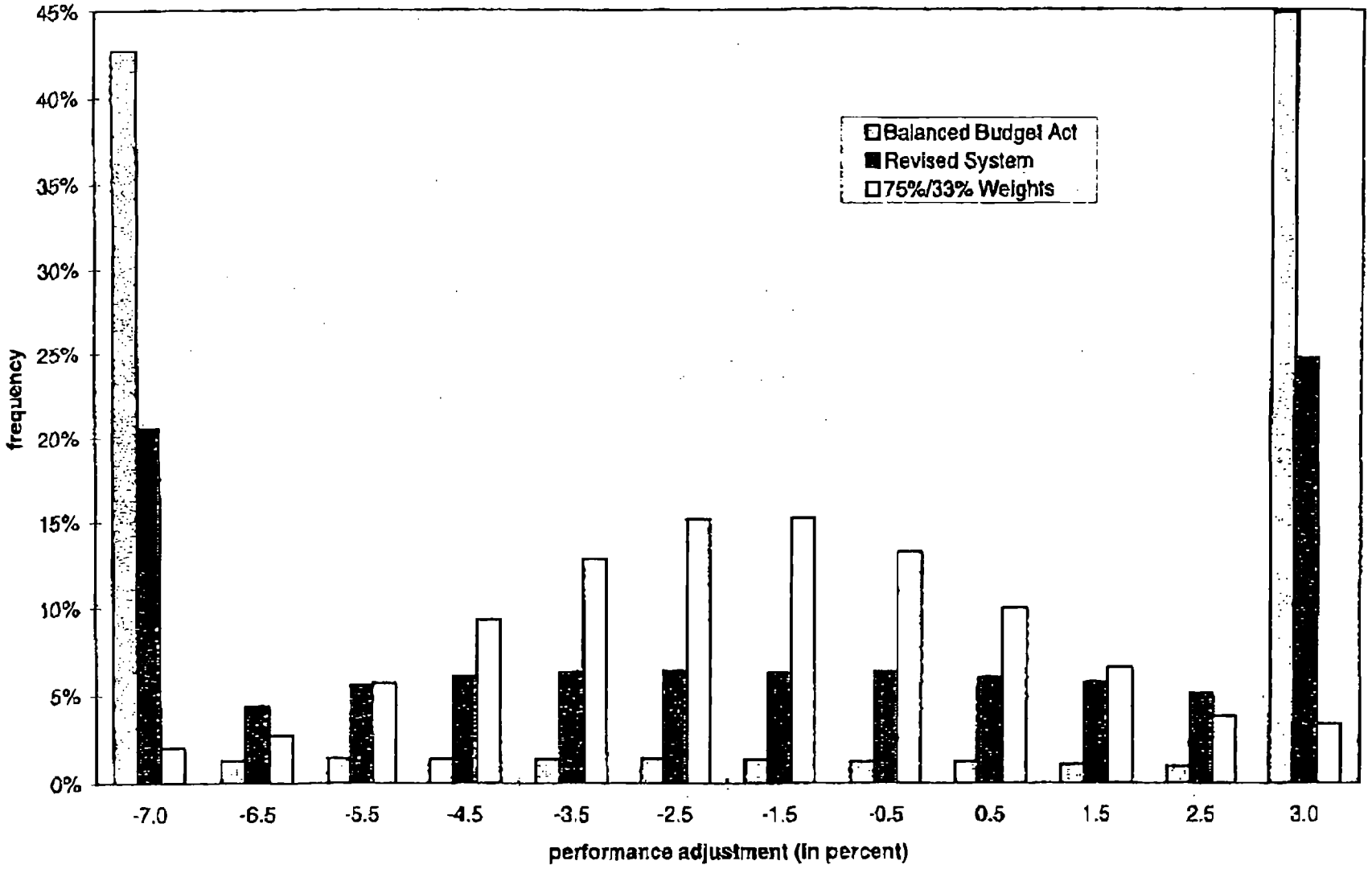


**Table 1. Simulation Results for Various Methodologies**

| A<br>% of Actual Difference | B<br>% of Cumulative Actual Difference | | Standard Deviation of Actual Expenditures (in percent) | % of Performance Adjustments at limit (+3%, -7%) | Years until Mean Actual equals Target |
|---|---|---|---|---|---|
| 100 | 100 | *1 | 3.36 | 45.2 | 0 |
| 100 | 50 | | 2.79 | 20.4 | 6 |
| 100 | 33 | | 2.60 | 10.9 | 10 |
| 100 | 25 | | 2.50 | 6.9 | 13 |
| 100 | 20 | | 2.44 | 5.0 | 17 |
| 100 | 0 | *2 | 2.00 | 1.1 | Never |
| 80 | 50 | | 2.77 | 14.2 | 4 |
| 80 | 33 | | 2.57 | 6.2 | 7 |
| 80 | 25 | | 2.50 | 3.4 | 10 |
| 80 | 20 | | 2.45 | 2.2 | 13 |
| 75 | 50 | | 2.79 | 13.4 | 6 |
| 75 | 33 | | 2.57 | 5.4 | 6 |
| 75 | 25 | | 2.50 | 2.9 | 9 |
| 67 | 50 | | 2.78 | 11.2 | 7 |
| 67 | 33 | | 2.60 | 4.2 | 9 |
| 50 | 50 | | 2.88 | 8.6 | 11 |

*1 Revised system
*2 MVPS system

$$\frac{\sum_{t=1996}^{n} (TargetExpenditures)_t - \sum_{t=1996}^{n-1} (ActualExpenditures)_t}{(ActualExpenditures)_{n-1}\,(1 + SGR_n)} - 1 \qquad (1)$$

$$\frac{(TargetExpenditures)_{n-1} - (ActualExpenditures)_{n-1}}{(ActualExpenditures)_{n-1}} + \frac{\sum_{t=1996}^{n-1} (TargetExpenditures)_t - \sum_{t=1996}^{n-1} (ActualExpenditures)_t}{(ActualExpenditures)_{n-1}\,(1 + SGR_n)} \qquad (2)$$

Marcia

Molly – ~~people for~~ organ donation ceremony

Bob – ~~rate hike~~ ~~for~~ FEHBP

Gretchen 578227

Jen Ryan – NY

~~Peter~~

Tom Morris –

~~Jeff~~ – 66410

Bradley 225 7508

Barry Price 6002725

~~Cynthia~~

## The Medicare Physician Sustainable Growth Rate

**Problems with the SGR System**:

The SGR and update involve three different time periods:

1. The SGR applies on a fiscal year basis.

2. Performance relative to the fiscal year SGR is measured based on expenditures for the 12-month period ending March 31st of the year before the update.

3. The performance adjustment will apply to the update for a calendar year nine months after the March 31st end of the measurement period.

After the legislation was enacted, actuarial analysis has suggested that the SGR system is unstable. In the long-term, updates could oscillate between the maximum bonus and penalty performance adjustments. Two problems cause this instability. The first problem is the lag between the performance measurement and the application of the adjustment. The second problem is the mismatch of target and performance periods. An additional problem involves adjustment of the SGR for later data.

legislative proposal to smooth the update

Time Lag Problem: The essence of the time lag problem is that because the SGR system is cumulative, the longer that physician expenditures are off target, the greater the adjustment required to bring expenditures back into line. The current 9-month lag time between measurement of when expenditures are determined to be off target and when the corrective adjustment is made is too long. With a time lag before adjustment this lengthy, the only way that expenditures will get back on target is if actual expenditures equal targeted expenditures during the 9-month lag. Since it is unlikely for actual expenditures to equal targeted expenditures for 9 months, the system is always trying to "catch up" to the target. In practice, this creates large swings in the updates. This phenomenon is illustrated in the hypothetical example at the top of Attachment 1. Since the statute limits performance bonuses to +3 percentage points and performance penalties to -7 percentage points, in the long term the system oscillates between the minimum and maximum performance adjustments. As illustrated in the table in the middle of Attachment 1, there would be severe oscillation in the update if there was no limit on the performance adjustment factor.

Mismatched Period Problem: This problem is caused in the measurement of the actual-vs.-target expenditures which is used to calculate the performance adjustment. The actual expenditures are measured for the 12-month period ending March 31st of the year before the update, while the target applies to expenditures for the fiscal year preceding the update. The result of this comparison of different time periods also contributes to the instability problem, but to a lesser extent than the time lag problem.

Use of Estimates in Computing the Sustainable Growth Rate: The statute requires the each year the Secretary establish the SGR for the upcoming fiscal year based on the "Secretary's estimates"

of four factors: the percentage increase in physicians' fees, the percentage increase in fee-for-service enrollment, the projected percentage growth in per capita gross domestic product, and the percentage change in expenditures for physicians' services resulting from changes in law or regualtions. Because the calculation of the SGR for a given year is based on projected values, updates may be either lower or higher than they would have been if later data were used. Thus, we initially considered revising estimates of the factors used in setting the SGR when later data had become available. However, as indicated in the Federal Register Notice published on November 2, 1998, we had concerns about whether we had the statutory authority to make these revisions under current law and invited comments regarding how an adjustment could be made consistent with the law. We continue to believe that we do not have the authority to make adjustments to the SGR based on later data.

**Proposal**: A proposal to address the SGR time period mismatch problem would change all time periods to a calendar year basis. The time lag problem would be solved by applying adjustments to the update in the immediate subsequent calendar year (i.e. expenditures compared to the SGR for 1999 would affect the 2000 update). Eliminating the lag period between the SGR measurement period and the subsequent adjustment to the physician fee schedule update would mean that the update would be based on an estimate of expenditures under the SGR. The proposal would also give the Secretary authority to further adjust (up or down) future updates to account for differences between estimated expenditures and actual expenditures and adjust the SGR based on later data. Revised SGRs would be established for two prior calendar years. Expenditures under the SGR would be measured from January 1, 1997 rather than April 1, 1997 as under current law. The following timeline outlines how the SGR would work under such a proposal.

1. On or before November 1, 1999. The Secretary would publish the calendar year SGRs for 1997-2000. For past periods, the SGRs would reflect data on actual enrollment and per capita GDP growth. The 1999 SGR would be based in part on actual data and a forecast. The 2000 SGR would be a projection. The 1999 and 2000 SGRs would be subject to change based on later data. The Secretary would also publish the fee schedule update for 2000 which reflects expenditures relative to the SGR through 1999. The adjustment to the update would reflect actual expenditures for physicians' services through June of 1999 and an estimate of expenditures under the SGR for the remainder of the calendar year. There could be adjustments to future year updates to reflect actual expenditures relative to the 1999 SGR which are different from earlier estimates.

2. On or before November 1, 2000. The Secretary would publish revised SGRs for 1999 and 2000 based on later data and the 2001 SGR based on projections. The Secretary would also publish the physician fee schedule update for 2001 which reflects estimated expenditures under the SGR for 2000 and any further adjustments required to reflect differences between estimated and actual expenditures relative to the SGR in 1999.

3. On or before November 1 for each subsequent year. This process would continue in each

subsequent year with the Secretary publishing revised SGRs based on later data for the contemporaneous year and the preceding year and the estimated SGR for the next year. The Secretary would also publish the physician fee schedule update for the next year which reflects any additional adjustments which may be required if actual expenditures for the preceding year differ from earlier estimates and estimated expenditures under the SGR for the contemporaneous year.

**Other Technical Aspects of the Proposal**

The proposal would correct the time lag problem and the severe oscillation in the physician fee schedule update. However, under a cumulative expenditure target system like the SGR, adjusting for deviation from the target in a single year can result in larger oscillation in the update than may be desirable. This effect can be illustrated by assuming an annual target of $100. If expenditures in the first year are $102, expenditures would need to be $98 in the second year for cumulative expenditures over 2 years to equal $200. This requires a 4 percent reduction in the update (98/102 or 0.96). Expenditures would need to equal $100 in the next year for cumulative expenditures over 3 years to equal $300. This would require annual expenditures of $98 to be updated by 2.0 percent (100/98 or 1.02). Thus, if expenditures exceed that target by 2.0 percent in a single year, a downward of adjustment of 4.0 percent is required one year and a upward adjustment of 2.0 percent the following year. This proposal would provide more predictability and stability in the physician fee schedule update by adjusting for deviation from the target over multiple years rather than in a single year. This is illustrated in the hypothetical example at the bottom of Attachment 1. The proposal would restate and make modifications to the formula in the law for determining the performance adjustment factor. Attachment 2 provides the technical details of how the formula would work.

Attachment 1

## Balanced Budget Act of 1997

| Year | Annual Target | Cumulative Target | SGR | Annual Actual | Cumulative Actual | Actual Growth | Capped Performance Adjustment |
|---|---|---|---|---|---|---|---|
| 1 | 100 | 100 | | 100 | 100 | | |
| 2 | 104 | 204 | 4% | 106 | 206 | 6% | |
| 3 | 108 | 312 | 4% | 112 | 318 | 6% | |
| 4 | 112 | 425 | 4% | 115 | 433 | 6% | -3.7% |
| 5 | 117 | 542 | 4% | 113 | 546 | 6% | -7.0% |
| 6 | 122 | 663 | 4% | 111 | 658 | 6% | -7.0% |
| 7 | 127 | 790 | 4% | 122 | 779 | 6% | 3.0% |
| 8 | 132 | 921 | 4% | 133 | 912 | 6% | 3.0% |
| 9 | 137 | 1,058 | 4% | 145 | 1,057 | 6% | 3.0% |
| 10 | 142 | 1,201 | 4% | 143 | 1,200 | 6% | -7.0% |
| 11 | 148 | 1,349 | 4% | 141 | 1,341 | 6% | -7.0% |
| 12 | 154 | 1,503 | 4% | 139 | 1,480 | 6% | -7.0% |

## Balanced Budget Act of 1997 w/o Cap on Performance Adjustment Factor

| Year | Annual Target | Cumulative Target | SGR | Annual Actual | Cumulative Actual | Actual Growth | Uncapped Performance Adjustment |
|---|---|---|---|---|---|---|---|
| 1 | 100 | 100 | | 100 | 100 | | |
| 2 | 104 | 204 | 4% | 106 | 206 | 6% | |
| 3 | 108 | 312 | 4% | 112 | 318 | 6% | |
| 4 | 112 | 425 | 4% | 115 | 433 | 6% | -3.7% |
| 5 | 117 | 542 | 4% | 111 | 544 | 6% | -9.0% |
| 6 | 122 | 663 | 4% | 107 | 650 | 6% | -9.0% |
| 7 | 127 | 790 | 4% | 118 | 768 | 6% | 4.1% |
| 8 | 132 | 921 | 4% | 157 | 925 | 6% | 25.7% |
| 9 | 137 | 1,058 | 4% | 208 | 1,133 | 6% | 25.3% |
| 10 | 142 | 1,201 | 4% | 181 | 1,314 | 6% | -18.2% |
| 11 | 148 | 1,349 | 4% | 60 | 1,374 | 6% | -68.9% |
| 12 | 154 | 1,503 | 4% | 12 | 1,385 | 6% | -81.5% |

## SGR Proposal Using the 75/33 Performance Adjustment Factor

| Year | Annual Target | Cumulative Target | SGR | Annual Actual | Cumulative Actual | Actual Growth | 75/33 Performance Adjustment |
|---|---|---|---|---|---|---|---|
| 1 | 100 | 100 | | 100 | 100 | | |
| 2 | 104 | 204 | 4% | 106 | 206 | 6% | |
| 3 | 108 | 312 | 4% | 110 | 316 | 6% | -2.0% |
| 4 | 112 | 425 | 4% | 114 | 430 | 6% | -2.5% |
| 5 | 117 | 542 | 4% | 118 | 548 | 6% | -2.4% |
| 6 | 122 | 663 | 4% | 122 | 670 | 6% | -2.2% |
| 7 | 127 | 790 | 4% | 127 | 797 | 6% | -2.0% |
| 8 | 132 | 921 | 4% | 132 | 929 | 6% | -1.9% |
| 9 | 137 | 1,058 | 4% | 137 | 1,066 | 6% | -1.9% |
| 10 | 142 | 1,201 | 4% | 143 | 1,208 | 6% | -1.9% |
| 11 | 148 | 1,349 | 4% | 148 | 1,357 | 6% | -1.9% |
| 12 | 154 | 1,503 | 4% | 154 | 1,511 | 6% | -1.9% |

Attachment 2

After correcting for lags mismatched time periods, the formula specified in the BBA for determining the performance adjustment factor for calendar year $n$ is:

$$\frac{\sum_{t=1996}^{n} (TargetExpenditures)_t - \sum_{t=1996}^{n-1} (ActualExpenditures)_t}{(ActualExpenditures)_{n-1}(1 + SGR_n)} - 1$$

This formula is equivalent to:

$$\frac{(TargetExpenditures)_{n-1} - (ActualExpenditures)_{n-1}}{(ActualExpenditures)_{n-1}} + \frac{\sum_{t=1996}^{n-1} (TargetExpenditures)_t - \sum_{t=1996}^{n-1} (ActualExpenditures)_t}{(ActualExpenditures)_{n-1}(1 + SGR_n)}$$

The formula is rewritten this way to illustrate two separate factors contributing to the performance adjustment. The first is the difference between the actual and target expenditures for the previous year. The second is the difference between the cumulative actual and the cumulative target expenditures through the previous year. Under the performance adjustment factor in the BBA (after correcting for lags and mismatched periods), there is an implicit weight of 1.00 for each of the two factors. A weight of 1.00 for both factors results in a performance adjustment factor which brings expenditures in line with the SGR in a single year. By varying the weights of the two factors between 0 and 1, the performance adjustment factor can spread adjustments in the update over multiple years and makes less likely the number of years in which the performance adjustment is at the statutory maximum or minimum. However, this also increases the number of years in which expenditures are different than the SGR. The weights can be adjusted to balance between these competing goals. A weight of 0.75 for the first factor and 0.33 for the second factor results in a balance between bringing expenditures into line with the SGR within a reasonable time frame and reducing oscillation in the physician fee schedule update.

American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005

Please deliver ASAP.

# FAX TRANSMISSION SHEET

**Date:** 9/24/99

**To:** Chris Jennings
c/o Theresa Jones

**From:** Richard A. Deem
Vice President
Government Affairs
**Tel:** (202)789-7413

**Message:** Backgrounder for Monday's 1:30 p.m. Mtg. on SGR.

**Total Pages (including cover sheet):** 3

Reply Fax Number: (202)789-4692
Government Affairs

**Correcting Projection Errors in the SGR**

Since BBA enactment, HCFA has published two SGR notices, on 10/31/97 and 11/2/98. Each fiscal year SGR is based on 4 Factors: GDP growth, fee-for-service enrollment growth, inflation, and spending growth due to law and regulation. The BBA requires the SGR to be published August 1, two months before each fiscal year begins. Since HCFA cannot know what GDP growth will be before the year starts, nor how many people will enroll in fee-for-service vs. managed care, its projections are virtually guaranteed to be faulty.

HCFA admitted this in its 10/31/97 notice and stated "[d]ifferences between projected and actual real gross domestic product per capita growth will be adjusted for in subsequent years," and "[d]ifferences between projected and actual enrollment will be adjusted for in subsequent years." The 10/31/97 notice had underestimated FY98 GDP growth by a factor of 3, but HCFA's 11/2/98 notice retracted its pledge to adjust for differences between projected and actual growth, stating "we have concerns about how this could best be accomplished, if at all, under current law."

Despite its concerns that differences between projected and actual GDP and enrollment growth could not be corrected, HCFA projected a 29% increase in FY99 Medicare+Choice enrollment, which meant a corresponding 4.3% drop in fee-for-service enrollment and a –0.3% SGR for FY99. With annual spending on physician services of about $49 billion, a 1% error in the SGR is about $490 million (of which Medicare pays 80%). The table below shows the magnitude of the errors that HCFA has made to date in its estimates of GDP and enrollment growth.

| Year | Factor | Projected | Actual | $ Difference |
|---|---|---|---|---|
| FY98 | GDP growth | 1.1% | 2.8% | $ 0.8 billion |
| FY98 | FFS enrollment change | -2.4% | -2.6% | $-0.1 billion |
| FY99 | GDP growth | 1.3% | 3.2% | $ 0.9 billion |
| FY99 | FFS enrollment change | -4.3% | -1.1% | $ 1.6 billion |
| TOTAL PROJECTION ERRORS TO DATE: | | | | $3.2 billion |

The SGR is a cumulative system. Payment updates are based on comparisons between cumulative allowed spending and cumulative actual spending. The 1998 SGR error was $700 million. The 1999 SGR error is $2.5 billion; this 1999 error, alone, will grow to $5 billion by the end of the year 2000, if left uncorrrected. In a very short period of time, therefore, a huge disparity will develop between the cumulative SGR target and actual data on the factors that underpin the SGR.

The AMA believes the statutory authority that HCFA needs in the BBA to correct its errors without any new legislation being enacted is found in Factor 4 of the SGR: "...the Secretary's estimate of the percentage change ... in expenditures for all physicians' services in the fiscal year ... which will result from changes in law and regulations." The variances between actual numbers and estimated projections are created as a direct result of regulatory action.

Under the Medicare program, directions for and changes in the process for setting program payments are addressed through the regulatory process. Section 1871 of the Social Security Act, reads (in part):

> (a)(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.
>
> (2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

The SGR requirement is a substantive legal standard governing the payment for services, and its promulgation, even as a "final notice" and as a "final notice with comment period," clearly has the weight of regulation.

DATE: 4/18

*U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES*
*ROOM 405H, HUMPHREY BUILDING*
*200 INDEPENDENCE AVE, SW*
*WASHINGTON, D.C. 20201*

*PHONE: (202)690-7450* *FAX: (202)690-8425*

**FROM:**

[ ] JANE HORVATH
[ ] JOANNE JEE
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[ ] LEO LUBERECKI
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[ ] ROGER MCCLUNG
[ ] TANISHA PARKER
[ ] LAURA BARNICKOL
[✓] PAUL SELTMAN
[ ] STEPHANIE WILSON
[ ]

**TO:** CHRIS

**OFFICE:**

**ROOM:**

**PHONE:**

**FAX:**

THOMAS/STARK
LETTER

**(INCLUDING COVER):** 3

**REMARKS:**

# COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

April 14, 2000

The Honorable Gail Wilensky
Chair
Medicare Payment Advisory Commission
1730 K Street NW, Suite 800
Washington, DC 20006

Dear Madame Chair:

We were surprised to hear about the Commission's recommendation for an inpatient hospital update in the range of 3.5 to 4 percent. This is more than the hospital industry itself has been asking for in legislation. More importantly, we do not see the hard data that supports such a multi-billion dollar across-the-board increase.

Please provide us immediately with an analysis, in graph form and in numbers, of the increases in hospital costs (over the last five years and trended forward) compared to the market basket and the payment updates as provided by law. Are we correct in understanding that hospital costs are increasing at rates below the market basket? We would also like to know the actual increases in Medicare inpatient costs and payments, separating the impact of the reductions resulting from the 1997 Balanced Budget Act from changes in hospital case mix.

