ABSTRACTS OF STATE RATE REVIEW AND PROSPECTIVE PAYMENT LEGISLATION

FREDRIC L. SATTLER AND DANIEL BURNS
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STATE RATE REVIEW

AND

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LEGISLATION

Fredric L. Sattler* and Daniel Burns
InterStudy, Minneapolis, Minnesota
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*(Fredric L. Sattler is Director of Research
for the Minnesota Hospital Association)

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FOREWORD

The abstracts of State Health Care Facility Rate Review and Prospective Payment Legislation contained in this work were compiled for the Division of Health Insurance Studies, Office of Research and Statistics of the Social Security Administration under a contract (DHEW-SSA 600-75-0136) with InterStudy, Minneapolis, Minnesota. At the time the research was carried out (August 1975), a number of states had already enacted rate review or prospective payment legislation and several state legislatures were seriously considering this type of legislation.

The purpose of this paper is to concisely present a summary of health care facility rate review and prospective payment legislation, both enacted and pending. Key features of these statutes and bills are highlighted, which include: the purpose, the administering agency, the regulated parties (providers and payers), type of participation, rate-setting procedure and special provisions

(uniform accounting and reporting, Certificate-of Need, retroactive adjustments, etc.). A summary table, as well as an overall summary, is provided, so that patterns and trends can be more readily discerned. It should be noted that the abstracts of statutes are ordered chronologically, while those with pending bills are listed alphabetically by state.

SUMMARY

(Also see Table I, Summary of Selected Provisions)

The abstracts of enacted and proposed prospective rate-setting and rate-review legislation contained in this report represent the efforts of state legislatures to curtail the rising cost of health care within their states. These bills and statutes apply only to institutions that fall within the jurisdiction of the State (i.e., nonfederal health care facilities).

Many of the statutes provide little more than a general mandate to a state agency to review or to review and approve rates. The promulgation of regulations by the reviewing or rate-setting agency is an important and often critical factor in shaping the programs mandated by law. Even over the relatively short period of time that legislation of this type has been in force, changes have occurred within various programs and the regulations that govern program operations and legislation has been amended. But in all cases the abstracts are of the legislation as enacted or proposed, rather than a description of prospective rate-setting or rate-review programs and/or administrative regulations.

Generally, the laws and bills contain provisions dealing with the rate-setting or review procedure, the nature and duties of the rate-setting or review agency, and the classes of purchaser covered by the rates set or reviewed.

The rate-setting or review procedures typically involve one or more of the following:

(a) simple financial and rate disclosure for health care facilities (e.g., California);

(b) financial disclosure for health care facilities with review agency comment as to the reasonableness of operating budget and/or rates (e.g., Arizona); and

(c) financial disclosure for health care facilities with binding rate and/or budget approval by the reviewing agency (e.g., Washington).

The reviews may be made or the rates may be set on a retrospective or prospective basis.*

The rate-setting and review methods can apply to all purchasers (private payers and governmental and non-governmental third-party payers), private payers only (those who pay charges, or third-party payers only (hospital service corporations and/or Medicaid). Examples of the above are Washington, Connecticut and Rhode Island, respectively.

As of August 1975, eleven states had enacted prospective rate-setting or rate review legislation, and bills were before legislatures in seven other states.** Since the

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*Prospective in this context refers to a statutory provision that requires review, approval and/or disclosure to occur prior to the actual implementation of the rate or budget.

**These are states where the bills were given reasonably serious consideration and are presented here as examples of current legislative thinking.

enactment of the first statute of this type by the New York State Legislature in 1969, there has been a definite trend away from relatively short, loosely drawn statutes to more detailed specificly drawn legislation covering numerous operational aspects of the review and/or rate-setting process. This trend has diminished the reliance on regulations to define the rate control program (compare the pre-amended New York and Rhode Island statutes with the Washington statute and Florida bill). The earlier statutes are vague with respect to the type of information required from health care facilities, how it is to be reported, and what standards the reviewing agency should use when evaluating the data. In New Jersey, Rhode Island, and New York, the statutes offer few, if any, requirements or standards for the rate-setting process, leaving all operational details to regulations and guidelines.

In contrast the new statutes and bills pending are, with few exceptions, detailed. They specify such items as uniform accounting and/or reporting systems, the type of information required, and how it shall be treated (e.g., at least three of the pending bills mention gifts to hospitals and prescribe their treatment in budget review).

In general, the newer statutes and bills pending are more self-contained than the older ones. Certificate-of-Need is more commonly incorporated into the law as a facet of cost-control, as are positive incentive provisions

rewarding efficient management. In addition, where programs under most of the existing statutes are funded by state appropriations, four out of five of the bills pending have an assessment provision providing for a percentage levy on either the health care facility or third-party payers to finance the program, in whole or in part.