Second, since the Commission's recommendation will undoubtedly cause many hospital representatives to visit Congress requesting a higher update than current law or pending legislation provides, we would like to consider such updates with the benefit of hard data--not anecdotes. Please provide us data from 1996, 1997 and 1998 on Medicare cost per discharge and margins (inpatient Medicare, outpatient, most-of-Medicare, non-Medicare, and total) on a hospital-specific basis. We understand that these measures are calculated from publicly available information on the Medicare Cost Report, and will assist us in assessing whether an inpatient update is warranted.

Additionally, since the data presented to the Commission are from the period prior to last year's Balanced Budget Refinement Act (BBRA), we are curious to know the impact of that legislation on margins in FY 2000 through FY 2002, including the impact on outpatient margins, PPS-exempt unit margins, and hospital-based home heath and skilled nursing margins. We would like this information on a hospital-specific basis.

Yesterday's action will generate considerable pressure in Congress. We need an immediate response and hard statistical support from you and the Commission staff, if the Commission is to serve its purpose of helping Congress, rather than simply being an organized forum for the voice of self-interested lobbying.

Sincerely,

Bill Thomas
Chairman

Pete Stark
Ranking Minority

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

# FACSIMILE TRANSMISSION

Date: 9-13-99

Time: 5:20 p.m.

TO: Chris Jennings
(202) 456-5557

FROM: **Kenneth E. Raske**
President

Phone: 212-246-7100
e-Mail: raske@gnyha.org

We are transmitting 21 pages including this cover sheet. If you have not received all of the pages PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

MESSAGE:

Main Number (212) 246-7100
Fax Number (212) 262-6350

Hard Copy [ ] will [x] will not be sent by mail.

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

**Greater New York Hospital Association**
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

September
Thirteen
1999

Christopher C. Jennings
Deputy Assistant to the President for Health Policy Development
216 Old Executive Office Building
17th St. and Pennsylvania Avenue, N.W.
Washington, DC 20502

Dear Chris:

Thank you for the opportunity to provide you and your colleagues with additional data regarding the impact of the Balanced Budget Act of 1997 (BBA) on the nation's teaching hospitals, in general, and on our member hospitals, in particular. I know we have had numerous conversations about the financial condition of our member hospitals. I hope the additional data we are providing will be dispositive about the need for a freeze in the indirect medical education (IME) adjustment at the FY 1999 level of approximately 65% of each hospital's ratio of interns and residents to beds (IRB). First I'd like to review our analysis of the fiscal impact of the BBA, and then I shall discuss our members' limitations with respect to making the cost reductions that would be required to maintain financial viability, and, thus, their urgent need for relief.

As you know, we modeled the impact of the BBA on hospital Medicare and total margins assuming no changes in non-Medicare revenue or in the hospitals' cost structures. The purpose of this exercise was to assess the level of cost reduction that hospitals would have to achieve to maintain financial viability. First, with respect to the revenue reduction alone, owing to the cuts in the IME and disproportionate share hospital (DSH) adjustments, major teaching hospitals took a harder hit from the BBA than other hospitals. Our model shows that they lost 14.0% of their baseline Medicare revenue compared with 12.2% for non-teaching hospitals, and, more importantly, that the BBA actually reduced payments from the 1996 level for major teaching hospitals — *unadjusted for inflation* — rather than merely slowing the growth of payments, as it did for other hospitals.

With respect to the Medicare inpatient margin, we found that the BBA forced Medicare revenue significantly below cost for all hospitals, *including* major teaching hospitals. We believe that this finding has been obscured by the margins computed by the Medicare Payment Advisory Commission (MedPAC), which failed to accurately match payments and costs by including DSH revenue but no associated DSH costs. DSH payments are provided to facilitate access by Medicare beneficiaries to hospitals that serve large indigent and uninsured patient populations. Thus, the correct Medicare inpatient margin calculation should either exclude DSH payments from the revenue calculation or include an allocation of uncompensated care in the cost calculation. Our analysis excluded DSH payments because uncompensated care costs are not currently reported on the Medicare cost report. Attachment A shows the margin calculations with no associated DSH costs, both including and excluding DSH revenue. Including DSH revenue, as MedPAC does, implicitly reallocates DSH payments to standard operating payments, thus effectively eliminating the DSH adjustment, which was not Congressional intent.

Regardless of whether DSH is treated as a Medicare payment or a non-Medicare payment in the Medicare margin calculation, the total margin is the same. Thus, Attachment A shows that with no

changes in non-Medicare revenue or in the hospitals' cost structures, the BBA would force the total margin into a negative position for major teaching hospitals as opposed to other hospitals. The only way the hospitals could avoid this outcome would be to increase revenue from other sources, to decrease expenses, or both. Increasing revenue from other sources is not a viable option, first because many teaching hospitals derive most of their revenue from regulated payments, leaving little flexibility for cost-shifting, and, second, because hospitals have very little bargaining power in the current market environment. Therefore, in order to maintain financial viability, the BBA is effectively asking major teaching hospitals to cut their budgets, while other hospitals merely have to tolerate a reduction in their profitability. This begs the question of whether that requirement is reasonable.

Here, we must switch our focus from a national analysis to a local analysis, since national data about current cost trends are not yet available. To evaluate the feasibility of making cost reductions in the 4% range, first we compared our members' current efficiency with their national counterparts. Attachment B provides state-level comparative data from The Center for Healthcare Industry Performance Studies. These data show that when adjusted for differences in case-mix and regional wage levels, New York hospitals' median cost, price, surplus, and staffing per inpatient are among the lowest in the United States, as are its median cost, price, and surplus per outpatient visit. Furthermore, the financial condition of New York's hospitals is almost the worst in the nation, as measured by profitability, liquidity, capital structure, and overall financial flexibility.

Second, to confirm that our members have little to no ability to reduce their budgets further, we surveyed their first-quarter 1999 financial statements. The results of our analysis are found in Attachment C. The vast majority of our members are teaching hospitals. Furthermore, the 50 hospitals that responded to our survey represent a broad cross-section of our membership with respect to size, location, case mix, and payer mix. In aggregate, from the 1998 first quarter to the 1999 first quarter, operating revenue grew by 2.7% and operating expenses grew by 4.3%. Thus, the hospitals were unable to cut expenses or even hold expense growth to the revenue growth rate. Therefore, aggregate operating income fell by $56 million from positive $17 million to negative $38 million, and the operating margin decreased by 1.6 percentage points from 0.51% to –1.09%. Because of a reduction in non-operating income, aggregate net income fell by $78 million from positive $75 million to negative $2 million. Furthermore, this trend was evident for most of our members, with 74% experiencing a decrease in their operating margin, and 78% experiencing a decrease in their total margin.

All told, our member hospitals are already quite efficient compared with their national counterparts, but are also in deep financial distress, in contrast with their national counterparts. The recent worsening of their financial condition was caused by the BBA, which cut Medicare payments to teaching hospitals too much, too soon. Medicare inpatient payments are now significantly below cost when measured correctly, that is, by allocating DSH payments to uncompensated care, which is their intended purpose. Thus, it is appropriate for the Administration to support some short-term relief by freezing the IME adjustment at its FY 1999 level. There is absolutely no doubt that failing to do so will cause immediate service and access problems in the metropolitan New York area.

Thank you for your consideration of these materials. I look forward to talking with you soon about this matter.

My best.

Sincerely,

Kenneth E. Raske
President

Cc: Dennis Rivera
Attachments

# Letters

## Teaching hospitals' Medicare margins wrong

I've been troubled for some time that Medicare margins for teaching hospitals are overstated, because disproportionate-share hospital (DSH) revenues are factored in without an offset for uncompensated-care costs and because teaching hospitals receive two-thirds of all DSH payments.

When DSH revenues ostensibly paid for Medicare beneficiary costs that were higher because of a hospital's high indigent patient load, no one challenged the Medicare Payment Advisory Commission's margin analysis. Now, however, MedPAC has explicitly recognized DSH payments as Medicare's contribution to uncompensated-care costs. It has revised the DSH adjustment to serve the broader purpose of protecting access to care for Medicare beneficiaries and low-income patients by assisting the hospitals they use. According to a MedPAC report, these hospitals have not only large uncompensated-care burdens but difficulty in attracting privately insured patients.

MedPAC recommended basing the adjustment on inpatient and outpatient costs associated with these patients, patients in other indigent-care programs and uninsured and underinsured patients as represented by uncompensated care.

Because MedPAC changed its characterization of DSH payments, the commission should change the way it computes Medicare margins. The need for change is urgent, because the current method is obscuring the damage the Balanced Budget Act of 1997 has done to the nation's teaching hospitals. In fact, some policymakers have said that the positive inpatient operating PPS margins for teaching hospitals reported by MedPAC under the budget law show that the law is not contributing to the industry's financial troubles.

Because uncompensated-care costs are not included on the Medicare cost report, an equally valid way to match Medicare payments and costs is to remove the DSH payments from Medicare revenues for the margin analysis. That way, the impact of the budget law on Medicare margins for teaching hospitals is revealed to be much worse than otherwise thought.

Raske

An analysis by the Greater New York Hospital Association shows that if post-budget law payment policy had been in effect in 1996, the Medicare inpatient operating PPS margins for teaching hospitals would have been -3.9%, and the total Medicare acute-care margin would have been a distressing -8.6%.

Productivity improvements are unlikely to mitigate this margin; preliminary 1998 and 1999 audited financial statements from GNYHA member hospitals have shown costs are increasing. That is why teaching hospitals have turned to Congress and the Clinton administration to provide budget relief.

*Kenneth Raske*
*President*
*Greater New York Hospital Association*
*New York*

## Comparison of the Effect of the BBA on Medicare Margins Including and Excluding DSH Revenue

| | Including DSH Revenue | | | | Excluding DSH Revenue | | | |
|---|---|---|---|---|---|---|---|---|
| Margins | 1996 | 1999 | 2000 | 2002 | 1996 | 1999 | 2000 | 2002 |
| Total Medicare Inpatient (a) | | | | | | | | |
| All Hospitals | 12.0% | 2.4% | 0.7% | -1.3% | 7.3% | -2.9% | -4.7% | -6.7% |
| Major teaching | 18.7% | 9.2% | 6.9% | 4.7% | 11.7% | 1.3% | -1.2% | -3.5% |
| Other teaching | 11.0% | 1.2% | -0.5% | -2.5% | 6.5% | -3.9% | -5.6% | -7.7% |
| Total teaching | 14.2% | 4.5% | 2.6% | 0.5% | 8.6% | -1.8% | -3.8% | -6.0% |
| Non-teaching | 9.3% | -0.3% | -1.6% | -3.5% | 5.7% | -4.3% | -5.7% | -7.5% |
| Total Medicare Acute Care (b) | | | | | | | | |
| All Hospitals | 8.9% | -1.0% | -2.7% | -4.7% | 4.8% | -5.6% | -7.4% | -9.4% |
| Major teaching | 15.0% | 5.3% | 2.9% | 0.5% | 8.6% | -1.9% | -4.5% | -7.1% |
| Other teaching | 8.4% | -1.6% | -3.2% | -5.1% | 4.4% | -6.1% | -7.7% | -9.6% |
| Total teaching | 11.1% | 1.3% | -0.7% | -2.8% | 6.1% | -4.4% | -6.4% | -8.6% |
| Non-teaching | 6.2% | -3.7% | -5.0% | -6.9% | 3.1% | -7.1% | -8.5% | -10.3% |
| Total Hospital (c) | | | | | | | | |
| All Hospitals | 5.8% | 2.9% | 2.4% | 1.9% | 5.8% | 2.9% | 2.4% | 1.9% |
| Major teaching | 3.0% | 0.3% | -0.3% | -0.9% | 3.0% | 0.3% | -0.3% | -0.9% |
| Other teaching | 6.9% | 3.9% | 3.4% | 2.9% | 6.9% | 3.9% | 3.4% | 2.9% |
| Total teaching | 5.1% | 2.2% | 1.7% | 1.1% | 5.1% | 2.2% | 1.7% | 1.1% |
| Non-teaching | 6.8% | 3.8% | 3.4% | 2.9% | 6.8% | 3.8% | 3.4% | 2.9% |

(a) Includes PPS, direct GME, and Inpatient TEFRA.
(b) Includes all inpatient and outpatient.
(c) Represents the total margin, which is the net change in unrestricted net assets.

Source: Greater New York Hospital Association Center for Applied Health Economics.

ATTACHMENT B

# THE 1998-99 ALMANAC

## OF HOSPITAL FINANCIAL & OPERATING INDICATORS

William O. Cleverley, Ph.D.
President
The Center for Healthcare Industry Performance Studies
Professor
The Ohio State University

The Center for Healthcare
CHIPS
Industry Performance Studies
*A Division of St. Anthony Publishing, Inc.*
1550 Old Henderson Road, Suite S-277
Columbus OH 43220-3626 • (800) 859-2447

## Net Price per Discharge (Adjusted for Wage Index & Case Mix)

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | 5,288 | 5,385 | 5,231 | 5,237 | 5,275 | 3,833 | 4,451 | 6,275 | 7,390 |
| Medium | 4,727 | 4,771 | 4,969 | 4,807 | 5,049 | 3,671 | 4,360 | 6,057 | 7,074 |
| Low | 5,171 | 5,144 | 5,088 | 5,229 | 5,141 | 3,933 | 4,275 | 6,110 | 6,980 |
| **States** | | | | | | | | | |
| Alabama | 5,552 | 5,435 | 4,806 | 5,360 | 5,706 | 4,040 | 4,719 | 6,240 | 6,492 |
| Alaska | 6,056 | 5,900 | 6,104 | 6,142 | 6,208 | 4,383 | 4,780 | 6,728 | 6,991 |
| Arizona | 5,458 | 5,349 | 5,693 | 6,320 | N/A | N/A | N/A | N/A | N/A |
| Arkansas | 4,811 | 5,408 | 5,424 | 5,176 | 5,187 | 4,166 | 4,523 | 5,433 | 6,930 |
| California | 4,717 | 4,625 | 4,633 | 4,830 | 5,249 | 3,350 | 4,092 | 6,274 | 7,133 |
| Colorado | 5,170 | 5,682 | 5,752 | 5,160 | 5,169 | 4,443 | 4,766 | 5,833 | 6,158 |
| Connecticut | 5,234 | 5,016 | 5,219 | 4,940 | 4,901 | 4,174 | 4,416 | 5,717 | 6,322 |
| Delaware | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | 7,245 | 6,891 | 6,133 | 5,614 | N/A | N/A | N/A | N/A | N/A |
| Florida | 5,406 | 5,670 | 5,271 | 5,028 | 5,510 | 4,715 | 5,116 | 5,868 | 6,717 |
| Georgia | 5,244 | 5,585 | 5,456 | 5,692 | 5,756 | 4,397 | 4,971 | 6,512 | 6,782 |
| Hawaii | 6,441 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Idaho | 4,581 | 5,008 | 5,018 | N/A | N/A | N/A | N/A | N/A | N/A |
| Illinois | 5,653 | 5,783 | 5,679 | 5,626 | 5,567 | 4,481 | 4,909 | 6,252 | 7,331 |
| Indiana | 5,227 | 5,414 | 5,460 | 5,668 | 5,844 | 4,024 | 5,073 | 6,329 | 6,639 |
| Iowa | 5,303 | 5,369 | 5,209 | 5,498 | 5,506 | 4,619 | 5,094 | 6,174 | 7,953 |
| Kansas | 4,928 | 5,089 | 5,634 | 5,408 | 6,393 | 4,375 | 4,966 | 7,327 | 7,685 |
| Kentucky | 4,846 | 4,805 | 4,906 | 4,858 | 5,529 | 3,284 | 4,349 | 5,842 | 6,520 |
| Louisiana | 5,770 | 5,767 | 6,178 | 6,187 | 5,925 | 4,523 | 5,370 | 6,288 | 6,972 |
| Maine | 4,710 | 4,951 | 5,384 | 5,623 | 5,589 | 4,539 | 5,041 | 6,291 | 7,936 |
| Maryland | 4,774 | 4,909 | 4,586 | 4,806 | 4,907 | 4,586 | 4,643 | 5,221 | 6,221 |
| Massachusetts | 4,270 | 3,868 | 3,798 | 3,443 | 3,611 | 2,767 | 3,344 | 4,554 | 6,392 |
| Michigan | 4,529 | 4,675 | 4,667 | 4,740 | 4,498 | 3,854 | 4,002 | 5,242 | 5,702 |
| Minnesota | 4,595 | 4,951 | 5,022 | 5,036 | 5,103 | 4,515 | 4,710 | 5,549 | 5,726 |
| Mississippi | 5,897 | 5,487 | 6,685 | 6,536 | N/A | N/A | N/A | N/A | N/A |
| Missouri | 5,342 | 5,603 | 5,741 | 5,539 | 6,202 | 4,442 | 5,281 | 6,670 | 7,456 |
| Montana | 5,584 | 4,233 | 5,558 | 5,359 | 5,202 | 4,340 | 4,715 | 6,216 | 6,363 |
| Nebraska | 5,421 | 5,497 | 5,536 | 5,371 | 5,921 | 4,634 | 5,211 | 6,504 | 7,633 |
| Nevada | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| New Hampshire | 4,735 | 4,897 | 5,249 | 5,685 | 5,042 | 3,915 | 4,381 | 5,509 | 5,686 |
| New Jersey | 4,743 | 4,652 | 4,785 | 4,964 | 4,810 | 4,030 | 4,493 | 5,411 | 6,347 |
| New Mexico | 5,675 | 5,441 | 5,123 | 5,784 | 6,364 | 4,773 | 5,573 | 7,006 | 7,539 |
| New York | 4,389 | 4,252 | 4,476 | 4,243 | 4,426 | 3,606 | 4,014 | 5,095 | 6,522 |
| North Carolina | 5,171 | 5,495 | 5,455 | 5,548 | 5,544 | 4,238 | 4,806 | 6,674 | 7,136 |
| North Dakota | 5,569 | 5,881 | 5,557 | 6,076 | 5,731 | 5,221 | 5,607 | 6,744 | 7,257 |
| Ohio | 5,036 | 5,064 | 5,026 | 5,115 | 5,422 | 4,669 | 4,992 | 6,340 | 6,904 |
| Oklahoma | 4,807 | 4,957 | 4,969 | 5,878 | 5,721 | 5,170 | 5,523 | 6,457 | 7,270 |
| Oregon | 4,299 | 4,722 | 4,711 | 4,292 | 4,439 | 3,682 | 3,808 | 4,637 | 5,629 |
| Pennsylvania | 4,508 | 4,426 | 4,453 | 4,587 | 4,236 | 3,509 | 3,843 | 4,972 | 6,422 |
| Rhode Island | 3,976 | 3,822 | 4,046 | 4,100 | N/A | N/A | N/A | N/A | N/A |
| South Carolina | 5,994 | 6,308 | 6,573 | 5,926 | 5,715 | 4,917 | 5,360 | 7,117 | 7,181 |
| South Dakota | 6,164 | N/A | 6,459 | 6,234 | N/A | N/A | N/A | N/A | N/A |
| Tennessee | 5,390 | 5,895 | 5,149 | 6,121 | 5,148 | 4,053 | 4,696 | 6,525 | 6,685 |
| Texas | 5,148 | 5,565 | 5,508 | 5,307 | 5,490 | 4,532 | 4,973 | 6,468 | 8,055 |
| Utah | 4,669 | N/A | 5,455 | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 5,005 | 4,887 | 5,079 | N/A | N/A | N/A | N/A | N/A | N/A |
| Virginia | 5,644 | 5,465 | 5,280 | 5,401 | 5,468 | 4,940 | 5,014 | 6,132 | 7,270 |
| Washington | 4,687 | 4,822 | 4,705 | 4,419 | 4,395 | 3,677 | 4,019 | 5,354 | 5,932 |
| West Virginia | 5,180 | 5,282 | 5,083 | 5,243 | 4,922 | 4,101 | 4,699 | 5,297 | 6,945 |
| Wisconsin | 5,168 | 5,533 | 5,541 | 5,414 | 5,434 | 4,765 | 5,205 | 5,663 | 6,280 |
| Wyoming | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

## Cost per Discharge (Adjusted for Wage Index & Case Mix)

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | 5,356 | 5,339 | 5,335 | 5,232 | 5,133 | 3,874 | 4,477 | 6,373 | 7,667 |
| Medium | 4,817 | 4,866 | 5,021 | 4,913 | 5,036 | 3,738 | 4,390 | 6,153 | 7,391 |
| Low | 5,146 | 5,144 | 5,060 | 5,110 | 5,007 | 3,827 | 4,438 | 6,065 | 7,117 |
| **States** | | | | | | | | | |
| Alabama | 5,422 | 5,658 | 4,750 | 5,316 | 5,538 | 3,897 | 4,580 | 6,276 | 6,477 |
| Alaska | 6,655 | 5,927 | 6,783 | 6,258 | 6,955 | 5,169 | 6,129 | 7,258 | 7,448 |
| Arizona | 5,692 | 5,128 | 5,879 | 5,735 | N/A | N/A | N/A | N/A | N/A |
| Arkansas | 4,513 | 4,966 | 5,295 | 4,980 | 4,864 | 3,893 | 4,413 | 5,219 | 6,853 |
| California | 4,796 | 4,601 | 4,634 | 4,849 | 5,057 | 3,628 | 4,345 | 6,354 | 8,722 |
| Colorado | 5,278 | 5,686 | 5,733 | 5,077 | 4,873 | 4,180 | 4,342 | 5,641 | 6,184 |
| Connecticut | 5,312 | 5,213 | 5,227 | 5,096 | 4,969 | 4,085 | 4,392 | 5,911 | 6,302 |
| Delaware | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | 7,324 | 6,809 | 6,640 | 5,732 | N/A | N/A | N/A | N/A | N/A |
| Florida | 5,316 | 5,521 | 5,212 | 5,177 | 5,512 | 4,665 | 5,057 | 6,060 | 7,550 |
| Georgia | 5,241 | 5,317 | 5,168 | 5,260 | 5,965 | 4,255 | 4,563 | 6,272 | 6,547 |
| Hawaii | 6,424 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Idaho | 4,543 | 4,764 | 4,931 | N/A | N/A | N/A | N/A | N/A | N/A |
| Illinois | 5,642 | 5,752 | 5,608 | 5,742 | 5,629 | 4,268 | 4,827 | 6,268 | 7,206 |
| Indiana | 5,129 | 5,247 | 5,366 | 5,376 | 5,900 | 3,974 | 4,841 | 6,162 | 6,673 |
| Iowa | 5,136 | 5,179 | 5,320 | 5,225 | 5,608 | 4,727 | 5,052 | 6,010 | 8,677 |
| Kansas | 4,828 | 5,187 | 5,474 | 5,145 | 6,189 | 4,191 | 4,747 | 7,148 | 7,620 |
| Kentucky | 5,020 | 4,724 | 5,125 | 5,123 | 5,287 | 3,697 | 4,250 | 5,597 | 6,077 |
| Louisiana | 5,953 | 5,454 | 5,675 | 5,945 | 5,639 | 5,342 | 5,457 | 6,049 | 6,779 |
| Maine | 4,734 | 4,899 | 5,376 | 5,629 | 5,579 | 4,666 | 4,766 | 6,084 | 7,743 |
| Maryland | 4,792 | 4,751 | 4,570 | 4,674 | 4,732 | 4,371 | 4,475 | 5,028 | 6,165 |
| Massachusetts | 4,287 | 4,051 | 3,881 | 3,572 | 3,729 | 2,866 | 3,389 | 4,827 | 7,473 |
| Michigan | 4,564 | 4,596 | 4,601 | 4,661 | 4,445 | 3,685 | 4,027 | 5,126 | 5,570 |
| Minnesota | 4,507 | 4,762 | 4,789 | 4,829 | 4,955 | 4,314 | 4,620 | 5,483 | 5,655 |
| Mississippi | 5,682 | 5,425 | 6,235 | 6,080 | N/A | N/A | N/A | N/A | N/A |
| Missouri | 5,266 | 5,474 | 5,833 | 5,621 | 6,440 | 4,327 | 5,681 | 6,797 | 7,413 |
| Montana | 5,622 | 4,314 | 5,214 | 5,124 | 5,023 | 4,095 | 4,680 | 5,849 | 6,239 |
| Nebraska | 6,027 | 5,412 | 5,358 | 5,272 | 5,678 | 4,648 | 5,113 | 6,225 | 7,362 |
| Nevada | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| New Hampshire | 4,790 | 4,700 | 5,326 | 5,560 | 4,970 | 3,744 | 4,195 | 5,381 | 5,772 |
| New Jersey | 4,756 | 4,742 | 4,848 | 4,993 | 4,904 | 4,132 | 4,583 | 5,648 | 7,021 |
| New Mexico | 5,594 | 5,280 | 4,788 | 5,770 | 5,956 | 4,635 | 5,050 | 6,825 | 7,174 |
| New York | 4,544 | 4,492 | 4,649 | 4,432 | 4,609 | 3,712 | 3,993 | 5,298 | 6,780 |
| North Carolina | 5,219 | 5,537 | 5,100 | 5,099 | 5,364 | 4,541 | 4,704 | 6,456 | 7,072 |
| North Dakota | 5,570 | 6,154 | 5,428 | 6,126 | 5,597 | 5,002 | 5,210 | 6,650 | 6,904 |
| Ohio | 4,896 | 4,993 | 4,928 | 5,096 | 5,261 | 4,387 | 4,729 | 6,015 | 7,157 |
| Oklahoma | 4,887 | 4,948 | 4,944 | 5,800 | 5,425 | 4,928 | 5,213 | 6,343 | 7,440 |
| Oregon | 4,468 | 4,544 | 4,713 | 4,254 | 4,263 | 3,529 | 3,659 | 4,704 | 5,426 |
| Pennsylvania | 4,499 | 4,492 | 4,433 | 4,651 | 4,252 | 3,388 | 3,777 | 5,203 | 6,554 |
| Rhode Island | 4,283 | 4,263 | 4,192 | 4,297 | N/A | N/A | N/A | N/A | N/A |
| South Carolina | 5,664 | 6,204 | 6,176 | 5,820 | 5,660 | 4,574 | 5,024 | 6,862 | 7,051 |
| South Dakota | 6,084 | N/A | 6,197 | 6,257 | N/A | N/A | N/A | N/A | N/A |
| Tennessee | 5,703 | 5,710 | 4,983 | 5,658 | 4,515 | 3,634 | 4,411 | 6,030 | 6,631 |
| Texas | 4,964 | 5,763 | 5,606 | 5,119 | 5,424 | 4,448 | 4,891 | 6,964 | 8,097 |
| Utah | 5,170 | N/A | 5,447 | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 5,007 | 4,818 | 4,930 | N/A | N/A | N/A | N/A | N/A | N/A |
| Virginia | 5,491 | 5,264 | 5,086 | 5,252 | 5,178 | 4,236 | 4,586 | 5,742 | 7,154 |
| Washington | 4,725 | 4,646 | 4,467 | 4,357 | 4,366 | 3,687 | 3,962 | 4,956 | 6,211 |
| West Virginia | 4,754 | 5,261 | 4,755 | 5,233 | 4,839 | 3,885 | 4,355 | 5,236 | 6,825 |
| Wisconsin | 4,952 | 5,442 | 5,336 | 5,436 | 5,303 | 4,658 | 4,836 | 5,629 | 6,382 |
| Wyoming | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

## Profit per Discharge

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | -34.21 | -1.66 | 14.74 | -33.62 | -54.86 | -1,618.47 | -477.37 | 227.88 | 461.85 |
| Medium | -103.20 | -60.50 | -36.27 | -29.23 | -55.92 | -673.13 | -314.69 | 214.31 | 593.63 |
| Low | -23.07 | -18.85 | -8.19 | -13.42 | 10.32 | -623.25 | -179.70 | 245.00 | 443.39 |
| **States** | | | | | | | | | |
| Alabama | -28.96 | -56.71 | -93.33 | 39.58 | 14.35 | -196.69 | -35.79 | 109.10 | 335.68 |
| Alaska | -343.33 | -173.94 | -203.03 | -180.45 | -360.22 | -1,627.17 | -846.15 | -36.32 | 85.59 |
| Arizona | 256.75 | 155.42 | 143.61 | 221.94 | N/A | N/A | N/A | N/A | N/A |
| Arkansas | 51.69 | 126.70 | 152.18 | 187.57 | 124.11 | -13.00 | 64.12 | 319.21 | 471.05 |
| California | -75.91 | -17.04 | -80.02 | -129.36 | -402.48 | -3,907.85 | -1,539.22 | 133.03 | 432.02 |
| Colorado | 209.23 | 50.29 | 90.02 | 239.48 | 234.09 | -128.24 | 145.14 | 318.67 | 351.54 |
| Connecticut | -74.65 | -121.44 | -59.25 | -29.43 | -64.66 | -453.97 | -391.11 | 61.89 | 280.46 |
| Delaware | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | -208.72 | 65.41 | 66.68 | -1,371.89 | N/A | N/A | N/A | N/A | N/A |
| Florida | 53.51 | 62.03 | 106.95 | 90.55 | 74.43 | -619.30 | -170.26 | 301.27 | 463.88 |
| Georgia | 103.99 | 127.54 | 199.37 | 185.56 | 68.81 | -256.06 | -60.45 | 706.30 | 851.66 |
| Hawaii | -213.93 | -237.89 | -210.38 | N/A | N/A | N/A | N/A | N/A | N/A |
| Idaho | -52.18 | 65.96 | 73.81 | N/A | N/A | N/A | N/A | N/A | N/A |
| Illinois | 14.23 | 52.14 | 104.36 | 52.26 | 68.45 | -578.90 | -191.54 | 257.56 | 447.33 |
| Indiana | 139.64 | 122.76 | 158.90 | 206.32 | 116.10 | -476.32 | -90.43 | 324.19 | 547.50 |
| Iowa | -18.50 | -2.05 | -11.19 | 56.49 | 3.80 | -424.56 | -156.07 | 151.66 | 337.18 |
| Kansas | 23.43 | 91.92 | 145.39 | 77.11 | 187.08 | -50.98 | 36.19 | 271.64 | 659.84 |
| Kentucky | -26.10 | 0.28 | 57.32 | 190.21 | 164.73 | 1.95 | 82.01 | 241.52 | 285.44 |
| Louisiana | 201.51 | 241.78 | 228.96 | 225.60 | 168.36 | -249.07 | -33.35 | 394.66 | 449.51 |
| Maine | -23.18 | 45.35 | 52.59 | 8.59 | 179.06 | -150.42 | -39.14 | 260.76 | 446.65 |
| Maryland | 56.44 | 111.49 | 70.00 | 138.18 | 129.59 | -131.93 | 56.50 | 278.64 | 376.84 |
| Massachusetts | -78.47 | -84.48 | -123.96 | -125.60 | -138.56 | -1,080.21 | -296.55 | -52.48 | 14.85 |
| Michigan | 32.10 | 30.88 | 117.11 | 125.29 | 157.20 | -192.77 | -71.84 | 320.61 | 432.55 |
| Minnesota | -14.01 | 37.50 | 67.88 | 41.23 | 47.41 | -327.37 | -35.97 | 165.36 | 309.06 |
| Mississippi | 72.53 | -2.92 | 0.44 | 58.20 | N/A | N/A | N/A | N/A | N/A |
| Missouri | -2.14 | 16.25 | 75.08 | 85.54 | 22.59 | -1,001.48 | -556.37 | 266.68 | 370.56 |
| Montana | 120.76 | 50.69 | 126.02 | 286.61 | 263.42 | -143.92 | -124.71 | 408.51 | 458.22 |
| Nebraska | -16.23 | 70.38 | 126.55 | 105.76 | 143.94 | -150.48 | -3.87 | 226.74 | 269.26 |
| Nevada | 76.39 | 133.11 | 532.05 | N/A | N/A | N/A | N/A | N/A | N/A |
| New Hampshire | -62.62 | 105.66 | 27.45 | 45.46 | 181.44 | -174.53 | 34.86 | 184.44 | 192.53 |
| New Jersey | -26.43 | -77.30 | -130.80 | -158.08 | -116.40 | -1,540.15 | -1,014.18 | 51.92 | 112.50 |
| New Mexico | -94.24 | 170.80 | 82.22 | 336.12 | 244.51 | -49.75 | 35.50 | 444.59 | 513.77 |
| New York | -188.80 | -149.93 | -181.45 | -104.63 | -143.82 | -725.49 | -473.21 | -45.03 | 149.69 |
| North Carolina | 82.93 | 87.58 | 180.23 | 226.96 | 220.45 | -500.90 | 33.73 | 424.60 | 570.31 |
| North Dakota | 3.62 | -68.77 | 116.64 | -49.23 | 132.94 | -135.94 | -32.97 | 217.19 | 589.18 |
| Ohio | 19.17 | 29.70 | 64.43 | 38.78 | 71.12 | -447.01 | -191.04 | 315.26 | 532.73 |
| Oklahoma | 56.66 | 10.26 | -11.61 | 66.93 | -16.29 | -333.88 | -89.10 | 265.23 | 338.49 |
| Oregon | 24.18 | 52.56 | 77.23 | 79.44 | 122.86 | -388.31 | -70.71 | 302.50 | 483.86 |
| Pennsylvania | -61.06 | -67.15 | -61.45 | -82.87 | -23.21 | -404.05 | -130.07 | 74.52 | 165.61 |
| Rhode Island | -191.32 | -218.22 | -172.58 | -174.85 | N/A | N/A | N/A | N/A | N/A |
| South Carolina | -25.84 | 90.36 | 282.38 | 136.54 | 246.94 | 70.77 | 128.35 | 411.62 | 442.72 |
| South Dakota | 41.48 | -201.04 | 100.92 | -61.81 | N/A | N/A | N/A | N/A | N/A |
| Tennessee | -37.44 | 70.51 | 157.05 | 238.96 | 373.66 | -270.28 | 136.78 | 599.42 | 747.31 |
| Texas | 133.11 | 8.72 | -46.54 | 45.49 | 105.35 | -2,016.86 | -593.53 | 315.70 | 429.33 |
| Utah | -115.57 | N/A | 44.85 | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | -44.38 | 130.58 | -21.58 | 31.38 | N/A | N/A | N/A | N/A | N/A |
| Virginia | 115.01 | 171.88 | 265.94 | 218.39 | 358.07 | 34.80 | 134.57 | 464.36 | 721.36 |
| Washington | -21.93 | 77.52 | 14.47 | -2.31 | -41.86 | -446.00 | -279.84 | 246.72 | 382.13 |
| West Virginia | 38.95 | -1.24 | 43.17 | 72.65 | 62.66 | -259.14 | -88.11 | 196.46 | 561.58 |
| Wisconsin | 79.94 | 99.70 | 149.60 | 140.67 | 121.87 | -132.85 | 34.86 | 284.80 | 417.81 |
| Wyoming | 58.04 | 214.58 | -102.34 | 238.32 | N/A | N/A | N/A | N/A | N/A |

## Cost per Visit (Adjusted for Wage Index)

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | 216.39 | 222.72 | 233.29 | 236.10 | 240.27 | 121.10 | 166.20 | 304.64 | 408.01 |
| Medium | 212.45 | 230.33 | 229.10 | 239.69 | 253.12 | 141.65 | 205.78 | 369.68 | 475.95 |
| Low | 200.66 | 212.36 | 210.30 | 208.22 | 220.99 | 109.47 | 160.60 | 295.25 | 418.94 |
| **States** | | | | | | | | | |
| Alabama | 368.57 | 368.93 | 400.51 | 356.24 | 320.35 | 130.69 | 201.12 | 430.29 | 477.79 |
| Alaska | 152.06 | 180.53 | 182.66 | 151.23 | 127.48 | 112.19 | 121.10 | 216.00 | 328.48 |
| Arizona | 171.70 | 249.23 | 269.21 | 257.28 | N/A | N/A | N/A | N/A | N/A |
| Arkansas | 317.76 | 356.28 | 385.60 | 479.52 | 402.86 | 331.00 | 391.48 | 434.08 | 534.67 |
| California | 170.31 | 180.03 | 189.61 | 186.02 | 177.56 | 109.61 | 140.65 | 251.50 | 324.32 |
| Colorado | 176.85 | 248.63 | 276.47 | 186.72 | 200.53 | 144.82 | 159.82 | 242.68 | 268.91 |
| Connecticut | 220.17 | 201.66 | 188.57 | 178.96 | 224.06 | 137.33 | 195.52 | 322.35 | 356.12 |
| Delaware | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | 195.69 | 357.76 | 291.99 | 245.52 | N/A | N/A | N/A | N/A | N/A |
| Florida | 263.28 | 286.46 | 285.96 | 290.01 | 308.95 | 221.47 | 258.44 | 367.94 | 416.64 |
| Georgia | 313.86 | 261.02 | 285.08 | 358.76 | 343.68 | 245.56 | 280.38 | 439.09 | 493.55 |
| Hawaii | 211.63 | 172.24 | 154.46 | N/A | N/A | N/A | N/A | N/A | N/A |
| Idaho | 236.47 | 200.15 | 253.06 | N/A | N/A | N/A | N/A | N/A | N/A |
| Illinois | 213.58 | 226.17 | 236.80 | 235.49 | 253.95 | 156.45 | 194.54 | 345.18 | 409.43 |
| Indiana | 187.38 | 201.31 | 221.61 | 203.57 | 241.95 | 123.38 | 169.88 | 371.04 | 393.65 |
| Iowa | 181.72 | 199.66 | 220.68 | 217.45 | 245.72 | 126.78 | 191.42 | 337.14 | 449.98 |
| Kansas | 173.14 | 186.49 | 215.50 | 260.57 | 263.30 | 134.33 | 221.42 | 421.80 | 497.08 |
| Kentucky | 251.12 | 303.66 | 309.89 | 266.26 | 272.75 | 190.36 | 242.56 | 395.97 | 435.81 |
| Louisiana | 340.25 | 380.24 | 380.69 | 350.04 | 321.94 | 135.77 | 257.34 | 421.35 | 473.62 |
| Maine | 142.22 | 151.04 | 179.35 | 189.85 | 219.05 | 182.33 | 210.39 | 256.21 | 344.89 |
| Maryland | 197.56 | 222.25 | 193.84 | 290.52 | 252.33 | 106.02 | 161.61 | 309.14 | 348.57 |
| Massachusetts | 225.79 | 203.06 | 214.17 | 225.34 | 257.86 | 144.26 | 202.44 | 357.99 | 441.40 |
| Michigan | 220.16 | 214.03 | 209.39 | 197.04 | 210.90 | 133.74 | 159.82 | 245.83 | 300.72 |
| Minnesota | 232.51 | 297.28 | 268.92 | 254.39 | 254.35 | 190.23 | 206.48 | 364.18 | 459.67 |
| Mississippi | 428.17 | 278.80 | 424.00 | 371.70 | N/A | N/A | N/A | N/A | N/A |
| Missouri | 336.00 | 307.66 | 332.36 | 322.53 | 316.66 | 151.22 | 202.54 | 412.25 | 502.75 |
| Montana | 241.38 | 198.45 | 235.47 | 255.62 | 279.13 | 222.27 | 257.18 | 295.24 | 312.25 |
| Nebraska | 245.20 | 195.39 | 248.70 | 324.54 | 290.81 | 181.74 | 249.33 | 375.68 | 532.22 |
| Nevada | 203.63 | 252.68 | 231.09 | N/A | N/A | N/A | N/A | N/A | N/A |
| New Hampshire | 217.60 | 206.88 | 238.07 | 208.93 | 266.77 | 152.32 | 173.99 | 290.96 | 330.75 |
| New Jersey | 145.18 | 142.58 | 156.46 | 175.01 | 232.25 | 97.61 | 154.87 | 258.92 | 301.09 |
| New Mexico | 238.20 | 305.61 | 250.89 | 354.71 | 327.42 | 222.46 | 253.46 | 392.68 | 408.00 |
| New York | 155.94 | 167.17 | 169.34 | 183.58 | 170.10 | 118.60 | 145.87 | 235.90 | 387.71 |
| North Carolina | 263.70 | 279.88 | 294.86 | 327.83 | 332.89 | 192.90 | 227.45 | 446.16 | 508.91 |
| North Dakota | 367.62 | 337.62 | 310.22 | 448.68 | 503.78 | 381.95 | 415.15 | 660.02 | 767.41 |
| Ohio | 216.51 | 234.11 | 241.78 | 243.49 | 259.16 | 177.45 | 224.83 | 362.09 | 394.92 |
| Oklahoma | 367.26 | 357.85 | 359.13 | 371.88 | 340.88 | 304.34 | 324.23 | 528.34 | 584.64 |
| Oregon | 220.25 | 201.84 | 191.43 | 248.57 | 214.89 | 100.96 | 116.58 | 294.56 | 314.14 |
| Pennsylvania | 170.74 | 170.73 | 185.64 | 187.47 | 196.17 | 127.04 | 167.67 | 241.84 | 277.68 |
| Rhode Island | 236.68 | 291.24 | 285.47 | 349.44 | N/A | N/A | N/A | N/A | N/A |
| South Carolina | 245.84 | 275.25 | 281.31 | 304.15 | 286.62 | 160.17 | 220.34 | 340.75 | 371.96 |
| South Dakota | 281.61 | 307.06 | 247.88 | 185.81 | N/A | N/A | N/A | N/A | N/A |
| Tennessee | 286.14 | 273.83 | 298.45 | 276.28 | 294.60 | 212.91 | 245.53 | 442.26 | 546.44 |
| Texas | 293.79 | 306.92 | 290.88 | 294.52 | 291.74 | 199.79 | 246.97 | 377.51 | 396.79 |
| Utah | 174.06 | N/A | 133.34 | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 194.50 | 185.63 | 160.87 | 227.97 | N/A | N/A | N/A | N/A | N/A |
| Virginia | 233.33 | 242.72 | 249.12 | 263.83 | 259.52 | 189.82 | 207.68 | 325.87 | 366.75 |
| Washington | 223.24 | 227.49 | 241.17 | 244.29 | 252.54 | 142.05 | 192.13 | 316.21 | 355.49 |
| West Virginia | 219.41 | 222.54 | 207.80 | 195.22 | 183.87 | 135.96 | 156.02 | 264.89 | 286.00 |
| Wisconsin | 245.00 | 213.72 | 222.76 | 237.93 | 266.27 | 175.84 | 225.43 | 324.33 | 425.62 |
| Wyoming | 228.61 | 331.34 | 225.88 | 268.75 | N/A | N/A | N/A | N/A | N/A |