Rate control programs are for the most part administered by an existing department or agency of state government. However, a trend appears to be emerging wherein independent agencies or commissions are established for the purpose of administering cost-control programs.

The majority of the laws cover all hospitals in a state. Usually included with hospitals are nursing homes and inpatient treatment centers for chronic diseases. The two statutes (Colorado and Delaware) which do not cover all hospitals have programs based on prospective budget negotiations between selected hospitals and third-party payers. In addition, the newer statutes and bills include a comprehensive purchaser coverage section. Most of them provide for the coverage of all purhcasers, as opposed to the older statutes which often covered only hospital service corporations (e.g., Blue Cross Plans) and purchases made by state governments.

TABLE 1

STATE PROSPECTIVE PAYMENT AND RATE REVIEW LEGISLATION
ENACTED AND PENDING AS OF AUGUST 1975

SELECTED PROVISIONS

(The items (provisions) which are checked (✓) in this table are specifically included in the statutes or bills reviewed in this paper. The absence of a checkmark, however, does not necessarily mean that a particular item is not applicable in a particular State. Thus, all of the States with enacted legislation shown in this table have certificate-of-need requirements. Only in the cases of New York, New Jersey, Arizona, and Connecticut did this requirement materialize as a result of the legislation reviewed in this paper.)

	Enacted											Pending						
State	NY	N J	Ariz	R I	Cal	Ore	Wash	Md	Col	Conn	Mass	Cal	Del	Fla	Mich	Penn	Vt	Wis
Year	69	71	71	71	73	73	73	73	74	74	75							
Rates set or approved prospectively	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Agency																		
Independent					✓		✓			✓	✓	✓	✓				✓	
Within another department	✓	✓	✓	✓		✓		* ✓	✓					✓	* ✓	✓		✓
Provider Coverage																		
All hospitals	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓
Selected hospitals									✓				✓					
Purchaser Coverage																		
All purchasers							✓	✓				✓		✓	✓	✓	✓	✓
Hospital service corps	✓	✓		✓					✓				✓					
Medicaid	✓	✓		✓														
General public			✓							✓	✓							
Assessment																		
Hospital					✓		✓					✓		✓				✓
Third party payer																	✓	
Reporting System																		
Uniform accounting and reporting	✓	✓	✓		✓	✓	✓	✓				✓			✓	✓	✓	
Uniform reporting										✓				✓				✓
Special Provisions																		
Certificate-of-need	✓	✓	✓							✓		✓				✓	✓	✓
Retroactive adjustment							✓	✓	✓			✓		✓	✓	✓	✓	✓
Incentive provision									✓			✓		✓		✓	✓	

*The agency in Maryland and the proposed agency in Michigan are established within existing agencies or departments; although each of these agencies has or will have autonomous operating authority.

STATE LAWS ENACTED AS OF AUGUST 1975

(New York, New Jersey, Arizona,
Rhode Isalnd, California, Oregon,
Washington, Maryland, Colorado,
Connecticut, and Massachusetts.)

STATE: New York

Statute: Public Health Law Section 2800 through 2807

Date: 1969 and Amendments

Purpose: To promote hospital- and health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost. The statute is aimed at correcting wide unexplained variations in the costs of the same services rendered by hospitals in the same area, needless duplication of facilities, and elimination of inefficient operation and resultant high costs. To do this, the legislation requires formulation of measures that, when uniformly applied, will produce a control program that will both enable and motivate hospitals to control their spiraling costs without sacrificing quality of services.

Agency: Department of Health.

The State Hospital Review and Planning Council, an already existing body, is a 31-member group within the Department of Health. Council members are appointed by the Governor and confirmed by the senate and include:

(a) seven members nominated by various regional hospital-planning councils;

(b) six members engaged in hospitals or nursing home work on policy-making or administrative levels;

(c) six licensed physicians; (The Council may not have more than 15 physicians or full-time employees of hospitals or nursing homes.)

(d) one representative of home health agencies;

(e) representatives of the public, including persons identifying with consumers of hospitals and nursing home services.

Members serve 3 year, staggered terms. The Council meets a minimum of four times per year.

Parties: All hospitals and health related service facilities (i.e., nursing homes).
Purchasers covered are nonprofit medical and dental indemnity insurers (e.g., union medical benefit funds) or hospital service corporations and governmental agencies.