## Net Price per Visit (Adjusted for Wage Index)

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | 207.65 | 216.18 | 228.02 | 231.39 | 228.77 | 118.02 | 163.82 | 306.97 | 396.50 |
| Medium | 209.69 | 231.67 | 226.04 | 231.28 | 262.66 | 133.15 | 206.49 | 365.31 | 468.95 |
| Low | 194.80 | 210.00 | 200.44 | 203.63 | 215.32 | 108.08 | 170.54 | 304.89 | 417.72 |
| **States** | | | | | | | | | |
| Alabama | 370.48 | 351.20 | 409.85 | 356.45 | 332.43 | 131.00 | 210.87 | 431.32 | 483.79 |
| Alaska | 140.45 | 165.02 | 185.58 | 151.95 | 124.73 | 88.38 | 102.05 | 201.12 | 327.11 |
| Arizona | 176.02 | 266.61 | 275.33 | 238.89 | N/A | N/A | N/A | N/A | N/A |
| Arkansas | 316.52 | 362.18 | 384.33 | 495.16 | 414.33 | 335.30 | 397.16 | 462.95 | 608.78 |
| California | 159.22 | 186.00 | 176.57 | 184.29 | 167.36 | 103.84 | 121.61 | 220.15 | 272.80 |
| Colorado | 194.02 | 232.04 | 284.22 | 190.55 | 211.47 | 153.45 | 166.08 | 237.68 | 269.97 |
| Connecticut | 237.99 | 195.24 | 181.81 | 179.24 | 235.05 | 138.70 | 198.58 | 321.51 | 352.54 |
| Delaware | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | 161.94 | 311.02 | 311.75 | 240.53 | N/A | N/A | N/A | N/A | N/A |
| Florida | 261.86 | 288.00 | 285.48 | 296.79 | 297.08 | 223.77 | 241.61 | 369.06 | 402.38 |
| Georgia | 307.89 | 266.18 | 296.45 | 382.35 | 367.58 | 240.47 | 274.80 | 437.28 | 509.31 |
| Hawaii | 216.49 | 171.96 | 152.29 | N/A | N/A | N/A | N/A | N/A | N/A |
| Idaho | 243.25 | 201.59 | 253.28 | N/A | N/A | N/A | N/A | N/A | N/A |
| Illinois | 210.64 | 226.47 | 237.13 | 233.21 | 252.33 | 153.46 | 177.16 | 353.37 | 414.82 |
| Indiana | 194.41 | 192.99 | 231.88 | 206.77 | 247.57 | 110.88 | 176.20 | 349.69 | 411.97 |
| Iowa | 184.61 | 191.31 | 222.31 | 230.62 | 247.08 | 124.48 | 174.71 | 343.45 | 447.85 |
| Kansas | 176.04 | 195.38 | 222.02 | 276.03 | 269.82 | 137.94 | 227.98 | 435.74 | 520.41 |
| Kentucky | 247.37 | 302.67 | 302.60 | 271.45 | 267.58 | 200.62 | 247.68 | 416.35 | 443.96 |
| Louisiana | 348.24 | 389.32 | 384.40 | 364.31 | 320.13 | 119.60 | 272.43 | 428.53 | 471.62 |
| Maine | 143.70 | 151.84 | 184.17 | 182.19 | 232.43 | 181.29 | 202.15 | 256.62 | 351.49 |
| Maryland | 208.53 | 222.37 | 200.50 | 302.41 | 267.96 | 115.89 | 159.47 | 316.32 | 363.08 |
| Massachusetts | 215.85 | 197.16 | 192.34 | 219.25 | 255.82 | 144.39 | 201.64 | 347.89 | 431.84 |
| Michigan | 220.64 | 215.30 | 210.90 | 204.31 | 209.04 | 136.42 | 166.07 | 244.70 | 310.20 |
| Minnesota | 229.88 | 299.72 | 302.93 | 253.09 | 268.70 | 193.93 | 217.33 | 384.76 | 471.03 |
| Mississippi | 451.33 | 282.28 | 433.87 | 376.33 | N/A | N/A | N/A | N/A | N/A |
| Missouri | 346.84 | 308.78 | 334.94 | 331.66 | 318.57 | 130.00 | 208.18 | 400.11 | 452.61 |
| Montana | 231.03 | 195.48 | 257.03 | 280.79 | 293.39 | 221.38 | 253.97 | 308.01 | 330.81 |
| Nebraska | 213.94 | 188.67 | 247.05 | 290.89 | 299.57 | 192.78 | 262.68 | 345.54 | 548.33 |
| Nevada | 202.35 | 256.45 | 257.39 | N/A | N/A | N/A | N/A | N/A | N/A |
| New Hampshire | 220.48 | 206.46 | 236.45 | 202.30 | 251.65 | 155.06 | 179.53 | 302.65 | 342.93 |
| New Jersey | 145.81 | 138.70 | 151.30 | 163.03 | 227.20 | 92.03 | 156.05 | 256.73 | 287.80 |
| New Mexico | 258.94 | 340.09 | 266.97 | 388.17 | 356.29 | 234.63 | 280.28 | 407.55 | 408.68 |
| New York | 149.62 | 163.02 | 165.27 | 180.14 | 177.89 | 112.11 | 133.98 | 228.69 | 340.74 |
| North Carolina | 259.87 | 296.25 | 303.37 | 340.59 | 335.52 | 178.02 | 230.30 | 466.98 | 558.74 |
| North Dakota | 375.86 | 336.54 | 305.77 | 437.01 | 520.73 | 283.58 | 412.93 | 720.08 | 836.24 |
| Ohio | 222.43 | 237.15 | 246.78 | 243.08 | 271.53 | 181.47 | 227.18 | 344.41 | 397.28 |
| Oklahoma | 375.56 | 374.07 | 356.49 | 368.22 | 378.38 | 286.38 | 308.30 | 560.46 | 604.64 |
| Oregon | 214.13 | 214.78 | 195.60 | 251.80 | 193.84 | 102.77 | 122.49 | 304.77 | 322.24 |
| Pennsylvania | 169.03 | 175.24 | 188.09 | 181.66 | 194.29 | 128.33 | 172.84 | 238.66 | 274.26 |
| Rhode Island | 230.34 | 271.20 | 277.37 | 333.78 | N/A | N/A | N/A | N/A | N/A |
| South Carolina | 259.97 | 271.92 | 282.89 | 293.79 | 301.41 | 174.33 | 234.70 | 348.55 | 388.86 |
| South Dakota | 261.78 | 300.39 | 254.23 | 162.14 | N/A | N/A | N/A | N/A | N/A |
| Tennessee | 285.65 | 288.96 | 322.48 | 281.96 | 306.23 | 221.32 | 238.82 | 498.72 | 628.10 |
| Texas | 297.15 | 294.69 | 288.30 | 285.55 | 284.18 | 171.07 | 241.57 | 362.19 | 399.26 |
| Utah | 177.83 | N/A | 126.48 | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 191.27 | 184.97 | 165.58 | 222.00 | N/A | N/A | N/A | N/A | N/A |
| Virginia | 234.83 | 250.59 | 262.68 | 280.07 | 282.37 | 211.16 | 228.14 | 343.74 | 379.87 |
| Washington | 224.49 | 228.36 | 239.61 | 239.33 | 233.02 | 136.67 | 181.57 | 292.10 | 380.18 |
| West Virginia | 225.39 | 217.55 | 206.82 | 200.73 | 189.86 | 139.80 | 155.22 | 259.75 | 290.04 |
| Wisconsin | 244.57 | 212.33 | 229.78 | 230.32 | 271.13 | 188.74 | 226.00 | 332.63 | 441.32 |
| Wyoming | 194.97 | 322.20 | 209.11 | 247.93 | N/A | N/A | N/A | N/A | N/A |

## Profit per Visit

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | -1.29 | 0.80 | 0.76 | -1.26 | -1.25 | -44.64 | -15.90 | 10.30 | 22.58 |
| Medium | -2.74 | -2.05 | -1.28 | -1.17 | -2.02 | -22.71 | -9.95 | 9.28 | 20.76 |
| Low | -0.74 | -0.31 | -0.41 | -0.63 | 0.17 | -22.19 | -6.83 | 6.60 | 16.23 |
| **States** | | | | | | | | | |
| Alabama | -2.03 | -1.13 | -6.09 | 1.63 | 0.94 | -5.99 | -0.28 | 6.55 | 10.69 |
| Alaska | -3.13 | -6.95 | -4.84 | -6.75 | -17.83 | -37.83 | -27.41 | -0.43 | 2.76 |
| Arizona | 6.61 | 10.64 | 7.52 | 9.61 | N/A | N/A | N/A | N/A | N/A |
| Arkansas | 2.96 | 7.14 | 5.94 | 12.31 | 9.77 | -0.07 | 5.30 | 21.78 | 52.90 |
| California | -2.63 | 0.36 | -2.77 | -3.64 | -8.07 | -86.98 | -39.19 | 1.56 | 10.01 |
| Colorado | 5.77 | 1.96 | 5.96 | 9.60 | 9.13 | -2.82 | 4.54 | 11.55 | 11.71 |
| Connecticut | -2.83 | -4.39 | -3.91 | -1.16 | 0.98 | -10.19 | -4.29 | 5.86 | 9.59 |
| Delaware | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | -4.05 | 1.43 | 6.73 | -45.86 | N/A | N/A | N/A | N/A | N/A |
| Florida | 2.13 | 2.82 | 3.30 | 5.13 | 3.50 | -30.41 | -9.00 | 10.15 | 13.74 |
| Georgia | 3.17 | 6.56 | 10.81 | 8.87 | 2.40 | -17.47 | -9.03 | 25.18 | 35.97 |
| Hawaii | -2.42 | -2.38 | -2.44 | N/A | N/A | N/A | N/A | N/A | N/A |
| Idaho | -0.11 | 3.59 | 2.48 | N/A | N/A | N/A | N/A | N/A | N/A |
| Illinois | 0.40 | 2.20 | 2.68 | 2.42 | 1.86 | -19.84 | -5.63 | 11.56 | 26.31 |
| Indiana | 4.36 | 5.15 | 7.19 | 7.37 | 3.12 | -26.25 | -4.28 | 11.69 | 26.42 |
| Iowa | -0.84 | -0.93 | -0.37 | -1.19 | -0.97 | -15.60 | -4.49 | 9.08 | 17.09 |
| Kansas | 2.83 | 3.39 | 13.52 | 4.09 | 5.35 | -0.70 | 1.11 | 19.47 | 21.99 |
| Kentucky | -1.45 | -0.04 | 4.98 | 8.92 | 8.52 | -4.02 | 3.84 | 15.64 | 23.68 |
| Louisiana | 10.69 | 11.87 | 11.01 | 11.56 | 5.31 | -18.46 | -2.13 | 7.09 | 15.42 |
| Maine | -1.04 | 1.27 | 2.29 | 0.17 | 2.29 | -5.33 | -2.40 | 9.37 | 12.16 |
| Maryland | 2.47 | 5.27 | 3.51 | 7.83 | 3.56 | -6.01 | -2.19 | 12.47 | 15.64 |
| Massachusetts | -2.10 | -2.63 | -5.46 | -4.77 | -9.40 | -39.68 | -13.47 | -1.72 | 2.40 |
| Michigan | 1.34 | 1.28 | 3.79 | 3.66 | 4.00 | -9.33 | -4.91 | 10.41 | 17.12 |
| Minnesota | 0.03 | 1.51 | 3.84 | 4.12 | 6.49 | -15.65 | -1.17 | 10.13 | 19.71 |
| Mississippi | 3.85 | 1.91 | -0.40 | 7.56 | N/A | N/A | N/A | N/A | N/A |
| Missouri | 0.37 | 1.57 | 3.12 | 6.02 | 0.68 | -37.67 | -15.05 | 11.74 | 20.95 |
| Montana | 5.95 | -4.86 | 10.27 | 15.50 | 4.42 | -8.11 | -6.63 | 18.66 | 21.09 |
| Nebraska | -0.40 | 3.05 | 6.55 | 6.81 | 8.01 | -19.14 | -0.01 | 12.99 | 16.76 |
| Nevada | 3.13 | 7.06 | 18.47 | N/A | N/A | N/A | N/A | N/A | N/A |
| New Hampshire | -1.54 | 2.99 | 2.30 | 1.61 | 7.19 | -6.08 | 2.16 | 12.43 | 15.46 |
| New Jersey | -0.03 | -1.61 | -2.93 | -4.35 | -3.18 | -44.77 | -16.63 | 1.92 | 2.61 |
| New Mexico | -6.23 | 11.71 | 3.56 | 18.95 | 11.49 | -5.66 | -0.42 | 22.36 | 25.73 |
| New York | -5.82 | -5.41 | -6.65 | -3.76 | -4.81 | -17.70 | -10.55 | -1.71 | 3.81 |
| North Carolina | 4.23 | 6.51 | 14.20 | 11.74 | 14.97 | -15.46 | 1.89 | 27.44 | 32.06 |
| North Dakota | 2.31 | -1.94 | 5.01 | -5.32 | 10.63 | -42.52 | -7.01 | 33.07 | 50.98 |
| Ohio | 0.95 | 1.38 | 3.36 | 2.83 | 3.88 | -18.18 | -5.30 | 11.75 | 20.70 |
| Oklahoma | 4.70 | 0.88 | 3.93 | 1.10 | -0.98 | -12.26 | -7.33 | 19.21 | 28.04 |
| Oregon | 1.65 | 2.54 | 4.27 | 5.39 | 5.42 | -13.18 | -1.33 | 13.14 | 20.19 |
| Pennsylvania | -1.97 | -2.47 | -1.32 | -3.08 | -0.34 | -11.87 | -4.21 | 3.62 | 8.78 |
| Rhode Island | -8.17 | -22.32 | -3.78 | -17.36 | N/A | N/A | N/A | N/A | N/A |
| South Carolina | 0.20 | 2.86 | 14.34 | 9.51 | 9.28 | 2.44 | 4.65 | 14.55 | 26.73 |
| South Dakota | 0.71 | -7.49 | 4.06 | -1.40 | N/A | N/A | N/A | N/A | N/A |
| Tennessee | -1.49 | 2.02 | 7.07 | 10.24 | 18.84 | -9.68 | 4.49 | 43.07 | 66.03 |
| Texas | 8.37 | 1.95 | 0.23 | 1.00 | 5.55 | -90.29 | -23.93 | 16.03 | 17.93 |
| Utah | -5.46 | N/A | 1.07 | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | -1.44 | -0.09 | -1.10 | 1.39 | N/A | N/A | N/A | N/A | N/A |
| Virginia | 5.26 | 6.11 | 10.24 | 7.45 | 14.76 | 1.23 | 5.63 | 23.69 | 36.79 |
| Washington | -0.35 | 2.47 | 2.14 | 0.49 | -0.48 | -23.96 | -9.10 | 15.45 | 24.54 |
| West Virginia | 1.69 | -0.06 | 1.43 | 1.80 | 2.57 | -14.56 | -5.01 | 7.34 | 16.56 |
| Wisconsin | 3.23 | 3.62 | 5.15 | 5.22 | 6.64 | -3.46 | 1.56 | 15.16 | 22.06 |
| Wyoming | -4.07 | -10.36 | 0.95 | 15.44 | N/A | N/A | N/A | N/A | N/A |

# FTEs per Occupied Bed

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | 5.37 | 5.56 | 5.69 | 5.66 | 5.96 | 4.60 | 5.33 | 7.27 | 8.25 |
| Medium | 4.71 | 4.95 | 5.21 | 5.33 | 5.60 | 3.98 | 4.75 | 6.53 | 7.44 |
| Low | 4.76 | 4.82 | 5.03 | 5.10 | 5.22 | 3.97 | 4.43 | 6.22 | 7.13 |
| **States** | | | | | | | | | |
| Alabama | 4.77 | 5.22 | 5.05 | 5.31 | 5.31 | 4.24 | 4.55 | 6.09 | 6.13 |
| Alaska | 6.19 | 6.40 | 7.18 | 6.71 | 8.16 | 6.57 | 7.45 | 9.22 | 10.87 |
| Arizona | 6.15 | 5.45 | 5.59 | 5.87 | N/A | N/A | N/A | N/A | N/A |
| Arkansas | 4.62 | 4.35 | 4.51 | 4.75 | 5.39 | 3.95 | 4.40 | 5.94 | 6.42 |
| California | 5.73 | 5.78 | 6.17 | 5.84 | 6.72 | 4.59 | 5.49 | 7.90 | 10.05 |
| Colorado | 6.27 | 6.52 | 5.78 | 6.25 | 6.50 | 5.57 | 5.85 | 7.77 | 8.18 |
| Connecticut | 4.74 | 5.00 | 5.30 | 5.86 | 5.42 | 4.89 | 5.22 | 6.08 | 6.84 |
| Delaware | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | 5.33 | 5.65 | 6.11 | 5.58 | N/A | N/A | N/A | N/A | N/A |
| Florida | 4.67 | 4.98 | 5.01 | 5.14 | 5.45 | 4.70 | 4.93 | 6.03 | 7.09 |
| Georgia | 5.24 | 5.39 | 5.26 | 5.44 | 5.73 | 4.57 | 5.46 | 6.25 | 7.45 |
| Hawaii | 4.98 | 4.79 | 5.13 | N/A | N/A | N/A | N/A | N/A | N/A |
| Idaho | 5.59 | 5.44 | 6.35 | N/A | N/A | N/A | N/A | N/A | N/A |
| Illinois | 5.05 | 5.12 | 5.53 | 5.77 | 5.90 | 4.50 | 5.02 | 7.02 | 7.69 |
| Indiana | 5.45 | 5.48 | 5.82 | 5.77 | 6.54 | 5.29 | 5.83 | 7.08 | 7.38 |
| Iowa | 5.09 | 5.00 | 5.55 | 6.43 | 6.19 | 4.16 | 5.23 | 7.38 | 9.99 |
| Kansas | 5.48 | 5.18 | 5.53 | 6.47 | 5.98 | 5.25 | 5.46 | 6.59 | 7.55 |
| Kentucky | 4.41 | 4.33 | 4.49 | 4.80 | 4.54 | 3.65 | 4.19 | 5.34 | 5.78 |
| Louisiana | 5.30 | 5.41 | 5.62 | 5.91 | 6.80 | 4.21 | 6.27 | 7.22 | 8.29 |
| Maine | 5.27 | 5.94 | 5.45 | 6.08 | 5.94 | 4.49 | 5.40 | 6.60 | 6.93 |
| Maryland | 4.37 | 4.65 | 4.83 | 4.87 | 5.38 | 4.78 | 5.17 | 5.76 | 6.17 |
| Massachusetts | 4.01 | 4.42 | 4.56 | 4.36 | 4.82 | 3.29 | 3.59 | 6.10 | 7.00 |
| Michigan | 4.95 | 5.22 | 5.08 | 5.74 | 5.73 | 4.38 | 5.12 | 6.28 | 8.40 |
| Minnesota | 5.70 | 5.64 | 5.68 | 5.70 | 6.43 | 4.46 | 5.53 | 8.20 | 10.63 |
| Mississippi | 4.80 | 4.67 | 4.61 | 5.45 | N/A | N/A | N/A | N/A | N/A |
| Missouri | 5.08 | 5.54 | 5.90 | 5.55 | 5.78 | 4.15 | 4.56 | 6.72 | 7.88 |
| Montana | 5.93 | 5.78 | 5.71 | 5.91 | 7.02 | 4.10 | 5.44 | 8.96 | 12.19 |
| Nebraska | 6.13 | 5.75 | 5.81 | 6.18 | 6.26 | 4.00 | 5.44 | 7.73 | 8.80 |
| Nevada | 5.79 | 5.63 | 4.80 | N/A | N/A | N/A | N/A | N/A | N/A |
| New Hampshire | 5.44 | 4.92 | 6.18 | 6.08 | 6.06 | 4.79 | 5.57 | 6.53 | 7.26 |
| New Jersey | 4.38 | 4.48 | 4.72 | 4.85 | 4.84 | 4.00 | 4.54 | 5.17 | 5.85 |
| New Mexico | 5.41 | 5.59 | 5.52 | 5.68 | 5.62 | 4.28 | 4.93 | 6.24 | 6.75 |
| New York | 3.92 | 4.21 | 4.23 | 4.43 | 4.27 | 3.49 | 3.85 | 5.82 | 7.73 |
| North Carolina | 4.63 | 4.67 | 4.69 | 4.68 | 4.83 | 3.85 | 4.42 | 5.65 | 7.29 |
| North Dakota | 5.12 | 5.14 | 5.04 | 5.81 | 5.96 | 3.99 | 4.37 | 6.96 | 11.05 |
| Ohio | 5.05 | 5.26 | 5.45 | 5.48 | 5.64 | 4.75 | 5.22 | 6.64 | 7.29 |
| Oklahoma | 5.18 | 5.06 | 5.23 | 6.00 | 5.26 | 4.61 | 4.98 | 5.76 | 6.87 |
| Oregon | 6.05 | 6.36 | 6.17 | 6.32 | 6.60 | 5.29 | 5.53 | 7.48 | 8.59 |
| Pennsylvania | 4.38 | 4.50 | 4.68 | 4.82 | 4.74 | 3.78 | 4.20 | 5.57 | 6.40 |
| Rhode Island | 4.33 | 4.95 | 5.04 | 5.22 | N/A | N/A | N/A | N/A | N/A |
| South Carolina | 4.62 | 4.36 | 4.66 | 4.75 | 4.98 | 4.49 | 4.83 | 5.35 | 6.07 |
| South Dakota | 5.82 | 6.04 | 6.03 | 6.30 | N/A | N/A | N/A | N/A | N/A |
| Tennessee | 5.25 | 4.95 | 5.15 | 5.37 | 5.07 | 4.30 | 4.67 | 5.58 | 6.71 |
| Texas | 5.01 | 5.29 | 5.36 | 5.33 | 5.68 | 4.73 | 5.25 | 6.62 | 9.53 |
| Utah | 7.03 | N/A | 6.93 | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 5.01 | 4.61 | 5.05 | 5.63 | N/A | N/A | N/A | N/A | N/A |
| Virginia | 4.85 | 4.91 | 5.27 | 5.01 | 5.51 | 4.37 | 4.78 | 5.99 | 6.79 |
| Washington | 5.95 | 6.18 | 5.90 | 6.08 | 6.17 | 4.99 | 5.47 | 7.13 | 8.76 |
| West Virginia | 4.47 | 4.40 | 4.56 | 4.71 | 5.19 | 4.00 | 4.37 | 5.82 | 6.65 |
| Wisconsin | 5.03 | 5.17 | 5.39 | 5.69 | 5.75 | 4.71 | 5.07 | 6.48 | 7.24 |
| Wyoming | 6.21 | 6.26 | N/A | 6.69 | N/A | N/A | N/A | N/A | N/A |

# Financial Flexibility Index

## Definition

The Financial Flexibility Index is a composite of seven financial ratios that measure a firm's ability to control funds flow. It is intended to give a measure of the overall financial health of a firm. Caution should be exercised in the use of this measure because, at the present time, all seven dimensions are weighted equally. Some aspects, such as profitability, would clearly justify greater weight.

## Trends

The Financial Flexibility Index median tracks closely with the general trend in profitability. Profitability has a pervasive effect upon almost any dimension of financial performance. This year's increase in the Financial Flexibility Index is attributable to the improvement in Total Margins and the increases in Replacement Viability.

Strong regional differences in the Financial Flexibility Index exist. The Northeast region has the lowest values, largely due to lower profits coupled with higher leverage.

Rural hospitals have a relatively strong Financial Flexibility Index that results primarily from low levels of debt.

A strong relationship between bond rating categories and Financial Flexibility Index values can be seen.

## Performance Implications

High-performance hospitals have much higher Financial Flexibility Index values than do low-performance hospitals. This is to be expected, since high-performance hospitals have better relative performance in each of the individual areas that comprise the Financial Flexibility Index.

## Forecast

Financial Flexibility Index values are expected to increase slightly during the next five years. Reduced reliance upon debt financing, coupled with increasing liquidity, will provide the source for modest improvement in Financial Flexibility. Values for the Financial Flexibility Index should reach 4.0 within five years.

# Financial Flexibility Index

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | 1.453 | 1.265 | 2.229 | 2.173 | 2.838 | -2.546 | 0.154 | 6.734 | 9.717 |
| Medium | 0.744 | 0.716 | 1.681 | 2.400 | 2.951 | -2.586 | 0.064 | 6.159 | 9.817 |
| Low | 2.395 | 2.052 | 2.697 | 2.155 | 3.311 | -2.709 | -0.091 | 7.198 | 11.255 |
| **States** | | | | | | | | | |
| Alabama | 3.590 | 3.488 | 4.619 | 4.277 | 3.618 | -0.166 | 0.698 | 6.124 | 7.587 |
| Alaska | 1.702 | 1.240 | 1.782 | 2.205 | 3.132 | -5.091 | -0.313 | 11.664 | 20.323 |
| Arizona | 1.336 | 1.199 | 0.609 | 3.965 | 5.813 | -3.579 | 1.513 | 10.289 | 12.299 |
| Arkansas | 1.017 | 2.716 | 3.707 | 4.244 | 5.188 | 3.445 | 4.892 | 6.046 | 9.416 |
| California | 1.812 | 1.455 | 2.201 | 2.653 | 2.583 | -3.218 | -1.153 | 6.447 | 8.945 |
| Colorado | 3.776 | 3.372 | 5.735 | 5.735 | 7.594 | 3.319 | 5.127 | 11.022 | 14.561 |
| Connecticut | 0.323 | -0.424 | 1.023 | 3.431 | 4.876 | -2.480 | 1.670 | 6.693 | 9.127 |
| Delaware | 3.685 | 3.535 | 4.376 | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | -0.883 | -1.782 | -1.068 | -1.585 | N/A | N/A | N/A | N/A | N/A |
| Florida | 3.175 | 2.337 | 2.597 | 2.220 | 3.142 | -1.476 | 0.248 | 7.127 | 9.675 |
| Georgia | 2.068 | 5.785 | 6.199 | 7.354 | 6.266 | 0.110 | 2.371 | 9.902 | 11.727 |
| Hawaii | 2.763 | 1.170 | 0.709 | -4.885 | -18.857 | -35.069 | -26.601 | -8.638 | 0.312 |
| Idaho | 4.559 | 3.648 | 5.056 | 5.653 | 1.690 | -2.482 | -1.071 | 4.896 | 6.301 |
| Illinois | 1.844 | 1.808 | 2.642 | 2.166 | 3.752 | -0.416 | 0.982 | 7.648 | 10.718 |
| Indiana | 3.130 | 2.614 | 3.498 | 3.733 | 3.822 | -4.771 | 0.539 | 9.121 | 13.252 |
| Iowa | 1.606 | 3.239 | 2.511 | 4.336 | 5.450 | -0.557 | 1.750 | 8.472 | 9.855 |
| Kansas | 3.301 | 2.443 | 2.106 | 2.107 | 4.380 | 0.248 | 0.831 | 7.223 | 13.896 |
| Kentucky | 1.209 | 1.699 | 2.935 | 3.126 | 8.071 | 2.213 | 5.256 | 9.142 | 12.274 |
| Louisiana | 3.006 | 3.091 | 3.350 | 4.138 | 4.125 | 0.427 | 1.643 | 7.106 | 9.409 |
| Maine | 0.630 | 1.113 | 2.349 | 1.785 | 3.902 | -0.914 | 1.588 | 7.001 | 11.876 |
| Maryland | 2.172 | 2.337 | 1.829 | 2.898 | 1.856 | -3.943 | -0.924 | 5.050 | 6.974 |
| Massachusetts | -0.072 | -0.412 | 0.097 | 1.043 | 2.233 | -2.153 | 0.970 | 4.882 | 10.798 |
| Michigan | 0.644 | 1.155 | 2.390 | 1.509 | 2.885 | -2.706 | -1.031 | 6.754 | 10.253 |
| Minnesota | 0.743 | 2.853 | 2.699 | 2.601 | 4.055 | -1.758 | -0.451 | 6.621 | 8.762 |
| Mississippi | 3.452 | 0.215 | 2.990 | 5.387 | 2.310 | -0.196 | 0.521 | 4.948 | 7.193 |
| Missouri | 2.874 | 1.769 | 3.646 | 3.068 | 3.374 | -2.419 | -0.756 | 11.756 | 15.693 |
| Montana | 3.446 | 3.082 | 4.749 | 6.777 | 4.803 | -4.197 | 0.145 | 9.921 | 11.185 |
| Nebraska | 2.708 | 4.036 | 4.173 | 4.063 | 4.113 | -3.938 | 1.225 | 7.295 | 14.736 |
| Nevada | 0.443 | 0.687 | 2.407 | 1.688 | 1.552 | -4.497 | -2.731 | 6.947 | 9.218 |
| New Hampshire | 0.381 | 3.775 | 4.576 | 5.287 | 6.080 | 3.523 | 4.720 | 7.170 | 8.622 |
| New Jersey | 1.081 | 0.915 | 1.209 | 0.011 | 0.805 | -3.756 | -1.438 | 3.692 | 6.851 |
| New Mexico | 1.400 | 3.342 | 2.230 | 6.873 | 11.233 | 5.498 | 7.293 | 15.557 | 18.043 |
| New York | -2.340 | -2.201 | -1.751 | -0.721 | -1.891 | -5.097 | -3.667 | 1.889 | 4.799 |
| North Carolina | 3.619 | 3.808 | 4.704 | 6.085 | 6.394 | 1.800 | 3.203 | 10.713 | 12.481 |
| North Dakota | 1.430 | 2.335 | 1.323 | 1.398 | 1.427 | -2.984 | -0.409 | 5.012 | 9.322 |
| Ohio | 1.469 | 1.815 | 2.556 | 3.253 | 4.570 | -1.596 | 1.696 | 8.137 | 14.398 |
| Oklahoma | 0.018 | -0.324 | -0.302 | 0.026 | 0.196 | -9.707 | -4.926 | 4.332 | 9.937 |
| Oregon | 2.354 | 3.616 | 2.868 | 1.887 | 4.499 | -1.633 | 0.183 | 9.467 | 13.820 |
| Pennsylvania | 0.817 | 0.845 | 1.531 | 1.331 | 2.316 | -1.045 | 0.314 | 5.544 | 10.029 |
| Rhode Island | -1.203 | -1.303 | -0.027 | 1.165 | 1.555 | -1.000 | 0.586 | 2.217 | 3.580 |
| South Carolina | 6.668 | 5.420 | 6.940 | 8.892 | 7.180 | -3.506 | 5.231 | 12.992 | 15.903 |
| South Dakota | 1.133 | 0.791 | 2.010 | 1.930 | N/A | N/A | N/A | N/A | N/A |
| Tennessee | 0.542 | 2.256 | 3.217 | 3.257 | 4.737 | 0.464 | 2.197 | 8.060 | 18.481 |
| Texas | 2.308 | 2.814 | 3.467 | 3.076 | 2.655 | -0.364 | 1.862 | 5.678 | 9.238 |
| Utah | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 2.606 | 1.775 | 1.625 | 2.606 | 5.331 | 2.708 | 3.745 | 5.696 | 9.214 |
| Virginia | 3.779 | 2.772 | 4.202 | 5.598 | 6.634 | 1.394 | 4.401 | 9.505 | 11.189 |
| Washington | 1.667 | 2.125 | 3.358 | 2.396 | 2.445 | -1.157 | 0.342 | 6.283 | 9.379 |
| West Virginia | -0.615 | -0.606 | -0.320 | 0.031 | 2.597 | -5.388 | -3.140 | 6.449 | 9.616 |
| Wisconsin | 1.509 | 2.121 | 2.868 | 3.641 | 4.556 | 0.135 | 1.275 | 7.632 | 9.689 |
| Wyoming | -1.517 | 0.945 | -1.852 | 0.663 | N/A | N/A | N/A | N/A | N/A |

# Total Margin

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| Managed Care Penetration | | | | | | | | | |
| High | 3.1 | 4.0 | 4.6 | 3.9 | 5.1 | -1.3 | 2.0 | 8.8 | 13.6 |
| Medium | 2.9 | 2.6 | 3.8 | 3.5 | 4.4 | -1.2 | 2.1 | 7.8 | 11.0 |
| Low | 3.7 | 3.6 | 4.2 | 3.9 | 5.2 | -1.7 | 2.3 | 9.0 | 12.6 |
| States | | | | | | | | | |
| Alabama | 4.6 | 4.1 | 4.8 | 6.1 | 6.4 | 3.6 | 4.1 | 8.7 | 9.8 |
| Alaska | 0.3 | 0.8 | 4.0 | 3.5 | 4.7 | -15.0 | -6.3 | 10.6 | 11.9 |
| Arizona | 4.7 | 3.9 | 3.9 | 6.8 | 5.4 | -7.8 | -1.3 | 14.8 | 17.1 |
| Arkansas | 3.1 | 6.6 | 5.9 | 7.0 | 9.3 | 3.7 | 4.5 | 10.5 | 14.5 |
| California | 3.1 | 4.0 | 4.5 | 3.3 | 4.3 | -4.7 | 1.0 | 8.3 | 14.2 |
| Colorado | 5.1 | 5.1 | 6.7 | 6.1 | 6.1 | 2.5 | 3.5 | 10.2 | 13.9 |
| Connecticut | 2.0 | 1.0 | 2.8 | 3.6 | 4.2 | -0.6 | 2.4 | 7.1 | 11.6 |
| Delaware | 2.9 | 4.9 | 5.6 | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | 1.3 | 1.0 | -0.8 | 1.3 | N/A | N/A | N/A | N/A | N/A |
| Florida | 3.9 | 3.9 | 5.1 | -2.0 | 6.0 | 2.5 | 3.9 | 8.8 | 10.9 |
| Georgia | 4.8 | 6.8 | 7.0 | 8.0 | 8.4 | 1.7 | 3.4 | 9.4 | 12.7 |
| Hawaii | 2.1 | 2.6 | 2.4 | -1.3 | -31.6 | -89.6 | -73.4 | -5.4 | 0.7 |
| Idaho | 5.0 | 5.1 | 5.5 | 8.6 | 5.5 | 1.8 | 3.2 | 8.0 | 9.1 |
| Illinois | 4.7 | 5.0 | 5.4 | 5.2 | 5.8 | 1.1 | 3.3 | 9.2 | 13.9 |
| Indiana | 5.8 | 4.6 | 5.8 | 6.7 | 6.2 | -0.6 | 3.6 | 11.6 | 16.1 |
| Iowa | 4.1 | 5.9 | 5.4 | 6.0 | 6.5 | 2.5 | 5.2 | 8.5 | 11.3 |
| Kansas | 3.0 | 3.2 | 3.7 | 4.1 | 5.0 | 2.5 | 3.6 | 9.1 | 11.7 |
| Kentucky | 3.6 | 3.7 | 7.4 | 4.2 | 7.1 | 5.2 | 5.5 | 9.9 | 10.3 |
| Louisiana | 6.2 | 7.9 | 7.7 | 7.1 | 7.0 | -1.1 | 4.3 | 9.9 | 10.7 |
| Maine | 2.2 | 2.3 | 3.8 | 4.5 | 7.1 | 1.8 | 3.8 | 8.7 | 11.8 |
| Maryland | 3.4 | 3.5 | 4.6 | 4.9 | 5.0 | -0.9 | 1.8 | 8.2 | 12.1 |
| Massachusetts | 1.7 | 1.3 | 2.4 | 3.5 | 5.0 | 0.3 | 2.6 | 6.4 | 8.8 |
| Michigan | 3.3 | 3.3 | 4.1 | 3.9 | 4.9 | -2.2 | 2.5 | 8.4 | 12.4 |
| Minnesota | 3.1 | 4.4 | 5.6 | 4.8 | 5.9 | 0.2 | 2.4 | 8.8 | 12.3 |
| Mississippi | 4.8 | 3.6 | 4.9 | 8.3 | 5.6 | -0.2 | 4.2 | 9.1 | 12.5 |
| Missouri | 4.1 | 4.1 | 6.0 | 5.3 | 4.5 | -1.6 | -0.3 | 9.5 | 12.2 |
| Montana | 6.3 | 4.7 | 6.5 | 7.5 | 10.3 | -2.0 | 3.0 | 10.8 | 12.1 |
| Nebraska | 4.2 | 5.4 | 5.5 | 6.0 | 5.2 | -5.1 | 2.0 | 9.0 | 12.3 |
| Nevada | 5.1 | 5.0 | 4.8 | 5.9 | 4.5 | -2.9 | -1.9 | 8.5 | 12.4 |
| New Hampshire | 3.0 | 6.0 | 6.0 | 6.6 | 6.7 | 2.9 | 5.9 | 9.6 | 11.0 |
| New Jersey | 3.9 | 2.7 | 3.5 | 2.2 | 3.0 | -3.2 | -0.4 | 4.9 | 8.0 |
| New Mexico | 4.6 | 5.7 | 4.3 | 7.4 | 8.9 | 6.6 | 7.4 | 10.0 | 12.6 |
| New York | 0.9 | 1.3 | 1.9 | 2.4 | 2.2 | -5.1 | 0.5 | 3.9 | 7.4 |
| North Carolina | 4.9 | 4.8 | 6.5 | 8.3 | 7.9 | 3.7 | 4.9 | 12.1 | 15.7 |
| North Dakota | 3.5 | 3.7 | 4.3 | 2.7 | 3.4 | -4.2 | -1.3 | 7.4 | 9.1 |
| Ohio | 3.8 | 4.0 | 5.7 | 5.2 | 7.8 | 0.6 | 3.1 | 11.3 | 14.8 |
| Oklahoma | 2.1 | 2.4 | 2.5 | 2.4 | 2.7 | -11.2 | -2.1 | 5.1 | 6.7 |
| Oregon | 4.9 | 5.1 | 5.0 | 5.8 | 4.9 | -1.3 | 1.2 | 10.4 | 13.1 |
| Pennsylvania | 2.6 | 2.8 | 3.6 | 2.9 | 4.7 | -0.6 | 2.8 | 7.0 | 9.9 |
| Rhode Island | 1.1 | 0.3 | 2.2 | 2.2 | 3.2 | 0.7 | 2.1 | 4.7 | 5.8 |
| South Carolina | 8.2 | 7.3 | 9.9 | 13.1 | 10.7 | -5.9 | 1.3 | 12.4 | 14.0 |
| South Dakota | 6.1 | 5.6 | 6.1 | 6.6 | 11.6 | 9.1 | 10.7 | 13.0 | 15.5 |
| Tennessee | 3.6 | 4.4 | 5.6 | 5.8 | 9.3 | 2.1 | 5.1 | 12.0 | 17.5 |
| Texas | 6.2 | 4.7 | 5.1 | 5.8 | 6.7 | -1.2 | 3.1 | 9.3 | 11.6 |
| Utah | 2.9 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 4.0 | 3.5 | 3.8 | 3.1 | 6.9 | 4.4 | 4.9 | 7.9 | 11.2 |
| Virginia | 4.9 | 4.8 | 6.4 | 8.2 | 7.6 | 1.5 | 4.1 | 11.8 | 12.9 |
| Washington | 4.6 | 4.6 | 6.2 | 6.1 | 6.0 | 1.3 | 2.8 | 9.9 | 11.6 |
| West Virginia | 3.3 | 2.6 | 3.8 | 3.4 | 5.8 | -11.3 | -0.6 | 9.8 | 13.2 |
| Wisconsin | 4.3 | 5.7 | 6.7 | 6.9 | 7.9 | 3.2 | 5.3 | 9.7 | 11.8 |
| Wyoming | 0.5 | 3.3 | 3.0 | 3.4 | 6.8 | -1.3 | 3.8 | 7.5 | 8.3 |

## Current Ratio

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | 1.83 | 1.81 | 1.83 | 1.67 | 1.86 | 0.99 | 1.25 | 2.59 | 3.61 |
| Medium | 1.68 | 1.63 | 1.63 | 1.63 | 1.66 | 1.00 | 1.27 | 2.23 | 3.04 |
| Low | 1.78 | 1.78 | 1.74 | 1.76 | 1.79 | 0.92 | 1.37 | 2.42 | 3.31 |
| **States** | | | | | | | | | |
| Alabama | 2.31 | 2.77 | 2.61 | 2.07 | 2.78 | 1.73 | 1.93 | 3.05 | 4.52 |
| Alaska | 2.40 | 2.27 | 2.45 | 2.83 | 3.17 | 1.53 | 2.19 | 3.79 | 5.59 |
| Arizona | 1.99 | 1.91 | 2.44 | 2.40 | 2.69 | 1.98 | 2.19 | 3.86 | 4.48 |
| Arkansas | 2.78 | 2.76 | 3.23 | 2.70 | 3.77 | 1.61 | 2.34 | 4.47 | 5.06 |
| California | 1.72 | 1.71 | 1.80 | 1.61 | 1.57 | 0.88 | 1.15 | 2.43 | 3.55 |
| Colorado | 2.01 | 1.91 | 1.79 | 1.86 | 1.70 | 1.01 | 1.45 | 1.79 | 1.96 |
| Connecticut | 1.79 | 1.68 | 1.62 | 1.71 | 1.68 | 1.04 | 1.27 | 1.97 | 2.71 |
| Delaware | 1.90 | 1.92 | 1.96 | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | 1.91 | 1.67 | 1.58 | 1.59 | N/A | N/A | N/A | N/A | N/A |
| Florida | 2.03 | 2.04 | 1.95 | 1.81 | 1.76 | 0.97 | 1.33 | 2.25 | 2.98 |
| Georgia | 2.08 | 2.47 | 2.61 | 2.23 | 2.50 | 1.78 | 2.02 | 2.79 | 4.54 |
| Hawaii | 1.07 | 1.01 | 1.01 | 0.91 | 0.99 | 0.43 | 0.66 | 2.63 | 3.70 |
| Idaho | 2.35 | 3.03 | 2.16 | 2.27 | 2.72 | 1.59 | 2.01 | 3.64 | 3.95 |
| Illinois | 2.18 | 2.28 | 2.25 | 2.27 | 2.37 | 1.38 | 2.04 | 3.13 | 3.98 |
| Indiana | 1.96 | 1.99 | 2.10 | 2.21 | 2.61 | 1.11 | 1.79 | 3.12 | 3.68 |
| Iowa | 2.14 | 2.11 | 2.05 | 2.13 | 2.33 | 1.45 | 1.63 | 2.70 | 3.31 |
| Kansas | 2.79 | 2.47 | 2.44 | 2.43 | 2.25 | 1.62 | 1.80 | 2.82 | 3.50 |
| Kentucky | 2.18 | 2.27 | 2.45 | 2.21 | 2.43 | 1.57 | 1.85 | 3.16 | 3.58 |
| Louisiana | 2.35 | 2.54 | 2.26 | 2.06 | 2.59 | 1.36 | 1.65 | 2.96 | 3.75 |
| Maine | 1.55 | 1.55 | 1.47 | 1.54 | 1.45 | 0.92 | 1.00 | 1.98 | 2.68 |
| Maryland | 1.77 | 1.76 | 1.91 | 2.20 | 1.76 | 1.14 | 1.54 | 2.28 | 3.45 |
| Massachusetts | 1.36 | 1.34 | 1.30 | 1.37 | 1.42 | 0.86 | 1.20 | 1.76 | 2.57 |
| Michigan | 1.63 | 1.78 | 1.71 | 1.63 | 1.68 | 0.75 | 1.20 | 2.12 | 2.83 |
| Minnesota | 2.00 | 1.99 | 1.97 | 2.03 | 2.05 | 1.35 | 1.63 | 2.75 | 3.35 |
| Mississippi | 2.90 | 3.79 | 3.72 | 3.04 | 2.64 | 2.21 | 2.27 | 3.00 | 3.38 |
| Missouri | 2.25 | 2.13 | 2.15 | 2.17 | 2.30 | 1.32 | 1.52 | 2.81 | 3.65 |
| Montana | 2.36 | 2.41 | 2.71 | 2.44 | 2.31 | 1.82 | 2.13 | 2.99 | 3.49 |
| Nebraska | 2.32 | 2.48 | 2.59 | 2.55 | 2.35 | 1.34 | 1.83 | 3.62 | 4.99 |
| Nevada | 2.36 | 2.25 | 2.81 | 2.73 | 3.06 | 1.37 | 1.76 | 3.65 | 3.86 |
| New Hampshire | 1.91 | 2.15 | 2.31 | 2.19 | 1.76 | 1.33 | 1.37 | 2.48 | 3.02 |
| New Jersey | 1.63 | 1.58 | 1.68 | 1.66 | 1.68 | 1.02 | 1.33 | 2.36 | 2.93 |
| New Mexico | 1.85 | 2.24 | 2.20 | 2.71 | 2.81 | 1.74 | 2.02 | 3.13 | 3.35 |
| New York | 1.25 | 1.29 | 1.25 | 1.41 | 1.40 | 0.98 | 1.14 | 1.73 | 2.05 |
| North Carolina | 2.52 | 2.47 | 2.42 | 2.05 | 2.06 | 1.37 | 1.63 | 2.68 | 3.57 |
| North Dakota | 2.41 | 2.65 | 2.49 | 2.44 | 2.27 | 1.16 | 1.86 | 2.86 | 3.27 |
| Ohio | 1.98 | 1.98 | 1.86 | 1.75 | 2.13 | 1.27 | 1.50 | 2.76 | 3.96 |
| Oklahoma | 2.68 | 2.68 | 2.38 | 2.40 | 2.40 | 1.08 | 1.63 | 3.17 | 4.43 |
| Oregon | 2.10 | 1.95 | 2.06 | 2.00 | 1.94 | 1.13 | 1.35 | 2.81 | 3.12 |
| Pennsylvania | 1.73 | 1.69 | 1.76 | 1.67 | 1.64 | 0.94 | 1.29 | 2.09 | 2.71 |
| Rhode Island | 1.46 | 1.29 | 1.49 | 1.64 | 1.78 | 1.40 | 1.46 | 1.95 | 2.29 |
| South Carolina | 2.76 | 2.89 | 3.24 | 2.88 | 2.44 | 1.46 | 1.82 | 4.22 | 6.64 |
| South Dakota | 2.24 | 2.03 | 2.00 | 1.68 | 2.22 | 1.25 | 1.76 | 2.40 | 2.41 |
| Tennessee | 2.16 | 2.36 | 2.06 | 2.48 | 2.64 | 1.27 | 1.60 | 3.98 | 4.79 |
| Texas | 2.29 | 2.20 | 2.23 | 2.04 | 1.92 | 1.46 | 1.72 | 3.49 | 4.42 |
| Utah | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 1.70 | 1.86 | 1.69 | 1.71 | 1.93 | 1.12 | 1.64 | 2.04 | 3.05 |
| Virginia | 2.30 | 2.22 | 2.41 | 2.35 | 2.50 | 1.00 | 1.55 | 3.35 | 4.14 |
| Washington | 1.85 | 1.92 | 1.81 | 1.93 | 2.01 | 1.36 | 1.51 | 2.57 | 3.78 |
| West Virginia | 1.88 | 1.88 | 1.90 | 1.97 | 1.96 | 1.17 | 1.56 | 2.47 | 3.34 |
| Wisconsin | 2.04 | 2.09 | 2.22 | 2.21 | 2.44 | 1.68 | 1.98 | 2.84 | 3.68 |
| Wyoming | 1.99 | 2.95 | 2.55 | 3.12 | 2.02 | 1.74 | 1.89 | 2.89 | 4.35 |