Participation: Mandatory

Rate-Setting Procedure: Prior to the approval of rates paid by hospital service corporations and Medicaid, the Commissioner of Health is to certify to the Superintendent of Insurance and the State Director of the Budget that the proposed hospital and/or health facility rate schedules are reasonably related to the cost of efficient production of service. When making his certification, the Commissioner is to take into consideration elements of cost, geographical differences, economic factors in the different areas where the hospitals are located, rate of increase or decrease in the economy

in the area where the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The State Director of the Budget, in the case of Medicaid, and the Superintendent of Insurance, in the case of indemnity insurers and hospital service corporations are then to approve the rates. The 1974 amendments also require the Commissioner of Health to notify each hospital and health related service facility (i.e., nursing home) of its approved rate at least 60 days prior to the fiscal year for which the rate is to become effective.

Another amendment effective January 1, 1974, requires disclosure of financial transactions by the hospitals to the Commissioner of Health within 120 days of the end of the hospital's fiscal year. Its purpose is to show the financial condition of each hospital. The report is to consider all financial transactions that the Commissioner determines necessary in making his evaluation, including but not limited to:

(a) operations and acccomplishments;

(b) receipts and disbursements, or revenues and expenses by categories, clinical services, and departments;

(c) assets and liabilities, including reserves and depreciation;

(d) loans, investments, interest, rent and profits; and

(e) location of any real property.

Special Provisions:

A system of uniform reporting and accounting was added to the statute by the 1974 amendments, effective January 1, 1975, for the purpose of assuring uniformity of implementation of state policies affecting such services, enabling performance comparisons between particular hospitals, and encouraging public and private third-party payers to take into account information provided under the act in establishing their reimbursement rates.

In developing the uniform system, existing systems used by hospitals are to be taken into consideration by the Council. Modifications will also be allowed to reflect differences in size, type and scope of services. The accounting and reporting systems include the following information to be filed at the close of the fiscal year with the Department of Health:

(a) balance sheet detailing assets, liabilities, and net worth of the hospital at the end of the fiscal year;

(b) statement of income, expenses, operating surplus or deficit, for the fiscal year;

(c) source of application of all funds expended by the hospital during the fiscal year; and

(d) a report of hospital expenditures which allocates the cost of a non-revenue producing department of a hospital to the other non-revenue and revenue producing departments which they serve.

Formerly, the statutory mandate was only that the council adopt and amend rules and regulations for the establishment of a system of accounts and cost finding used by hospitals, including a classification of such hospitals and a description of a system of accounts and cost finding for each class.

The statute includes a certificate-of-need provision.

The statute has no provision for retroactive adjustment of rates.

A 1974 amendment provides that the Commissioner shall not certify that a hospital's proposed rate schedule is reasonably related to the cost of efficient production unless the hospital is in full compliance with the reporting requirements of the act.

SUMMARY: Perhaps because of its age -- it was the first statute dealing with hospital cost control -- the New York statute is not as clear and cogent as many of the other statutes. Recent amendments have specified more clearly the type of information to be considered in setting rates, but precisely how the information is used in making rate determinations is left to regulation.

The program is administered by the Commissioner of Health and the State Hospital Review and Planning Council, a 31-member body within the Department of Health. The Commission and Council consider the financial condition of the hospital and make a determination that rates are reasonably related to the costs of efficient production of

such services, then the Commissioner submits his determination to the State Director of the Budget and the Superintendent of Insurance for final approval.

Despite its many new amendments, the New York statute is still skeletal. The actual mechanics of the system are laid out in extensive regulations promulgated by the Department of Health.

The statute includes a certificate-of-need provision.

STATE: New Jersey

Statute: Chapter 136 NJSA 26:2H-1 et seq.
New Jersey Health Care Facilities Planning Act

Date: May 10, 1971

Purpose: To provide for hospital and related health care services of the highest quality, efficiently provided and properly utilized at a reasonable cost.

Agency: Department of Health and Commissioner of Insurance.
The Health Care Administration Board was established within the Department of Health to aid the Commissioner of Health in adopting rules and regulations for the administration of the program. The Board consists of thirteen members, eleven of whom are appointed by the Governor and confirmed by the Senate. The Governor's appointees shall be representatives of medical and health care facilities and services, labor, industry, and the public at large. The Commissioners of Health and Insurance or their designated representatives shall be ex-officio voting members of the Board. Board members serve staggered four year terms, and the Board is to meet at least quarterly.

Parties: All hospitals. Purchasers subject to the act are hospital service corporations and Medicaid.

Participation: Mandatory

Rate-Setting Procedure: Hospitals are required to submit expense and statistical reports on standard forms. The Commissioner of Health will specify the elements and details of cost which are to be taken into account for the purposes of establishing Medicaid payment rates. The Commissioners of Health and Insurance shall establish Blue Cross payment rates and shall consider the total cost of each health care facility.

Blue Cross rates must be set prospectively and may be in the form of a level per diem and may not exceed customary charges.

A cost-review procedure for Medicaid rates is available in cases where the original budget projections were inaccurate. The appeals process is judicial.