## Equity Financing Ratio

| | Median Values | | | | | 1997 Percentile Values | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1993 | 1994 | 1995 | 1996 | 1997 | 10th | 25th | 75th | 90th |
| **Managed Care Penetration** | | | | | | | | | |
| High | 46.0 | 47.6 | 49.8 | 47.6 | 57.1 | 7.6 | 39.3 | 68.7 | 82.6 |
| Medium | 43.6 | 44.4 | 46.6 | 47.7 | 53.6 | 19.8 | 38.4 | 66.0 | 75.4 |
| Low | 48.0 | 47.2 | 49.4 | 51.3 | 52.2 | 23.9 | 40.1 | 64.7 | 76.1 |
| **States** | | | | | | | | | |
| Alabama | 53.0 | 48.5 | 53.2 | 52.0 | 61.6 | 47.0 | 52.6 | 74.3 | 83.9 |
| Alaska | 77.9 | 79.3 | 74.4 | 77.8 | 86.1 | 64.0 | 66.4 | 92.4 | 94.8 |
| Arizona | 32.9 | 31.6 | 39.5 | 45.8 | 50.5 | 39.4 | 42.1 | 73.9 | 86.2 |
| Arkansas | 57.9 | 60.1 | 63.7 | 66.2 | 70.6 | 60.1 | 67.2 | 86.7 | 89.5 |
| California | 48.1 | 48.3 | 49.4 | 44.1 | 56.7 | -7.3 | 26.6 | 70.3 | 91.7 |
| Colorado | 59.8 | 60.0 | 58.9 | 68.8 | 70.1 | 53.2 | 63.2 | 75.2 | 81.7 |
| Connecticut | 64.6 | 56.3 | 55.2 | 55.9 | 57.7 | 38.6 | 44.4 | 70.8 | 77.5 |
| Delaware | 53.1 | 52.8 | 54.0 | N/A | N/A | N/A | N/A | N/A | N/A |
| District of Columbia | 41.7 | 32.9 | 36.2 | 30.3 | N/A | N/A | N/A | N/A | N/A |
| Florida | 30.8 | 36.0 | 39.7 | 42.8 | 44.1 | 17.5 | 30.7 | 49.9 | 61.7 |
| Georgia | 55.8 | 62.0 | 65.6 | 59.3 | 59.9 | 44.1 | 50.9 | 74.3 | 78.8 |
| Hawaii | 51.9 | 48.2 | 51.6 | 47.2 | 41.3 | -1.2 | 28.4 | 63.1 | 76.5 |
| Idaho | 65.1 | 64.2 | 65.7 | 66.2 | 64.6 | 38.9 | 48.8 | 74.8 | 83.2 |
| Illinois | 57.0 | 57.4 | 56.9 | 59.7 | 60.8 | 38.2 | 48.5 | 74.6 | 82.8 |
| Indiana | 57.4 | 57.8 | 62.1 | 62.8 | 62.1 | 42.3 | 54.1 | 70.5 | 81.0 |
| Iowa | 61.9 | 65.9 | 60.7 | 63.1 | 67.3 | 47.2 | 52.9 | 84.2 | 92.1 |
| Kansas | 77.7 | 75.0 | 75.9 | 72.1 | 65.4 | 50.2 | 58.0 | 82.2 | 89.6 |
| Kentucky | 51.7 | 51.4 | 54.5 | 55.9 | 64.8 | 45.3 | 51.7 | 80.4 | 84.7 |
| Louisiana | 56.0 | 58.0 | 62.3 | 61.0 | 59.5 | 41.7 | 47.0 | 69.9 | 75.1 |
| Maine | 49.4 | 51.4 | 55.5 | 55.0 | 60.2 | 28.8 | 49.2 | 66.3 | 75.1 |
| Maryland | 42.4 | 41.7 | 45.5 | 48.7 | 49.1 | 23.8 | 41.7 | 59.8 | 69.1 |
| Massachusetts | 35.6 | 37.2 | 39.8 | 37.3 | 45.9 | 27.2 | 38.0 | 61.6 | 67.3 |
| Michigan | 48.2 | 48.7 | 50.0 | 50.7 | 53.5 | 23.3 | 41.3 | 66.8 | 74.9 |
| Minnesota | 58.3 | 58.4 | 60.3 | 60.9 | 61.4 | 38.1 | 48.5 | 76.9 | 85.9 |
| Mississippi | 61.0 | 57.8 | 59.8 | 67.5 | 63.7 | 34.2 | 45.6 | 81.3 | 88.3 |
| Missouri | 60.0 | 62.2 | 63.1 | 62.2 | 73.2 | 32.1 | 54.6 | 81.8 | 90.8 |
| Montana | 51.6 | 62.9 | 66.0 | 64.1 | 69.9 | 45.3 | 51.0 | 72.8 | 76.2 |
| Nebraska | 75.4 | 74.1 | 74.6 | 75.0 | 74.4 | 48.9 | 65.4 | 83.9 | 93.2 |
| Nevada | 62.8 | 52.9 | 55.6 | 56.4 | 58.6 | 33.6 | 42.1 | 73.6 | 76.0 |
| New Hampshire | 56.0 | 52.7 | 56.8 | 62.1 | 61.1 | 48.8 | 55.7 | 68.1 | 69.3 |
| New Jersey | 40.7 | 40.0 | 44.2 | 44.1 | 45.1 | 18.7 | 33.9 | 55.5 | 67.6 |
| New Mexico | 59.9 | 69.1 | 66.5 | 76.0 | 79.2 | 47.2 | 58.9 | 87.2 | 90.0 |
| New York | 31.9 | 32.8 | 34.1 | 41.3 | 44.0 | 12.7 | 25.0 | 56.3 | 71.7 |
| North Carolina | 60.0 | 60.1 | 63.7 | 63.3 | 63.8 | 52.1 | 57.0 | 73.4 | 84.8 |
| North Dakota | 69.1 | 73.1 | 70.1 | 70.9 | 61.2 | 38.4 | 44.9 | 78.6 | 87.2 |
| Ohio | 55.8 | 56.9 | 57.0 | 58.5 | 62.3 | 32.6 | 52.5 | 74.3 | 84.0 |
| Oklahoma | 68.4 | 69.5 | 67.9 | 60.8 | 61.1 | 22.5 | 44.9 | 77.3 | 88.0 |
| Oregon | 64.5 | 66.0 | 64.3 | 70.0 | 72.4 | 40.6 | 58.1 | 76.9 | 86.6 |
| Pennsylvania | 48.1 | 48.2 | 48.2 | 52.1 | 53.9 | 18.0 | 40.2 | 64.0 | 76.2 |
| Rhode Island | 52.0 | 52.2 | 56.3 | 60.5 | 59.2 | 43.1 | 48.1 | 69.8 | 81.4 |
| South Carolina | 62.2 | 61.9 | 61.2 | 58.8 | 56.8 | 16.2 | 38.4 | 70.6 | 78.2 |
| South Dakota | 66.2 | 63.2 | 60.4 | 50.4 | 59.5 | 53.1 | 54.1 | 67.2 | 72.3 |
| Tennessee | 55.2 | 58.2 | 60.3 | 64.6 | 63.1 | 49.5 | 58.7 | 77.8 | 84.3 |
| Texas | 54.0 | 54.7 | 57.1 | 55.9 | 60.6 | 35.6 | 46.2 | 67.4 | 74.7 |
| Utah | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Vermont | 62.3 | 60.8 | 60.2 | 58.2 | 61.9 | 54.4 | 55.9 | 68.8 | 69.4 |
| Virginia | 57.6 | 57.4 | 60.3 | 59.9 | 53.5 | 25.1 | 45.0 | 70.9 | 74.6 |
| Washington | 48.3 | 49.2 | 50.0 | 56.3 | 59.9 | 38.1 | 46.0 | 69.1 | 80.6 |
| West Virginia | 53.7 | 54.1 | 55.9 | 59.2 | 63.2 | 31.2 | 50.3 | 75.7 | 90.5 |
| Wisconsin | 51.9 | 52.7 | 56.1 | 58.2 | 60.6 | 48.2 | 57.2 | 73.3 | 75.7 |
| Wyoming | 60.6 | 65.6 | 71.7 | 74.9 | 67.3 | 58.5 | 61.4 | 72.6 | 74.3 |

September 10, 1999

The Honorable Dennis Hastert
Speaker
H232 Capitol
Washington, DC 20515

Dear Speaker Hastert:

The American Medical Group Association represents approximately 45,000 physicians in more than 250 medical groups from across 40 states. AMGA members are among the largest and most prestigious medical groups in the country and include such renowned organizations as the Palo Alto Medical Foundation, the Mayo Foundation, the Henry Ford Medical Group, the Cleveland Clinic, and the Permanente Federation, Inc. AMGA's mission is to shape the health care environment by advancing high quality, cost-effective, patient-centered and physician-directed health care.

It is our understanding that the House plans to consider a managed care reform bill this September that would waive the ERISA preemption of state causes of action to permit participants in employer-provided health plans the right to sue health plans for damages over delayed or denied benefits. While we appreciate the efforts of Representatives John Shadegg (R-AZ), Tom Coburn (R-OK), Charlie Norwood (R-GA), John Dingell (D-Mich), and others to try to limit the liability health plans and employers may face, AMGA cannot support any language that would eliminate the ERISA liability exemption.

As physician-led organizations, we strongly object to health plan interference in clinical decision-making. Expanding liability to health plans will provoke plans to micro-manage utilization and medical decision-making even more. While the idea of suing health plans may appear attractive from a consumer perspective, enacting such a provision into law will have the unintended effect of increased interference with physician medical decisions, increased numbers of lawsuits on both physicians and health plans, and a complete unraveling of managed care as we know it. Ultimately, expanding liability means more courts, more costs, higher premiums and more Americans added to the rolls of the uninsured. The following few paragraphs go into further detail about AMGA's concerns with imposing liability upon health plans:

1. While we agree that health plans should honor clinical decisions made by physicians, we worry that imposing liability may end up having the opposite result. First, it may derail the often useful "second opinion" that such reviews provide to physicians who may not know the latest scientific evidence. More importantly, it will invite health plans to proactively intrude into the process of medical decision-making, lessening physician clinical autonomy and damaging the patient-physician relationship. In order to protect themselves

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from exposure to monetary damages, health plans will feel compelled to tell physicians what tests, procedures, and treatments to use.

2. Expansion of liability will further obstruct health care by increasing the number of frivolous lawsuits on both physicians and health plans. Rather than suing just the physician for medical malpractice, lawyers will sue any party remotely involved in order to find the one with the deepest pockets and the greatest ability to pay a large damages award. Previously only physicians were sued for medical malpractice, however a law making health plans liable will result in lawyers expanding the circle of litigation by naming both the physicians and the health plans for medical malpractice.

3. Creating health plan liability for coverage decisions will reverse much of the progress that managed care has made in increasing the availability, efficiency, and quality of health benefits while maintaining cost control. Many of today's health plans have turned to physician-led medical groups to organize delivery systems that increasingly rely on performance and outcomes measures, "best practices", guidelines and protocols, and the use of financial incentives to improve the quality of care and eliminate inappropriate or ineffective treatment. Expanding liability to health plans is likely to call into question many of the compensation mechanisms (financial incentives, bonuses, withholds, etc.) health plans and organized delivery systems use to reward physicians for improving quality and reducing unnecessary, inappropriate and expensive procedures. Rather than the physician being professionally responsible for making a medical decision, the locus of responsibility will be on the health plan to prove that the payment mechanism was unrelated to the denial. To avoid the risk of triggering a lawsuit, health plans will abandon innovative compensation arrangements and eliminate incentives for quality improvement and evidence-based decision-making, leading to a return to an indemnity-based, fee-for-service environment.

4. Tort liability for health plans will ultimately raise health plan costs for employers and employees. Even without litigation, a liability law will increase health care costs. As mentioned earlier, health plans, as they exist today, will find it difficult to maintain their current compensation arrangements that provide incentives for providers to base their decisions on quality improvement and evidence-based studies. Moreover, health plans will be unlikely to review or deny numerous procedures and, instead, will engage in defensive utilization review, namely avoiding the questioning of even inappropriate and unnecessary treatment proposals. This, in turn, will raise premium costs for employers and employees.

5. The threat of litigation to medical directors of medical groups and health plans will discourage conscientious physicians from taking on the roles of peer reviewers, thus denying the systems the necessary medical expertise

for whatever review requirements survive the legislation. Despite the diversity of views on health plan liability, AMGA hopes that we can agree that medical decisions made at all levels, including the level of review, should be made by competent doctors.

6. Regardless of efforts to limit frivolous lawsuits or any of the unintended consequences of health plan liability, it is unclear what will occur once a liability law is passed. Is it possible to confine the law, or will the courts and future regulations expand the law to the further detriment of society? Without such insight, the dangers of expansion clearly outweigh any possible benefits.

Waiving the ERISA preemption is the wrong way to resolve patients' dissatisfaction with claims decisions. It is often after-the-fact – and of little value to the patient. Creating new avenues for litigation would not begin to solve the immediate problem for the patient – the need to get the best treatment when it can still do some good. Rather than increasing exposure to litigation and punitive damages, AMGA believes that external review, properly designed, is a more appropriate way to meet patient needs and ensure timely accountability of health plans for coverage decisions. External review ensures that medical coverage and treatment decisions will be evaluated by medical experts on the basis of the best medical evidence. Sound, measurable quality standards, not legal disputes, are the most effective means of holding health plans accountable for the care they provide.

We appreciate you taking our views into consideration. While we understand the efforts of Representatives Coburn, Shadegg, Norwood, Dingell, and others we cannot in good faith support any bill if it includes a right-to-sue provision because we fear it will damage our core mission to provide quality care to our patients. We stand ready to work with you to craft meaningful legislation that will promote the success of patient-centered health care and improve access to affordable, quality health care. We would appreciate an opportunity to meet with you and further explain and elaborate upon our concerns.

Sincerely,

Donald W. Fisher, Ph.D., CAE
Chief Executive Officer

Cc: Minority Leader Dick Gephardt
Majority Leader Dick Armey
Congressman Tom Bliley, Chairman
Congressman John D. Dingell,
Congressman Michael Bilirakis
Congressman Sherrod Brown
Senator Jim Jeffords, Chairman
Senator Edward Kennedy
Congressman Charlie Norwood
Congressman Tom Coburn
Congressman John Shadegg
Commerce Committee
Heath, Education, Labor and Pensions Committee
Mr. Christopher Jennings

NSCA
NATIONAL SUBACUTE CARE ASSOCIATION

## MEMORANDUM

**TO:** CHRIS JENNINIGS, SPECIAL ASSISTANT TO THE PRESIDENT-THE WHITE HOUSE.

**FROM:** DAVID RANDALL, BILL ROBINSON-NSCA.

**SUBJECT:** ANECDOCTAL INFORMATION ABOUT SNF PPS.

**DATE:** 08/09/99

**CC:** BOARD OF DIRECTORS

Per your request at our recent White House meetings, attached to this memo are individual examples of how the current implementation of the Skilled Nursing Facility Prospective Payment System (SNF PPS) has affected patient care.

The examples dramatically demonstrate the financial effects SNF PPS has had. We hope this information will further persuade the Administration to quickly deal with the devastating affects that PPS has had on the industry.

We look forward to working with you to deal with this important public policy concern.

7315 WISCONSIN AVENUE, SUITE 424 EAST, BETHESDA, MARYLAND 20814 TELEPHONE (301) 961-8680 FACSIMILE (301) 961-8681

# Anecdotal Examples of Placement Issues Due to Limitations set by the Balanced Budget Act of 1997.

**Dublin, GA**

Nursing Homes in our area do not want to accept patients who require outpatient treatment for specific illness, i.e. dialysis, cancer patients. The nursing homes have interpreted the PPS regs as their being responsible for all outpatient treatment or services. Therefore patients with diagnoses of cancer or end-stage renal disease are being denied admission to the nursing home, when their condition clearly warrants placement. The Nursing Homes state that they will have to pay for the dialysis, transportation to radiation centers, transportation for chemotherapy treatments and the actual cost of the chemotherapy.

Patient choices for nursing home care have diminished accordingly since the advent of RUGs, since the nursing homes are very reluctant to take patients who have a high level of care.

Example 1: patient with poor nutritional status is discharged to the nursing home, and the family has been unable to decide whether or not to have a PEG tube placement done, the nursing home does not want to accept the patient unless the tube placement is done prior to discharge to the nursing home.
Example 2: Patients who need respiratory therapy treatments are not being accepted unless it is a treatment such as a hand-held nebulizer treatment that a nurse can administer. These treatments are costly and not cost-effective for the nursing homes.
Example 3: Patients who will be high cost care, such as wound care and tube feeding, are being turned down by nursing homes, due to the reimbursement under the RUG patient. Nursing homes not accepting patients increases length of stay for the hospitals and in some cases where they are being held for the placement of the PEG tube, increase in cost.

Patients who fall within these categories are being taken home and do not receive the quality of care that they should.

**Palm Beach, FL**

Case Management at this acute care facility has experienced problems placing patients with the following:

- Dialysis and Radiation Therapy patients needing transportation for treatment provided outside of the SNF.
- Patients requiring high cost drugs, e.g., Vancomycin, etc.

**Aventura, FL**

Difficult placements for the Case Managers at this Hospital include:

**Fort Pierce, FL**

Dialysis and Radiation therapy patients are a real issue because they have to be transported out of the hospital for this care. I think this is also an issue for the Rehab. They also have difficulty getting any Vents that they have accepted from the acute side out into the community. The closest Vent nursing home is in West Palm Beach (IHS) and they don't want but a few at a time that come from West Palm Beach. If the SNU uses too many days or the patient has too many needs, the skilled facilities in the area do not want to take the patients.

Another facility in the area:

| SYNOPSIS | CLINICAL IMPACT |
|---|---|
| **<u>Acute-</u>**<br>**Long Term Vent patients - which requires frequent suctioning, vent regulation or frequent trach care.** | • **Extended LOS in acute facility...ICU or PCU.** |
| **Patient that requires complex care...Tube feedings, frequent extensive dressing changes, expensive IV medications or Hyperalimentation.** | • **Extended LOS in acute facility.**<br>• **High cost per case.**<br>• **Placement to area outside the community causing decrease in patient/family satisfaction.** |
| **<u>Home Health</u>** -<br>• **Difficulty placing heavy care patients that are repeat cases.**<br>• **Some of local home health agencies have closed due to PPS and reduction in reimbursement.** | • **Decreased visits to patients.**<br>• **Hospital having to assist in cost of medications or equipment.**<br>• **Extended LOS when placement to homecare is not possible due to heaviness of care.** |

**Riverside, CA**

We are a 362 licensed bed hospital in southern California. 34 of the beds are DP SNF. There has absolutely been an impact to our organization and the patients for whom we provide care. For instance:

1. 68-year-old female has been with us for an extremely rocky course. Multiple medical problems. S/p CABG, renal failure, infections, CVA by prior history. Has been with us for six months. She stabilized sufficiently approximately 6 – 8 weeks ago and was

1. Patient with multiple decubitus ulcers that require wound care and dressing changes, bedridden, and requires maximum nursing care.
2. Patient with tracheostomy, ventilator dependent. (Medicare patient with no secondary insurance and Medicaid patients)
3. Patients in restraints, combative, with history of psychiatric diagnosis.
4. Patients on IV antibiotics, some SNF facilities are not taking patients on expensive meds.

**Miami, FL**

The main problems are patients that require wound care or dialysis and ventilator dependant patients.

Examples

1. 87 years old male, LOS - 78 days, admitted with Acute Respiratory Failure and Sepsis. Is vent dependent, unable to be weaned - tried 7 times. Has a gastrostomy tube - due to impaired swallowing mechanism. Received multiple transfusions due to anemia. Has decubitus ulcers on his heels and buttocks. Is in renal failure. Have been unable to place this patient.

2. 90 years old male, LOS - 78 days, admitted with Acute Respiratory Failure and was intubated in the E.R. Is vent dependent and in Acute Renal Failure requiring Dialysis. Has multiple infections. Has had a PEG placement. Has Diabetes Mellitus, type II. Had a tracheostomy. Have been unsuccessful in placing this patient.

3. 75 years old female, LOS - 71 days, admitted with Acute Respiratory Failure. Is vent dependent and is unable to be weaned. Had a tracheostomy and PEG placement. Patient was denied by Vencor, The Palace, Green Briar. After patient was weaned from the vent was denied by 12 facilities. The patient was finally accepted by Claridge House.

4. 37 years old male, has had multiple admissions - LOS - 17 days (from the last admission). Patient is a paraplegic due to spinal cord injury. Has multiple pressure sores and Staph Aureus Septicemia. Is in congestive heart failure and has a urinary tract infection. Patient was denied by 7 nursing homes and remains in the acute facility.

5. 91-year-old female admitted from an Assisted Living Facility with Shortness of Breath and was intubated in E.R. The patient is septic and has renal failure that requires dialysis. Patient has Vancomycin resistant enterococcus. The patient is vent dependent and has gram negative pneumonia. The patient has been denied by Vencor, Green Briar, and The Palace.

PATIENTS ON RESPIRATORS, DIALYSIS AND WOUND CARE ARE ALMOST IMPOSSIBLE TO PLACE DUE TO COST TO THE FACILITY

ready for skilled level. We have been unable to place her successfully in any facility due to the ongoing hemodialysis she requires along with her vent. The organizations site that they are unable to provide dialysis under their per diem since this patient would be a medically complex RUG patient, no current rehab at a high enough level to assist in their payment.

2. Another patient, 50 plus years, on Medicare for prior disabling condition. Had tracheotomy done for airway management. Following three days of continued vent was able to wean and was medically ready to move to SNF. Although we moved the patient to the appropriate level of care that was SNF, this patient's total length of stay was 13 days. Review was that the trach was appropriate for his condition, but due to transfer DRG issue, there was significant impact to the organization in terms of dollars lost.

3. Have heard clearly from SNFs in local area that they are extremely reluctant to accept patients with no ultra high rehab needs because of reimbursement.

**Charleston, SC**

One example that comes to mind is a 54 year old female Medicare patient with MS who came in with pneumonia which progressed to respiratory failure and she was put on a vent and subsequently trached. Numerous attempts were made to wean the patient but because of her weakened thoracic muscles secondary to the advancing MS, she could not be weaned. She did not want to be DNR status. At the family's request, attempts were made to teach her elderly parents and daughter to manage her on a ventilator at home. Due to her overall medical complexity, however, it became apparent to the family that she could not be cared for at home. The patient and family agreed to Nursing Home placement. There are NO nursing homes in South Carolina which take patients on ventilators. Prior to PPS, we had ONE nursing home in Charleston, SC that took vent patients. Post PPS, they closed the vent unit because the cost for care of the patient exceeded the reimbursement. We were able to locate a NH in North Carolina that took vent patients and agreed to take her, however, the day before she was to be transferred, she developed pleural effusions that required 2 chest tubes, therefore, she was not stable for transfer. She was stabilized and ready for transfer 3 days later, but the bed at the NH was no longer available. She was put on a waiting list and subsequently expired in our hospital waiting on the NH bed. Her total LOS was 94 days. She passed away the day after her birthday. The week before she expired, she told her Case Manager that she was just tired of waiting to go somewhere that had people who could take care of her and that she had wanted to live past her 55th birthday so once it passed she might be "ready to go home"..... and she did.

**Male 46yrs / 99031**
DX: Respiratory Failure 2ndary to ALS
Days – 82 (February 10 – May 31st ,1999)

| Daily Cost | Mcare Rate | Variance |
|---|---|---|
| 25,666 .00 | 35,301.00 | + 9,635.00 |

| **Ancillaries** | **Charge** |
|---|---|
| Therapy | 1,999 |
| Medical Supplies | 6,797 |
| Pharmacy | 1,322 |
| Respiratory | 4,226 |
| Vent Rental | 16,200 |
| X ray | 527 |
| TOTAL | $31,071 |

Rate Variance - $9,635

**Net Deficit $21,436 = 261/patient day**

---

PROJECTED FY 2000 ( no increase cost/charges)

| Daily Cost | Mcare Rate | Variance |
|---|---|---|
| 25,666.00 | 30,478.00 | +4,812 |

Ancillary total $ 31,071
Rate Variance - $ 4,812
**Net Deficit $ 26,259 = $320/patient day = 22.4% variance**

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PROJECTED FY 2001
**Net Deficit $31,085 = 379/pt day = 18% variance**

---

PROJECTED FY 2002
**Net Deficit $35,902 = 438/patient day = 15.5% variance**

## Male:77 yr / 94129-2

Post Surgical; Infection / fistula 2ndary to pancreatitis. Removal of small bowel, gallstone.

Patient Days: 33 (May 20 – June 30th ,1999)

| Daily Cost | Mcare Rate | Variance |
|---|---|---|
| 10,329.00 | 11,946 .00 | +1,617.00 |

| **Ancillaries** | **Charge** |
|---|---|
| Therapy | 2,757 |
| Medical Supplies | 6,797 |
| Pharmacy | 5,356 |
| Laboratory | 2,757 |
| TOTAL | 17,667 |
| Rate Variance | - 1,617 |
| Net Deficit | $16,050 = 486/patient day |

---

PROJECTED FY 2000 (no increase cost/charges)

| Daily Cost | Medicare Rate | Variance |
|---|---|---|
| 10,329.00 | 10,650 | +321 |

| | |
|---|---|
| Ancillary total | $ 17,667 |
| Rate Variance | $ 321 |
| **Net Deficit** | **$ 17,346 = 526/patient day = 8% variance** |

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PROJECTED FY 2001

**Net Deficit** **18,657 = 565/patient day = 7.5% variance**

---

PROJECTED FY 2002

**Net Deficit** **19,940 = 604/patient day = 6.8%**

**Diagnosis: Respiratory Failure**
Days – 246

| Daily Cost | Mcare Rate | Variance |
|---|---|---|
| 84,870.00 | 139,356.00 | + 54,495.00 |

| **Ancillaries** | **Charge** | | |
|---|---|---|---|
| Therapy | 5,997 | | |
| Medical Supplies | 20,391 | RMC | 129 |
| Pharmacy | 3,966 | SE1 | 117 |
| Respiratory | 12,678 | | |
| Vent Rental | 48,600 | | |
| X ray | 1,581 | | |
| TOTAL | $93,213 | | |
| Rate Variance | - $54,495 | | |
| **Net Deficit** | **$38,718 = 157/patient day** | | |

---

PROJECTED FY 2000 ( no increase cost/charges)

| Daily Charge | Mcare Rate | Variance |
|---|---|---|
| 84,870.00 | 91,434.00 | +6,564.00 |

| | |
|---|---|
| Ancillary total | $ 93,213 |
| Rate Variance | - $ 6,564 |
| **Net Deficit** | **$ 86,649 = $352/patient day = 44.6% increase** |

---

Projected FY 2001
**Net Deficit 108,410 = 440/patient day = 8% increase**

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Projected FY 2002
**Net Deficit 115,580 = 470/patient day = 6.6% increase**

## Diagnosis: Orthopedics

Patient Days: 149
Ave LOS : 11 days

| Daily Charge | Mcare Rate | Variance |
|---|---|---|
| $ 51,405.00 | $ 49,075.00 | - $ 2,330.00 |

| Ancillary | Charge | | |
|---|---|---|---|
| Pharmacy | 2,574 | RMB | 7 |
| Medical Supplies | 1,299 | RHB | 55 |
| Laboratory | 1,914 | RVB | 36 |
| X-ray | 855 | RHC | 38 |
| Therapy | 18,924 | RVA | 11 |
| Transportation | 70 | SSA | 2 |
| Respiratory | 180 | | |
| TOTAL | 25,816 | | |

Rate Variance + 2,330

Net Deficit $ 28,146 = 189/patient day

---

PROJECTED FY 2000

| Daily Charge | Medicare Rate | Variance |
|---|---|---|
| $ 51,405.00 | $47011.00 | - $ 4,394.00 |

Ancillary Total 25,816
Rate Variance +4,394

**Net Deficit $ 30,210 = 203/patient day =10.7% increase**

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PROJECTED FY 2001
**Net Deficit 32,328 = 217/patient day = 7% increase**

---

PROJECTED FY 2002
**Net Deficit 38,344 = 257/patient day = 18.6% increase**

## Diagnosis: Wound Management

Patient Days: 122
ALOS 14

| Daily Charge | Mcare Rate | Variance |
|---|---|---|
| $ 38,186.00 | $ 43,107.00 | +$ 4,921.00 |

| Ancillary | Charge | | |
|---|---|---|---|
| Pharmacy | 5,295 | RHA | 18 |
| Medical Supplies | 2,556 | RMB | 8 |
| Laboratory | 4,099 | RMA | 40 |
| X ray | 137 | RHB | 28 |
| Therapy | 10,080 | RVB | 2 |
| Transport | 100 | SSA | 26 |
| TOTAL | 13,267 | | |

Rate Variance - 4,921
**Net Deficit $ 8,346 = 68.40/patient day**

---

PROJECTED FY 2000

| Daily Charge | Mcare Rate | Variance |
|---|---|---|
| $38,186.00 | $ 32,781.00 | -$ 5405.00 |

Ancillary Total $ 13,267
Rate Variance +$ 5,405
**Net Deficit $ 18,672 = 153/patient day = 44% increase**

---

PROJECTED FY 2001
**NET Deficit 23,435 = 192/patient day = 7.9% increase**

---

PROJECTED FY 2002
**Net Deficit 25,875 = 212/patient day = 10% increase**

## Diagnosis: Cardiac

Patient Days: 150

ALOS – 10 days

| Daily Charge | Mcare Rate | Variance |
|---|---|---|
| $51,750.00 | $ 53,171.00 | +$ 1,421.00 |

| Ancillary | Charge | | |
|---|---|---|---|
| Pharmacy | 3,965 | RHA | 15 |
| Medical Supplies | 3,697 | RMB | 9 |
| Laboratory | 2,962 | RMA | 15 |
| X ray | 262 | RHB | 39 |
| Respiratory | 3,984 | SSA | 2 |
| | | SE3 | 10 |
| TOTAL | 24,065 | SE2 | 60 |

Rate Variance - 1,421.00

**Net Variance $ 22,644 = 151/patient day**

---

PROJECTED FY 2000

| Daily Charge | Mcare Rate | Variance |
|---|---|---|
| $51,750.00 | $46,159.00 | - $ 5,591.00 |

Ancillary Total 24,065

Rate Variance + 5,591

**Net Deficit $29,656 = 198/patient day = 7.6% increase**

---

PROJECTED FY 2001

**Net Deficit 36,675 = 245/patient day = 8% increase**

---

PROJECTED FY 2002

**Net Deficit 43,689 = 291/patient day = 19% increase**

**Diagnosis: CVA**
Patient Days: 151

ALOS: 12 days

| Daily Charge | Mcare Rate | Variance |
|---|---|---|
| $ 52,095.00 | $ 54,925.00 | + $2,830.00 |

| Ancillary | Charge |
|---|---|
| Pharmacy | 24,401 |
| Medical Supplies | 1,165 |
| Laboratory | 1.189 |
| Respiratory | 672 |
| Therapy | 25,681 |
| TOTAL | 52,108 |
| Rate Variance | - 2,830 |

| | |
|---|---|
| RHA | 10 |
| RHB | 46 |
| RUB | 41 |
| RVC | 20 |
| RVA | 12 |
| RHC | 8 |
| RLB | 12 |
| SE2 | 2 |

**Net Deficit** **49,278 = 326/patient day**

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PROJECTED FY 2000

| Daily Charge | Mcare Rate | Variance |
|---|---|---|
| $ 52,095.00 | $ 49,266.00 | -$ 2,829.00 |

| | |
|---|---|
| Total Ancillary | 52,108 |
| Rate Variance | + 2,829 |
| **Net Deficit** | **54,937 = 364/patient day = 9.9% increase** |

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PROJECTED FY 2001
**Net Deficit 60,950 = 401/patient day 9% increase**

---

PROJECTED FY 2001
**Net Deficit 66,245 = 439/patient day = 8.6% increase**

Patient : 44yr old male
Diagnosis: RF secondary to ALS
Social: Married, 2 young children

Referral was made by MD Acute Care Hospital in 1/99 for placement of this patient in Subacute facility in DE. Patient had been handled as long as possible in home environment on ventilator, but condition had progressed to the point that the patient required continuous monitoring. Plan was for patient to be placed in Subacute for Long-Term Ventilator support care, as well as additional interventions as indicated.

No beds were available at the time of initial inquiry and referring facility indicated that they were not able to place pt in MD facility due to limitations on vent beds available to Medicare SNF patients.

Return call was placed 30 days later, as availability opened, and patient was found to still be in Acute Care setting. Family and patient were most desperate to be placed due to visitation constraints. The environment as well as the time allotments were interfering with the family relationships, particularly those of the children.

The decision was made to admit the patient on 2/10/99 in an effort to provide the family the best possible setting to spend the fathers remaining days. Please refer to the worksheet which chronicles current loss and projects future loss for the facility. Because this man had to be placed out of state due to bed availability, it is now left to another state to provide financial assistance as they make application for Medicaid.

ISSUES:
Access to care
Facility tolerance to loss
Burdening Medicaid

**Inadequate SNF reimbursement for complex medical & rehabilitation care**

Liberty Nursing and Rehabilitation Center in Allentown, PA is a 146 bed Skilled Nursing Facility with 22 of its 53 bed certified Medicare unit dedicated to subacute care. For over six years Liberty's subacute unit has provided care to patients discharged from acute hospitals, who require extensive nursing care, rehabilitation and respiratory therapy, substantial use of pharmaceuticals, specialized medical treatments and other non-therapy ancillaries. The care needs of these patients are far more extensive than those of the vast majority of long term care residents. Subacute patients admitted to Liberty cannot be discharged safely to home, assisted living—or even long term care, without significantly improved medical status and/or functional independence. The care Liberty provides is a vital, cost-effective component of the health care continuum—creating a link between hospital-based surgery and acute medical management and the array of post-acute options just mentioned.

The cost of providing the intensive therapy and nursing care these patients need, exceeds current Medicare S.N.F. reimbursement. These losses will make it impossible for facilities such as Liberty to continue to serve this high-acuity or subacute patient population. Already, the negative financial impact has resulted in the closing of a significant number of hospital-based and free standing S.N.F.s nationwide. The anticipated gridlock in hospital intensive care beds if beginning to surface.

The following patient profiles and financial analysis of actual Liberty patients provide an example of the value of the endangered services to patients, and the serious risk from the financial shortfall caused by inadequate Medicare reimbursement.

Table 1, which follows, displays an example of the financial loss experienced from caring for subacute patients at Liberty. It shows cost and revenue for a sample of subacute patients and demonstrates the cumulative financial loss and the per patient day (PPD) loss incurred to deliver their needed care (it also indicates each patient's assigned RUG categories). The costs and revenue in Table 1 were generated from March through the end of June, 1999. Based on this sample, representing 365 days of care provided, the facility's loss for these subacute patients was $52,827 or $144.73 PPD -- an annualized loss of $158,481.

As a provider, consumer, or policy maker, one must question whether subacute operations can be sustained in the face of the losses created by the current reimbursement system. If not, who will provide this care?

**Liberty Nursing and Rehabilitation Center**
***Analysis of High Acuity Residents***

| Patient | RUG Category | Days | | Cost: Routine | Cost: Non-Therapy Ancillaries | Cost: Rehab Therapy | Total Cost | Medicare Revenue | Loss |
|---|---|---|---|---|---|---|---|---|---|
| A | RMC | 6 | | | | | | | |
| | RHC | 30 | $$ | $ 6,408 | $ 10,237 | $ 2,046 | $ 18,691 | $ 11,676 | $ (7,015) |
| | Total | 36 | PPD | *$ 178.00* | *$ 284.36* | *$ 56.83* | ***$ 519.19*** | ***$ 324.33*** | ***$ (194.86)*** |
| B | RHB | 4 | | | | | | | |
| | SE3 | 1 | $$ | $ 890 | $ 2,407 | $ 228 | $ 3,525 | $ 1,618 | $ (1,907) |
| | Total | 5 | PPD | *$ 178.00* | *$ 481.40* | *$ 45.60* | ***$ 705.00*** | ***$ 323.60*** | ***$ (381.40)*** |
| C | SE3 | 23 | | | | | | | |
| | RVC | 30 | | | | | | | |
| | RHC | 26 | $$ | $ 14,095 | $ 27,480 | $ 3,807 | $ 45,382 | $ 25,715 | $ (19,667) |
| | Total | 79 | PPD | *$ 178.42* | *$ 347.85* | *$ 48.19* | ***$ 574.46*** | ***$ 325.51*** | ***$ (248.95)*** |
| D | RHC | 65 | $$ | $ 11,805 | $ 17,734 | $ 4,042 | $ 33,581 | $ 23,959 | $ (9,622) |
| | | | PPD | *$ 181.62* | *$ 272.83* | *$ 62.18* | ***$ 516.63*** | ***$ 368.60*** | ***$ (148.03)*** |
| E | RVC | 10 | | | | | | | |
| | RHC | 14 | $$ | $ 4,272 | $ 2,526 | $ 2,074 | $ 8,872 | $ 7,850 | $ (1,022) |
| | Total | 24 | PPD | *$ 178.00* | *$ 105.25* | *$ 86.42* | ***$ 369.67*** | ***$ 327.10*** | ***$ (42.57)*** |
| F | RMC | 65 | $$ | $ 11,613 | $ 16,008 | $ 3,226 | $ 30,847 | $ 21,274 | $ (9,573) |
| | | | PPD | *$ 178.66* | *$ 246.28* | *$ 49.63* | ***$ 474.57*** | ***$ 327.29*** | ***$ (147.28)*** |
| G | RHB | 3 | | | | | | | |
| | RUC | 25 | | | | | | | |
| | RVC | 25 | $$ | $ 16,282 | $ 14,433 | $ 3,643 | $ 34,358 | $ 30,337 | $ (4,021) |
| | RHC | 38 | PPD | *$ 178.92* | *$ 158.60* | *$ 40.03* | ***$ 377.56*** | ***$ 333.37*** | ***$ (44.19)*** |
| | | 91 | | | | | | | |
| **Total** | | **365** | **$$** | **$ 65,365** | **$ 90,825** | **$ 19,066** | **$ 175,256** | **$ 122,429** | **$ (52,827)** |
| | | | **Per Patient** | **$ 9,338** | **$ 12,975** | **$ 2,724** | **$ 25,037** | **$ 17,490** | **$ (7,547)** |
| | | | **PPD** | ***$ 179.08*** | ***$ 248.84*** | ***$ 52.24*** | ***$ 480.15*** | ***$ 335.42*** | ***$ (144.73)*** |

**Patient Profile**

J.M., a sixty five year old woman, with a history of stroke and breast cancer, developed a viral infection that led to Guillian Barre' syndrome, a neuralgic disease causing paralysis in all limbs and in this case affected the lungs, causing respiratory failure. She was in intensive care in Scranton, PA for 20 days where she was intubated, placed on a ventilator, and eventually required a tracheotomy. She underwent plasmaphoresis twelve times—a very expensive plasma irradiation and replacement therapy—while totally dependent on the ventilator for breathing.

The intensive care treatment expenses for this patient exceeded the Medicare DRG payment (DRG #483), within the first week of her almost three week hospital stay. She was weaned from the ventilator while still in intensive care, and transferred to Liberty Nursing and Rehabilitation Center in Allentown, PA, (80 miles from the referring hospital), for pulmonary and general medical rehabilitation.

**Medical and Functional Profile at Admission to Liberty Nursing and Rehabilitation Center**

- Severe general weakness and deconditioning from the viral infection.
- Dependent on supplementary oxygen and feeding tube.
- Catheterized for urinary incontinence.
- Tracheostomy due to decreased breathing capacity that was inadequate for normal activity. This made her unable to cough and eliminate lung secretions, and presented a serious risk for pneumonia.
- Total assistance required to walk and transfer from her bed to a wheelchair.
- Required significant assistance of nursing and therapy staff to dress, bathe, or use the toilet..

**Course of Treatment at Liberty Nursing and Rehabilitation Center**

- Physical and occupational therapy, six days/week—targeting strengthening, transferring, ambulation and self care.
- Respiratory therapy and nursing care round the clock for re-education of diaphramatic muscles and to allow removal of trach.

**Outcome**

- Discharged to home after 26 days of treatment
- Able to transfer from chair to standing without physical assistance
- Able to walk 200 ft with supervision only
- Able to walk up and down 10 steps with supervision only
- Able to perform all self care, including dressing, bathing, grooming, without physical assistance.
- Continent of bladder, and able to use the toilet independently, with supervision.
- Tracheostomy was removed—Husband was taught to care for trach site
- Recovered normal lung capacity—Oxygen was discontinued

**Patient Profile**

Patient L.E., a seventy four year old man, was admitted to acute care after a fall at home, and was found to have cerebellar bleed. The patient underwent drainage of the subdural hematoma and subsequently became dependent on a ventilator for breathing. During the hospital stay he developed profound diarrhea, and a feeding tube was inserted.

After 18 days in the hospital he was transferred to Liberty Nursing and Rehabilitation Center in Allentown, PA. for ventilator and trach weaning, antibiotic therapy and comprehensive rehabilitation.

**Medical and Functional Profile at Admission to Liberty Nursing and Rehabilitation Center**

- General weakness and deconditioning.
- Dependent on tracheostomy and ventilator for breathing
- Isolation precautions for C-Diff
- Dependent on a feeding tube for nutrition
- Catheterized for urinary incontinence
- Intravenous fluids and antibiotics
- Unable to walk or transfer from his bed to a chair without the total assistance of a therapist and/or nursing staff.
- Unable to dress, bathe, or perform any activities of daily living without the total assistance of nursing and therapy staff.

**Treatment Goals and Course of Treatment at Liberty Nursing and Rehabilitation Center**

- Physical, speech, and occupational therapy, five days/week—targeting the following treatment goals:
  - ⇒ Ambulate 50-100 feet with minimal assistance.
  - ⇒ Increase strength and endurance.
  - ⇒ Transfer to standing with minimal assistance.
  - ⇒ Independent mobility in bed.
  - ⇒ Minimum assist to independence with activities of daily living.
  - ⇒ Eat safely, without aspiration.
  - ⇒ Increase intelligibility of speech.
- Respiratory therapy and nursing care to accomplish the following goals:
  - ⇒ Discontinue ventilator and tracheostomy dependence.
  - ⇒ Discontinue tube feeding.
  - ⇒ Discontinue urinary catheter with the goal of continence.

**Outcome**

- Patient was progressing with rehabilitation goals including liberation from ventilator and insertion of metal trach tube, then sustained a profound stroke and expired.

**Patient Profile**

E.M., a seventy two year old retired nurse, had a stroke on 11/20/98 and was discharged home after a stay in acute and rehabilitation hospitals. On 12/26/98 she was again admitted to acute care with an extension of the stroke, complicated by aspiration pneumonia and fragile diabetes. She became ventilator dependent and required a tracheotomy following respiratory failure. After weaned from ventilator, patient was transferred to rehab hospital where she unable to participate due to medical conditions.

E.M. was transferred to Liberty Nursing and Rehabilitation Center in Allentown, PA., for comprehensive rehabilitation, removal of tracheostomy and medical management.

**Medical and Functional Profile at Admission to Liberty Nursing and Rehabilitation Center**

- Profound general weakness and deconditioning.
- Dependent on a tracheostomy for breathing.
- Dependent upon catheter for bladder voiding.
- Dependent on tube feeding for nutrition.
- Unable to walk or transfer from her bed to a wheelchair without the moderate assistance of a therapist.
- Unable to transfer to the toilet without maximum assistance.
- Unable to dress, bathe, or perform any activities of daily living, without minimum assistance of nursing and therapy staff.

**Current Medical and Functional Status**

- Aggressive therapy was provided by PT, OT, and speech until plateaus were reached. Continues with restorative nursing program. Currently walking with walker and moderate assistance of 2 people.
- Patient weaned from trach and continues nocturnal support through face mask.
- On continuous tube feedings for nutrition and stabilization of blood sugars.
- Continent of bowel and bladder.
- Education continuing to family regarding care needs and assistance provided for decision regarding discharge plans.

**Patient Profile**

Patient P.W., a sixty five year old woman, was admitted to an acute care hospital with shortness of breath and required a tracheotomy and mechanical ventilation. The patient suffered acute renal failure and was placed on renal dialysis following a course of antibiotics in the hospital. P.W had a significant cardiac history and frequent sepsis episodes but was off dialysis at transfer.

After 49 hospital days she was transferred to Liberty Nursing and Rehabilitation Center in Allentown, PA. for ventilator weaning and comprehensive rehabilitation.

**Medical and Functional Profile at Admission to Liberty Nursing and Rehabilitation Center**

- Profound anxiety proceeded hospitalization requiring Valium to leave the house.
- Profound general weakness and deconditioning.
- Dependent on a tracheostomy and ventilator for breathing.
- Dependent upon catheter for bladder voiding.
- Dependent on tube feeding for nutrition.
- Unable to walk or transfer from her bed to a wheelchair.
- Unable to dress, bathe, or perform any activities of daily living without maximum assistance of nursing and therapy staff.

**Treatment Goals and Course of Treatment at Liberty Nursing and Rehabilitation Center**

- Physical, speech, and occupational therapy, five days/week—targeting the following treatment goals:
  - ⇒ Ambulate 50-100 feet independently with a walker or cane.
  - ⇒ Increase strength and endurance.
  - ⇒ Transfer to standing with minimal assistance.
  - ⇒ Independent mobility in bed.
  - ⇒ Independent with bathing, dressing, grooming, eating.
  - ⇒ Eat safely, without aspirating, despite difficulty swallowing.
- Daily respiratory therapy and nursing care to accomplish the following goals:
  - ⇒ Wean from ventilator.
  - ⇒ Assist with behavioral management to reduce effect of profound anxiety.

**Current Status**

- Patient currently undergoing treatment at Liberty Nursing and Rehabilitation Center.
- Eats up to 5 teaspoons of liquids with no aspiration—tube feedings continue.
- Ventilator weaning discontinued due to significant lung disease and poor endurance.
- Anxiety has been reduced through medications.

**Patient Profile**

This patient, a seventy seven year old retired plumber living with his wife, was admitted to an acute care hospital in Allentown with rectal bleeding. He underwent a colectomy (bowel resection) which resulted in respiratory failure and dependence on a ventilator. During the hospital stay he sustained a stroke and developed renal insufficiency which required dialysis short term hemodialysis.

After 65 hospital days he was transferred to Liberty Nursing and Rehabilitation Center for ventilator and colectomy weaning, antibiotic therapy, and comprehensive rehabilitation including cognitive therapy.