Special Provisions: This statute is primarily certificate-of-need legislation, but it also requires the Commissioners of Health and Insurance to establish Medicaid and Blue Cross rates of reimbursement, respectively. In addition, there is the stipulation that a uniform system of cost accounting must be established and approved by the Commissioner of Health.

SUMMARY: The New Jersey statute is a very simple enabling act. The actual mechanics of rate review are in guidelines promulgated by the State Department of Health. Blue Cross rates must be set prospectively while Medicaid rates may be established retroactively.

In 1975, guidelines by which Medicaid and Blue Cross payment rates were determined were declared invalid on the grounds that they did not conform with the Administrative Procedure Act, P.L. 1968, c. 410 (c. 52: 14B-1 et seq.). New guidelines are currently being prepared for adoption.

STATE: Arizona

Statute: Arizona Revised Statutes Section 36

Date: May 1971, 1973

Purpose: To review rate schedules for new institutions, and rate increases for existing institutions.

Agency: Arizona Department of Health Services.

Parties: All hospitals.

Participation: Mandatory.

Rate-Setting Procedure: Rates are not set by the Director of the Department of Health Services. The Director publicly comments upon the proposed rates and charges, but has no approval authority. New hospitals may not engage in business until their schedules of rates and charges are filed with and reviewed by the Director of the Department of Health Services. Similarly, previously established health care institutions may not increase rates or charges until a proposed increase has been filed with, and is reviewed by, the Director.

As a basis for a review of proposed rate increases, regulations require reporting of the following:

(a) a statement of need for increased rates;

(b) a financial and statistical summary;

(c) a balance sheet;

(d) revenues and expenses;

(e) projected changes in revenue and expense;

(f) departmental cost findings;

(g) a schedule of rate changes.

The Director of the Department of Health Services reviews the proposed rate and charge increases and makes his findings public within 60 days of filing. His findings must indicate (a) how the rates and charges relate to the operating income and expenses of the institution, and (b) the institution's sources and application of funds.

The health care institution shall also file a copy of its existing rate schedule and proposed increases with the authorized local health planning agency which shall review the proposed rates and file a report with the Director with respect to its findings.

Special Provisions:

The Department prescribes uniform accounting practices and reporting systems for different classes and subclasses of hospitals. Classes and subclasses are determined according to type, size, range of service provided, special services offered, duration of care, and standards of patient care.

Institutions classed as hospitals are required to make annual financial and operating reports, but the Department may require any health care institution to submit an annual report.

A penalty provides for suspension or revocation of the license of a health care institution that violates provision of the chapter.

A certificate-of-need provision requires the Director's permission for the construction or substantial improvement of facilities.

SUMMARY: The Arizona statute is a disclosure act. The Department of Health Services prescribes uniform accounting practices and reporting systems for the different classes and subclasses of hospitals. Hospitals file annual financial reports with the Department of Health Services. Rates or charges may not be increased or, in the case of a new hospital, set, until they have been filed with and reviewed by the Director of the Department of Health Services.

While the statute mandates the filing of initial rates and proposed rate increases with the Department of Health Services, hospitals may ignore the Director's findings.

The statute includes a certificate-of-need provision.

STATE:	Rhode Island
Statute:	Chapter 208 27-19-14, 15, 16
Date:	July 16, 1971
Purpose:	To make the state a party to budget negotiations held to determine payment rates for hospitals by hospital service corporations and the state as a purchaser of hospital services.
Agency:	State Budget Office, Department of Administration.
Parties:	State, hospitals, and hospital service corporations.
Rate-Setting Procedure:	No specific methodology is required by the statute. The statute mandates only that the negotiations shall begin at least 90 days prior to the beginning of each hospital fiscal year, and that agreement between the negotiating parties be reached no later than 30 days prior to the beginning of the fiscal year. The negotiating parties may employ mediation and conciliation services as an aid to such negotiations.
Participation:	Mandatory for Blue Cross and Medicaid participating hospitals.
Special Provisions:	None

SUMMARY: The Rhode Island statute is one of the simplest and shortest enacted. Little more than an enabling act, it provides no direction or guidelines for establishing rates.

STATE: California

Statute: Senate Bill 283, Chapter 1242 California Health Facilities Disclosure Act

Date: 1973

Purpose: To review proposed budgets of all nongovernmental hospitals, and requiring licensed health facilities to make specified reports to the California Health Facilities Commission.

Agency: The California Health Facilities Commission.
The Commission consists of seven members appointed by the Governor. They serve staggered four-year terms. Four of the members represent the health care profession, and three represent the general public.

Parties: All nongovernmental hospitals.

Participation: Mandatory

Rate-Setting Procedure: None.
The Commission requires reports in accord with uniform systems of accounting and reporting approved by the Commission. The Commission makes available information required by other state agencies for programs they administer or in which they have an interest.