**Medical and Functional Profile at Admission to Liberty Nursing and Rehabilitation Center**

- Profound generalized weakness and deconditioning.
- Dependent on a ventilator and tracheotomy for breathing.
- Dependent on a feeding tube for nutrition.
- Catheterized for urinary incontinence.
- Intravenous fluids and antibiotics.
- Cognitively impaired—unable to follow commands.
- Unable to transfer from his bed to a wheelchair.
- Unable to dress, bathe, or perform any activities of daily living.

**Treatment Goals and Course of Treatment at Liberty Nursing and Rehabilitation Center**

- Physical, speech, and occupational therapy, five days/week—targeting the following treatment goals:
  - ⇒ Ambulate 50-100 feet with minimal assistance.
  - ⇒ Increase strength and endurance.
  - ⇒ Transfer to standing with minimal assistance.
  - ⇒ Independent mobility in bed.
  - ⇒ Minimum assist to independent with bathing, dressing, grooming, eating.
  - ⇒ Eat safely, without aspirating, despite difficulty swallowing.
  - ⇒ Increase intelligibility of speech.
- Respiratory therapy and nursing care to accomplish the following goals:
  - ⇒ Discontinue ventilator and tracheostomy dependence.
  - ⇒ Discontinue tube feeding.
  - ⇒ Discontinue urinary catheter with the goal of continence.

**Outcome**

- Patient was weaned from the ventilator and the trach was removed. Patient expired as a result of ongoing episodes of general sepsis which interfered with treatments.

**Patient Profile**

Patient B.B. is a thirty eight year old Medicare disability patient with a history of spastic quadriplegia, secondary to cerebral palsy. He was admitted to acute care for shortness of breath, and redness at the site where a pump had been inserted for pain medication infusion. A tracheotomy was performed to address his respiratory compromise. After one month in acute care the patient was transferred to Liberty Nursing and Rehabilitation Center in Allentown, PA. for pulmonary rehabilitation with continued vent weaning efforts and education of family for return home.

**Medical and Functional Profile at Admission to Liberty Nursing and Rehabilitation Center**

- Profound generalized weakness and deconditioning.
- Methicillin resistant staph aureus (MRSA) in sputum.
- Dependent on a tracheostomy and ventilator for breathing.
- Dependent on tube feeding for nutrition.
- Lift transfer required to move from his bed to chair.
- Maximum assistance of nursing and therapy staff required to dress, bathe, or perform any activities of daily living.

**Plan of Care**

- Total assistance for all care and activities of daily living.
- Treat MRSA.
- Restorative exercises to maintain muscle tone.
- Continue ventilator weaning efforts and secretion management.
- Continue with tube feeding.
- Reinforce weight shifting every hour while in wheelchair to prevent pressure sores.
- Convert to portable ventilator to enhance mobility.

**Current Status**

Progress toward goals continue. Patient and parents aware of continuous need for ventilator support due to limited lung capacity.

National Association of
Community Health Centers, Inc.

# MEMORANDUM

**TO:** Chris Jennings and Jeanne Lambrew

**FROM:** Dan Hawkins

**DATE:** August 31, 1999

**RE:** Data on the Impact of BBA for Federally Qualified Health Centers

Although I know we are not among the "interested parties" addressed in your memo of August 13, I would be remiss for not at least attempting to bring to your attention the very real problem facing Health Centers as a direct result of the BBA provision phasing out their Medicaid payment system, beginning on October 1st, and to appeal to you for support of an alternative to that phase-out.

As we have discussed several times over the past few years, we (NACHC and Health Centers generally) are not stuck on insisting that the Medicaid reasonable-cost payment system – under which Health Centers have been paid for the past 10 years – must continue indefinitely; in fact, we proposed and discussed possible replacements for that system as far back as 1995. On the other hand, I remember, however, that you (Chris) and I had a little mantra that went "no repeal without a replacement."

*What will be the impact of the BBA's phase-out of Medicaid reasonable cost payments to Health Centers?* The phase-out formula contained in the BBA penalizes even the most efficient Health Centers, and forces them to face revenue losses that are impossible to avoid or overcome no matter how much cost-cutting or other efficiencies might be attempted. Beginning with FY 2000, each Health Center will be paid first 95 cents of each dollar they spend on care for Medicaid clients, then 90 cents, then 85 cents, and so on. Thus, even if a Health Center were to cut its costs in half (say from $100 to $50 per visit), it would still receive only 95 percent of what it spends (in this case, $47.50). As the first chart (Attachment A) shows, total Medicaid payments reported by Health Centers in 1998 (not counting amounts that were for previous years' reconciliation or payments for non-FQHC services) were $898 million. Under the phase-out formula, then, the Health Centers will face an aggregate loss of at least $45 million next year – *equivalent to the cost of serving almost 130,000 people*, at their average per-patient annual cost of about $325. The following year, the losses double, to $90 million, then $135 million; in the fourth year, the losses reach $270 million (assuming no cost increases) – equivalent to the cost of serving nearly 800,000 people.

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*Why do Health Centers need (and deserve) a different payment system in Medicaid?* Because they are, in fact, very different from other ambulatory primary care providers, especially office-based physicians. As two charts from a recent report to the Kaiser Commission on Medicaid and the Uninsured (Attachment B) demonstrate, Health Centers have much higher concentrations of Medicaid-covered and uninsured patients than do private physicians – and thus cannot live on the marginal payment rates that most state Medicaid agencies (and most Medicaid managed care organizations) pay to private physicians. Equally important, the Health Centers serve a population that has much higher rates of serious and chronic conditions, thus requiring services of greater frequency and intensity. If Medicaid payments do not at least approximate the Centers' costs of serving their Medicaid clients, then they must cover those losses from the only other major, flexible revenue source they have – their federal grants that are supposed to cover the cost of caring for their uninsured clients. Under the phase-out, then, the real losers will be the uninsured families who today rely on Health Centers for the only locally-available, affordable, continuous health care they receive.

*What about the cost-efficiency of Health Centers? Aren't their costs too high to begin with?* A recent report prepared by American Express Tax and Business Services (Attachment C), a firm that provides financial services to dozens of Health Centers nationally, for presentation to HHS Deputy Assistant Secretary Gary Claxton, found that among some 40 Health Centers nationally, the average patient visit consumed 1.73 relative value units (RVUs) – nearly 50 percent more intensive than the MGMA average for private group practices. The report also found that, among a sample of Health Centers for which RVU data is available by payer source, the average cost per RVU was just above $60, about 50 percent higher than the current Medicare RVU conversion factor for primary care services. When the additional "enabling" services that Health Centers routinely provide – such as outreach, patient case management, transportation, or translation services – but which are not billed separately, are taken into account, Medicaid costs per RVU at Health Centers compare very favorably with costs per RVU for other payers and in other settings. Finally, the report found that, for each of the Centers studied, Medicaid revenues were consistently below total Medicaid costs – in one case (a Center in Tennessee, which does not pay costs under its 1115 waiver), less than 30 percent of costs.

While this last example is clearly excessive, we expect that – once the Health Centers' reasonable cost payment system is completely repealed (in FY 2004), Medicaid payments to Health Centers will average only 50 percent of their Medicaid costs. If correct, then Health Center Medicaid losses could approach $500 million annually, causing a potential loss of care for nearly 1.5 million people nationally – more than one-third of all uninsured people receiving care at Health Centers today – at a time when the uninsured population is growing by more than 1 million annually while other providers are shown to be cutting back dramatically on the level of charity care they provide.

For all the above reasons, we have come together nationally with a good contingent of Health Center supporters in the Congress, to lay out a most reasonable alternative that would avoid the disaster of a phase-out without returning to unfettered cost-based reimbursement. Introduced as the "Safety Net Preservation Act" (S. 1277, H.R. 2341), the bill calls for the establishment of a new Prospective Payment System under Medicaid for Health Centers (and rural health clinics). I would be more than happy to brief you or your staff on the bill (we have already done so with Gary and

other senior HHS officials). I don't know if we can gain your support for this vital measure, but I do hope that – unlike 1997 – when the final deals are being cut in the back room, Health Centers and rural health clinics, and the 15 million low income, mostly minority Americans they serve, will not be lost and forgotten as all the other so-called 'big ticket' issues are finalized.

I look forward to hearing from you at your earliest convenience.

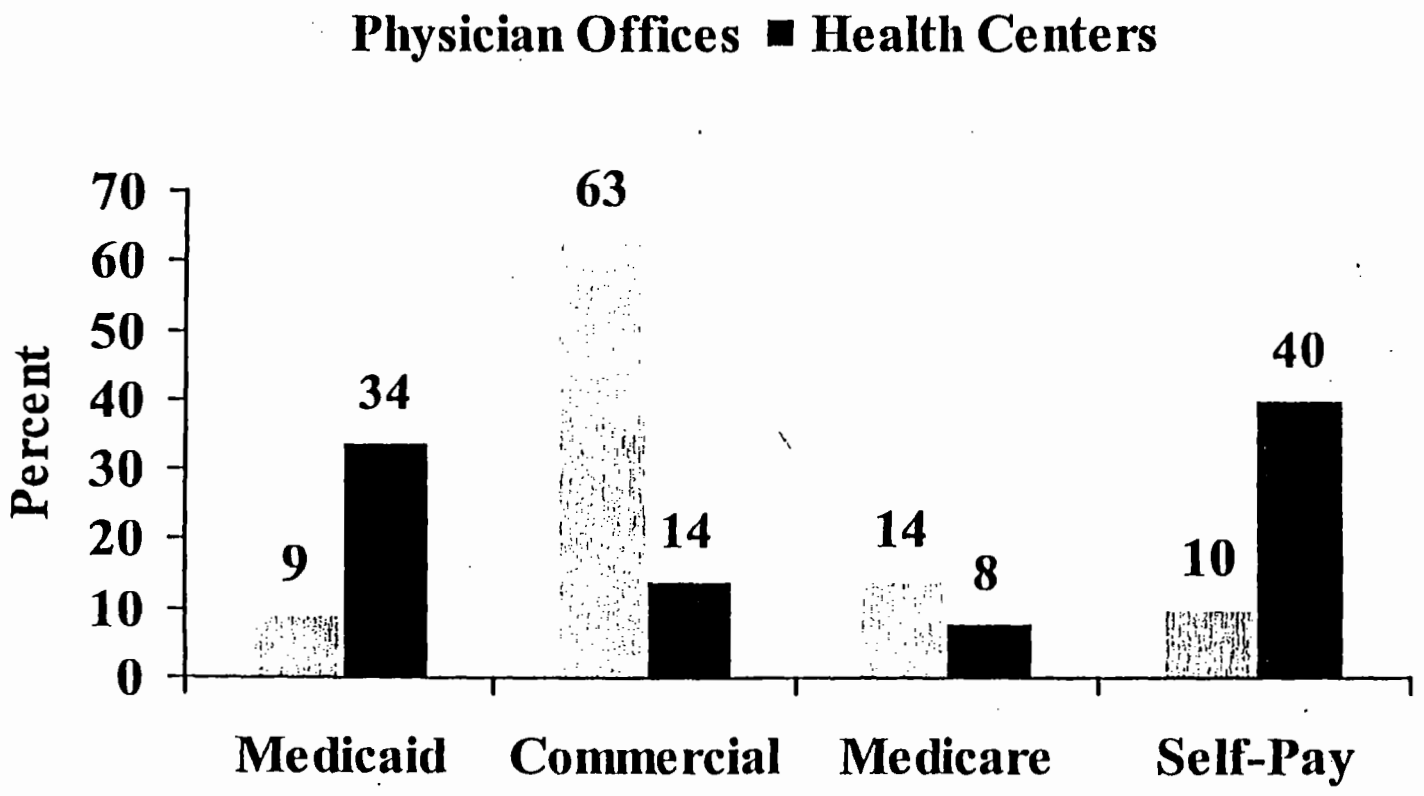
Attachments

## *Medicaid Payments to Health Centers*

| | |
|---|---|
| Total Medicaid Revenues, CY 1998 | $996M |
| Reconciliation, previous years | -53M |
| Managed care payments, non-FQHC | -45M |
| Medicaid FQHC payments, CY | $898M |
| Medicaid Patients Served, CY | 2.85M |
| Medicaid Cost per Patient, CY | $315 |
| Total Medicaid Visits, CY (est.) | 11.4M |
| Medicaid Cost per Visit, CY | $79 |

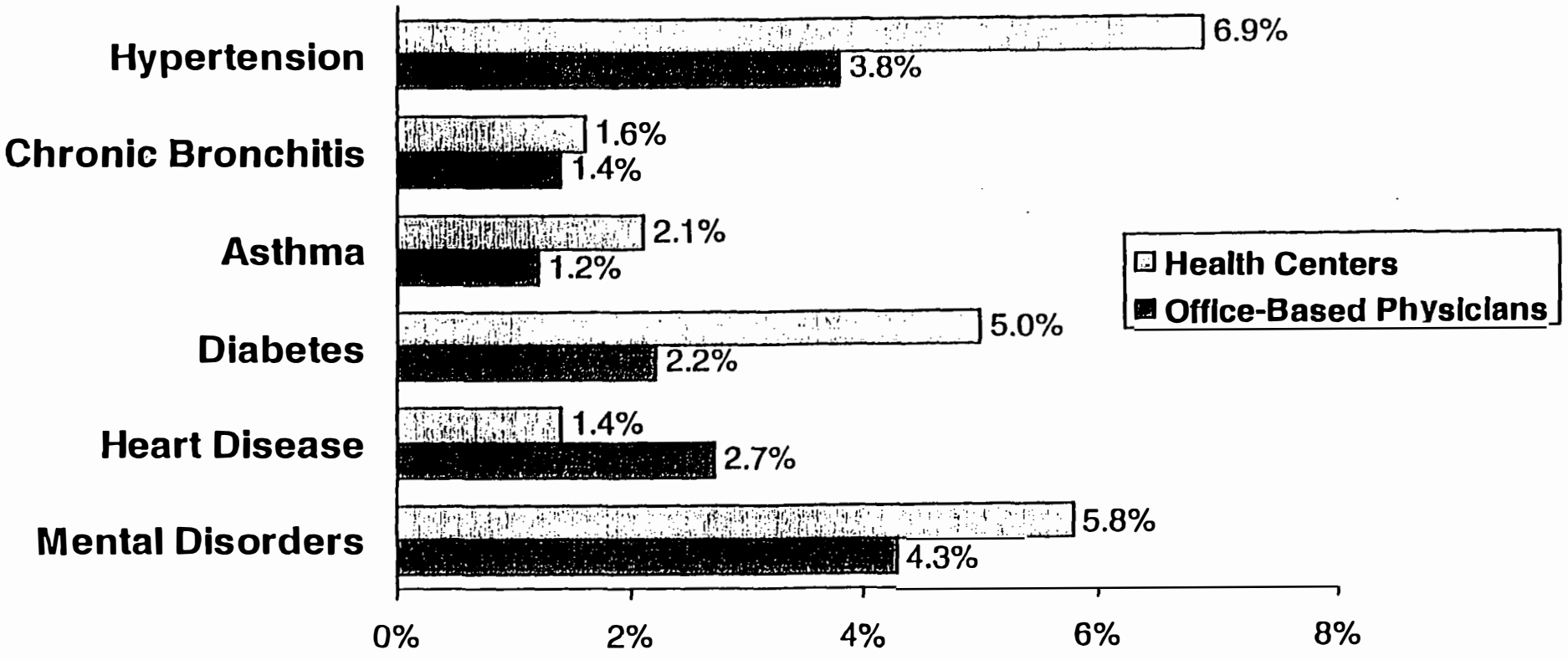
**Source: Health Center UDS Reports to HRSA for CY 1998**

# Figure 7. Comparison of Health Center and Physician Office Patients by Payor Source




Source: 1995 National Ambulatory Care Survey; Center for Health Services Research and Policy Analysis of 1997 UDS.

# Figure 8. Patient Visits for Selected Conditions Among Patients at Health Centers Compared to Office-Based Physician Practices




SOURCE: Center for Health Services Research and Policy analysis of 1997 UDS; U.S. Department of Health and Human Services, *Advance Data: National Ambulatory Medical Care Survey: 1996 Summary*, December 1997.

The National Association of Community Health Centers

# Findings from Health Center Service Intensity Analysis

## August 6, 1999

Presented by:

American Express Tax and Business Services Inc.


Tax & Business
Services

# Key Information Points

- American Express Tax and Business Services Inc. (TBS), has over twenty years of experience working with community health centers, providing a range of financial and operational services including Relative Value Unit (RVU) studies and diagnoses of organizational costs.

- TBS, in conjunction with the National Association of Community Health Centers, performed an analysis of Medicaid revenue based on data from five health centers across the country.

- The organizations selected for participation in the study represented health centers in different geographic settings (e.g. rural vs. urban, etc.) and experiencing various stages of managed care penetration among their Medicaid populations.

- Total Medicaid revenue per visit was consistently below the total Medicaid cost per visit for services among participating health centers.

# Average RVUs per Visit

The following data is a partial selection from the TBS Health Center Database:

| Health Center | RVUs per Visit (3) | Type | Geographic Area |
|---|---|---|---|
| Health Center A | 2.20 | Rural | Northwest |
| Health Center B | 2.29 | Urban | Northeast |
| Health Center C | 1.99 | Urban | Northeast |
| Health Center D | 1.34 | Rural | West |
| Health Center E | 1.75 | Rural | Northeast |
| Health Center F | 2.25 | Rural | West |
| Health Center G | 1.57 | Urban | MidAtlantic |
| Health Center H | 1.94 | Rural | Appalachia |
| Health Center I | 2.05 | Urban | Midwest |
| Health Center J | 1.55 | Rural | Northeast |
| Health Center K | 1.83 | Urban | West |
| **National Median (1)** | **1.75** | | |
| **Private Medical Group Practice (2)** | **1.23** | | |

(1) National median calculated from 40 health centers in TBS Health Center Database; Based 1998 Data
(2) MGMA 1998
(3) Source: TBS Database of Health Centers nationally; Based on 1998 Data

# Findings from Service Intensity by Payor

**RVUs per Visit**

| | Rural Southwestern Health Center | Urban Western Health Center | Urban Midwestern Health Center | Urban Southeastern Health Center | Urban Northeastern Health Center | Average |
|---|---|---|---|---|---|---|
| Medicaid | 1.82 | 2.25 | 1.75 | 1.54 | 2.43 | 2.23 |
| Medicare | 1.45 | 1.45 | 1.97 | 1.22 | 2.66 | 2.32 |
| Commercial | 1.45 | 2.76 | 1.61 | 2.57 | 2.49 | 2.13 |
| Self Pay | 1.44 | 1.73 | 1.00 | 1.39 | 2.66 | 1.87 |

**RVUs per User**

| | Rural Southwestern Health Center | Urban Western Health Center | Urban Midwestern Health Center | Urban Southeastern Health Center | Urban Northeastern Health Center | Average |
|---|---|---|---|---|---|---|
| Medicaid | 1.49 | 7.42 | 3.59 | 6.16 | 10.76 | 8.58 |
| Medicare | 4.00 | 6.15 | 5.85 | 6.33 | 21.18 | 15.91 |
| Commercial | 1.75 | 7.46 | 4.98 | 1.73 | 11.88 | 7.34 |
| Self Pay | 2.87 | 3.57 | 3.15 | 3.59 | 6.86 | 4.97 |

# Findings from Service Intensity by Payor

| Medicaid | Rural Southwestern Health Center | Urban Western Health Center | Urban Midwestern Health Center | Urban Southeastern Health Center | Urban Northeastern Health Center | Average |
|---|---|---|---|---|---|---|
| RVUs per Visit | 1.82 | 2.25 | 1.75 | 1.54 | 2.43 | 2.23 |
| Cost per RVU | $ 63.22 | $ 60.92 | $ 75.91 | $ 84.49 | $ 59.51 | $ 63.66 |
| Cost per Visit | $ 115.06 | $ 137.07 | $ 132.84 | $ 130.11 | $ 144.61 | $ 138.97 |

| Medicare | Rural Southwestern Health Center | Urban Western Health Center | Urban Midwestern Health Center | Urban Southeastern Health Center | Urban Northeastern Health Center | Average |
|---|---|---|---|---|---|---|
| RVUs per Visit | 1.45 | 1.45 | 1.97 | 1.22 | 2.66 | 2.32 |
| Cost per RVU | $ 63.22 | $ 60.92 | $ 75.91 | $ 84.49 | $ 59.51 | $ 62.70 |
| Cost per Visit | $ 91.67 | $ 88.33 | $ 149.54 | $ 103.08 | $ 158.30 | $ 136.23 |

| Commercial | Rural Southwestern Health Center | Urban Western Health Center | Urban Midwestern Health Center | Urban Southeastern Health Center | Urban Northeastern Health Center | Average |
|---|---|---|---|---|---|---|
| RVUs per Visit | 1.45 | 2.76 | 1.61 | 2.57 | 2.49 | 2.13 |
| Cost per RVU | $ 63.22 | $ 60.92 | $ 75.91 | $ 84.49 | $ 59.51 | $ 62.51 |
| Cost per Visit | $ 91.67 | $ 168.14 | $ 122.22 | $ 217.14 | $ 148.18 | $ 123.58 |

| Self Pay | Rural Southwestern Health Center | Urban Western Health Center | Urban Midwestern Health Center | Urban Southeastern Health Center | Urban Northeastern Health Center | Average |
|---|---|---|---|---|---|---|
| RVUs per Visit | 1.44 | 1.73 | 1.00 | 1.39 | 2.66 | 1.87 |
| Cost per RVU | $ 63.22 | $ 60.92 | $ 75.91 | $ 84.49 | $ 59.51 | $ 67.23 |
| Cost per Visit | $ 91.04 | $ 105.39 | $ 75.91 | $ 117.44 | $ 158.30 | $ 106.22 |




Tax & Business Services

# Findings from Service Intensity by Payor

| | Rural Southwestern Health Center | Urban Western Health Center | Urban Midwestern Health Center | Urban Southeastern Health Center | Urban Northeastern Health Center |
|---|---|---|---|---|---|
| Medicaid Revenue per Visit | $ 101.54 | $ 104.18 | $ 128.85 | $ 37.67 | $ 136.00 |
| Medicaid Cost per Visit | $ 115.06 | $ 137.07 | $ 132.84 | $ 130.11 | $ 144.61 |
| Loss per Medicaid Visit | $ (13.52) | $ (32.89) | $ (3.99) | $ (92.44) | $ (8.61) |
| Total Medicaid Visits | 3,909 | 28,716 | 23,200 | 12,342 | 70,740 |
| Loss on Medicaid Population | $ (52,850) | $ (944,469) | $ (92,457) | $ (1,140,894) | $ (609,071) |

# Findings from Service Intensity by Payor

For all participating health centers, the Medicaid Cost per Visit was higher than Medicaid Revenue per Visit.