SUMMARY: This is a disclosure act. The Commission has no power to approve or deny budgets or rate-schedule increases.

STATE: Oregon

Statute: Chapter 441 Sections 441.415 through 441.515

Date: 1973

Purpose: Recognizing that the rising costs of hospitals and other health care facilities are a matter of vital concern to citizens of the state, the statute requires that hospitals file for public disclosure all reports of accounting: (a) to enable both private and public purchasers of services to make informed decisions in purchasing such services; and (b) to encourage development of programs for research, innovation, and methods of delivery of institutional health care services of high quality at costs reasonably related to the nature and quality of the services rendered.

Agency: Health Facilities Cost Review Commission.

The statute establishes the Health Facility Cost Review Commission within the Department of Human Resources. The Commission consists of seven members appointed by the Governor and confirmed by the Senate. It includes:

(a) two members representing health care services, one of whom is a hospital administrator of a currently operating hospital in Oregon;

(b) one consumer representative of the Comprehensive Health Planning Authority;

(c) four representatives of the public who have no role in either the internal management policies of any health care facility, and who have no role in the development of public policy or the regulation of health care facilities. (One of the public representatives is to be knowledgeable in fiscal and accounting matters and one is to have knowledge and experience in the public utility regulatory field.)

The members serve two-year terms. The Governor appoints a chairman of the Commission who shall not be a health industry representative.

The Commission's duty is to conduct, or have conducted by contracting parties, technical or professional services analyses and studies relating to the costs of health care facilities. The analyses should include, but should not be limited to, methods of reducing costs, utilization review of services of health care facilities, peer review, quality control, financial status, and sources of public and private financing of the financial requirements of such facilities. The Commission was directed to report the results of such studies to the Governor on or before January 2, 1975.

Parties: All health care facilities. Includes hospitals, nursing homes, alcoholic treatment centers, college infirmaries, and most other institutions that treat human sickness.

Participation: Mandatory

Rate-Setting Procedure: In conducting its study, the Commission is to determine to its satisfaction that the total prices and costs of each facility are reasonably related to the total services offered by the facility, that the facility's aggregate rates are reasonably related to the facility's aggregate costs, and that rates are set equitably among purchasers or classes of purchasers. The Commission may also review the reasonableness of rates for particular supplies or materials established by the health care facility. If the Commission determines that rates charged by the facility are excessive because of underutilization or unnecessary duplication of services, it must report its findings to the facility and the comprehensive health planning agency. In determining the reasonableness of rates the Commission is to take into consideration the total financial requirements of the facility, including the following:

(a) necessary operating expenses relating to patient care;

(b) bad debts and charity care;

(c) properly incurred charges for capital expenses and operating needs;

(d) unreimbursed costs of education;

(e) unreimbursed costs of services related to patient care;

(f) amortization and depreciation expenses, requirements for capital expenditures, and requirements for necessary working capital; and

(g) Federal, state, and local taxes.

A broad declaratory provision states that the Commission is to take into consideration the need for health care facilities to establish rates that will enable them to render effective and efficient services while retaining their solvency.

The policies and advice of the Comprehensive Health Planning Authority should be considered when reviewing rate changes.

Special Provisions:

The statute requires the Commission to specify one or more uniform systems of accounting and financial reporting. The systems are to include cost-allocation methods, records, and report of revenue and expenses, other income, as well as other outlays, assets and liabilities, and units of service as the Commission prescribes. Existing systems of accounting and reporting in use by health care facilities are to be given due consideration by the Commission and these should not unreasonably increase the administrative costs of the facilities.

The accounting and reporting systems and procedures adopted are to reflect differences in the scope and type of services and financial structure among the various categories, sizes, or types of health care facilities. The Commission is also to establish specific annual reporting provisions for facilities that receive a majority of their

revenue from associated comprehensive group practice prepayment health service plans.

A penalty not exceeding $100 per day shall be levied on any health care facility that fails to file the financial records and reports required under the statute. The provision also states that a penalty not paid within ten days after the order of the Commission shall constitute a judgment against the institution.

SUMMARY: The Oregon Act only mandates the Health Facilities Cost Review Commission to determine that the total prices or costs and rates of health care facilities are reasonably related to their offered services and are set equitably among all purchasers or classes of purchasers. This is done through a review of the health facilities budgets. Their budgets are reported to the Commission using uniform systems of accounting and financial reporting. The Commission itself has no budget approval or rate-setting authority. Its powers and duties are only to conduct financial studies and analyses and to report conclusions and make recommendations to the Governor.

STATE: Washington

Statute: RCW Title 70, Chapter 5

Date: March 23, 1973

Purpose: To promote the economical delivery of high quality health services by establishing a Hospital Commission that will have authority over financial disclosures and budget and prospective rate review which is intended to assure all purchasers of health care services that costs are reasonably related to total services, that rates are reasonably related to aggregate costs, and the rates are set equitably among all purchasers of these services.

Agency: Hospital Commission.

An independent Hospital Commission composed of five members is appointed by the Governor. Members are to be selected from:

(a) consumers

(b) labor

(c) business

(d) hospitals

The act provides that the members are to be individuals concerned with the delivery of quality health care, but that no more than two may have a fiduciary duty to a health

facility or agency, or have a financial interest in the rendering of health services. In cases where a rate increase for an osteopathic hospital is being considered, a representative of osteopathic hospitals must replace a hospital representative on the Commission. Commission members serve 4 year terms.

The member representing consumers of health care services acts as chairman; a vice-chairman is elected from the members biennially. Meetings are held as frequently as required.

The Commission appoints a full-time executive director, who serves as chief administrative officer. To assist the Commission, the Governor appoints an 11 member technical advisory committee composed of:

(a) a certified public accountant;

(b) a state licensed health care practitioner, knowledgeable in hospital administration;

(c) five members representative of the interest of investor-owned district, nonprofit, osteopathic, and university hospitals;

(d) one representative of consumers of health care;

(e) the Secretary of the Department of Social and Health Services, or his designee;

(f) the Director of the Planning and Community Affairs Agency, or his designee;

(g) One member of the Commission.

All Committee members serve 4 year terms and meet on-call of the Chairman of the Commission. The Committee's duty is to consult with and make recommendations to the Commission on, matters of policy, rules and regulations promulgated by the Commission to implement the act, and analyses and studies of hospital health care costs.

The Commission may also create committees from its membership, and create ad hoc advisory committees in specialized fields as it deems necessary to supplement the assistance provided by the technical advisory committee.

The Commission must file a report each January to the Governor and members of the legislature detailing its operations and activities for the preceding fiscal year.

Parties: All hospitals and all purchasers of health care services.

Participation: Mandatory

Rate-Setting Procedure: Rates must be approved prospectively. Within 120 days of the close of the fiscal year each hospital files with the Commission:

(a) a balance sheet detailing the assets, liabilities, and net worth of the hospital;

(b) a statement of income and expenses; and

(c) such other reports as the Commission may prescribe.

The Commission has the power to initiate reviews and investigations necessary to assure all purchasers of hospital health care services that the total costs of a hospital are reasonably related to the total services offered by that hospital, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs, and that rates are equitably set among all purchasers or classes of purchasers without undue discrimination.

The Commission has full power to review projected annual revenues and approve the rates proposed to generate the projected revenues of a hospital. No hospital may charge for services at rates other than those established in accordance with the procedures outlined in this statute.

The Commission is authorized to permit changes in rate schedules to enable a hospital to generate sufficient revenue to meet its obligations; but no hospital may change its rates without prior approval of the Commission.

The Commission may also approve alternative methods of rate determination and payment of an experimental nature that may be in the public interest.

Special Provisions:

The Commission is to establish a uniform system of accounting and financial reporting including cost allocation methods, by which hospitals shall report their annual financial position. Consideration is given to accounting and reporting systems in use by hospitals.

Where appropriate, the accounting system shall be structured to reflect differences among hospitals rendering patient-related services, and those geared toward educational research and other activities unrelated to patient care. Also, differences among hospitals in size, financial structure, and scope and method of services offered may be recognized.

Violations of the provisions of the act are a misdemeanor.

Expenses of the Commission are financed by an assessment against hospitals. The assessment shall not exceed four one-hundredths of one percent of each hospital's gross operating costs determined biennially.

SUMMARY: The statute is specifically geared toward containing hospital costs through prospective rate setting.

To administer the act, a five-member Hospital Commission and an 11 member technical advisory committee was created. Commission expenses are financed by an assessment against the hospital.

The Commission adopts uniform systems of accounting and financial reporting for hospitals. The Commission has the power to review projected annual revenues and the reasonableness of the proposed rates.

The statute allows for modification in the accounting systems, based on recognizable differences among hospitals, and changes in rates, where appropriate, for a hospital's financial well being.

STATE: Maryland

Statute: Article 43, Sections 568H through 568Y Annotated Code of Maryland.

Date: July 1, 1973

Purpose: To create the Health Services Cost Review Commission, to examine and make public the financial position of all hospitals and related institutions and to verify total costs actually incurred by each institution in rendering health care services, and to review and certify the reasonableness of the rates established by these institutions. Effective July 1, 1974, to assure all purchasers of health care hospital services that the total costs of the hospitals are reasonably related to the total services offered by hospitals, that a hospital's aggregate rates are set in reasonable relationship to a hospital's aggregate costs, and that the rates are set equitably among all purchasers of services.

Agency: Health Services Cost Review Commission.

The act creates a seven-member Health Services Cost Review Commission as an independent Commission within the Department of Health and Mental Hygiene. The

members are appointed by the Governor. The sole statutory mandate for Commission membership is that the members have an interest in the problems of health care, and that four of them must have no connection with the management or policy of any hospital or related institution. The initial terms are of varied length to provide a staggering effect, thereafter each term is for 4 years.

The Governor annually selects a chairman who selects a vice-chairman. Meetings are to be held as often as the Commission duties require, but no fewer than six meetings per year are to be held. With the approval of the Governor, the Commission appoints an executive director as a chief administrative officer. The Commission may also create committees from its membership and appoint advisory committees composed of individuals and representatives of interested public and private groups and organizations.

The Commission is to prepare and transmit to the Governor, the Secretary of Mental Health and Hygiene, and each member of the General Assembly an annual report of its operations and activities by the first day of October each year.

Parties: All hospitals and related institutions, except those listed or certified by the First Church of Christ, Scientist, Boston, Massachusetts. Nursing homes are scheduled to be reviewed as of July 1, 1975.

All purchasers.

Participation: Mandatory

Rate-Setting Procedure: This statute requires that hospital rates are to be approved prospectively. Each hospital and related institution must file annually and when required by the Commission:

(a) a balance sheet detailing the assets, liabilities and net worth of the institution for its fiscal year;

(b) a statement of income and expenses for the fiscal year and such other reports of the costs incurred in rendering services as the Commission may prescribe; and

(c) other data that the Commission must consider in conducting rate review and approval, including operating expenses, appropriate expenses incurred for rendering services to patients who cannot or do not pay, all properly incurred interest charges, and reasonable depreciation expenses based on the expected useful life of the property and equipment involved.

Since July 1, 1974, the Commission has had the power to initiate such reviews or investigations necessary to assure purchasers that the total costs of a hospital are reasonably related to the total services offered by the hospital, that a hospital's aggregate rates are reasonably related to the hospital's aggregate costs, and

that rates are set equitably among all purchasers or classes of purchasers of services.

To discharge these duties the Commission has full power to review and approve the rates established or requested by any hospital subject to the statute. No hospital may charge for services at a rate other than that established in accordance with the statutory procedures. No hospital may change or amend a rate schedule without prior approval by the Commission. The Commission is given the power to approve alternate methods of rate determination and payment of an experimental nature that may be in the public interest.

A broad declaratory provision states that the Commission shall permit hospitals to operate effectively and efficiently while retaining solvency.

Special Provisions:

The Commission specifies a uniform system of accounting and financial reporting, including such cost allocation methods that it may prescribe.

The Commission may provide for modifications of reporting systems in order to correctly reflect differences in the scope or type of services and financial structure between the various categories, sizes or types of institutions subject to the act.

The penalty for willful failure to report as required by the Commission is a misdemeanor, punishable upon conviction by a fine of not more that $500.

The statute also has a conflict-of-interest disclosure provision covering trustees, directors, and officers of hospitals. All of the aforementioned must disclose any interest they have in business firms contracting to provide goods or services to hospitals valued at $10,000 or more.

SUMMARY: The act provides for prospective rate approval for all hospitals and purchasers of health services. The program is administered by the Health Services Cost Review Commission. The Commission is an independent body within the Department of Health and Mental Hygiene. All hospitals and related institutions must file a financial statement or report at least annually. The Commission reviews the reports and determines the reasonableness of the proposed or requested rates. No hospital may charge for services at a rate other than that established in accordance with the statutory procedure.

The statute includes a conflict-of-interest provision applicable to trustees, directors or officers of hospitals who have a financial interest in firms contracting with the hospitals in amounts of $10,000 or greater.

STATE: Colorado

Statute: Colorado Revised Statutes, 10-16-124, 10-16-30 through 33

Date: Effective January 1, 1974, through July 1, 1977

Purpose: To determine the effect of prospective reimbursement on reduction or stabilization of the costs of hospital services to the subscribers of hospital service corporations.

Agency: Department of Health and Commissioner of Insurance. The Commissioner's duties are overall supervision of the program and the submission of a final report to the Colorado General Assembly prior to January 30, 1977, on the effectiveness of the program. To assist the Commissioner, there is an 11 member advisory committee appointed by the Governor consisting of:

(a) the Commissioner, as an ex officio member;

(b) two representatives from corporations subject to pertinent sections of the act;

(c) two representatives from the institutions involved;

(d) one representative from the Department of Health;

(e) five persons who are subscribers of health service corporations subject to pertinent sections of the act.

Parties: The Department of Health selects from four to eight hospitals and four to eight nursing homes from lists presented by the Colorado Hospital Association and the Colorado Health Care Association. The institutions chosen are to represent a cross section of the state's population, operations at undercapacity and full capacity, and the variety of available hospital and nursing home services.

Payers covered are hospital service corporations that provide a service contract as distinguished from a fixed-dollar benefit contract.

Participation: Mandatory for those institutions selected.

Rate-Setting Procedure: The reimbursement rates are to be set prospectively and to be paid according to a schedule of rates agreed upon by the institution and the hospital service corporation. The rates are determined using established accounting principles and regulations utilized in the health care industry for the determination of reimbursement of providers. Factors considered are:

(a) historic expenses;

(b) currently predicted costs derived from an appropriate budget and accounting system used by the hospital;

(c) the hospitals and nursing homes operating requirements; and

(d) services offered, geographical characteristics, and changes in price-level indices.

When a contract has been signed, the hospital submits a copy to the Commissioner of Insurance.

The rates remain in force during the term of the contract, or for one calendar year if a contract has a longer term.

Special Provisions:

An incentive provision provides that the rates agreed upon are neither retroactively increased to account for unforeseen patient costs, nor retroactively decreased as a result of efficient institution management. However, gains to the provider resulting from modification of patient services, operating requirements, or changes in price-level indices that were included in setting the rate are subject to downward adjustment.

Adjustments are allowed for unpredictable major events requiring a rate change to meet the financial requirements of the provider of health services.

Rate negotiations are subject to arbitration by the Commissioner of Insurance after the parties have exhausted all other efforts.

The act provides that corporations subject to its provisions will not pay rates higher than those charged to commercial insurers.

SUMMARY:

The Colorado statute mandates a 42-month pilot project to determine the effect of prospective rate reimbursement on the reduction and stabilization of the cost of hospital services. The statute mandates that from four to eight hospitals and four to eight nursing homes and health service corporations participate in the pilot project. The statute is administered by the Department of Health and the Commissioner of Insurance. Rates are determined through negotiations between hospitals and health service corporations. Participating health service corporations then submit a copy of each contract to the Commissioner of Insurance. If after exhausting all other efforts the parties are unable to reach agreement, the contract is subject to arbitration by the Commissioner of Insurance.

The statute provides for financial incentives for hospitals and nursing homes that spend less than the prospective rate.

STATE: Connecticut

Statute: Public Act No. 73-117 Connecticut GSA 19-73a through 73q.

Date: Effective July 1, 1974.

Purpose: Control of health care costs. The act creates a Commission on Hospitals and Health Care to carry out studies and recommend programs and legislation for improving efficiency, lowering health care costs, coordinating the use of facilities and services, and expanding the availability of health care throughout the state.

Agency: The Commission on Hospitals and Health Care.

The Commission is composed of 15 members;

(a) one from a list of three names proposed by the Connecticut Hospital Association, who is appointed by the Governor;

(b) one from a list of at least three names proposed by the Connecticut nursing home industry, who is appointed by the Governor;

(c) one from a list of three names proposed by the Connecticut State Medical Society, who is appointed by the Governor;

(d) six public members representing a geographical balance of urban and rural areas, who are appointed by the Governor;

(e) the State Commissioners of Health, Mental Health, Insurance, and Finance and Control; and

(f) two public members appointed by the Speaker of the House of Representatives and the President Pro Tempore of the Senate.

Appointments by the Governor are for 5 year, staggered terms. The terms of the other Commissioners vary to coincide with the terms of the appointing authority. The Governor appoints a chairman and vice-chairman from among the public members of the Commission for a term of 2 years. The Commissioners are part-time, meeting at least twice annually, and at such other times as the chairman or a majority of the Commission determines necessary. The Commission appoints an executive director, experienced in the field of hospital administration, to administer and coordinate the functions of the Commission.

The Commission reports its findings, recommendations and proposals annually on January 1 to the Governor and General Assembly.

Parties: All health care facilities in the state excluding state, city, town or borough operated facilities.

Participation: Mandatory.

Rate-Setting Procedure: The Commission has a broad mandate to carry out state-wide health care facility utilization review, study existing health care delivery systems, and recommend improvements in health care delivery and procedures. Consistent with this mandate the

legislation requires the Commission to:

(a) Review the proposed annual operating and capital budgets of any health care institution that the Commission shall designate. The designated institution shall submit its budgets at least 90 days prior to their proposed adoption. The Commission shall inform the institution of the approval, modification or denial of the budgets within 45 days before the proposed adoption date. Within 10 days of denial or modification, the Commission and representatives of the institution affected take part in a hearing to consider and evaluate relevant data, and within 15 days of the hearing the Commission recommends a budget. If agreement cannot be reached by the Commission and the institution, the Commission orders the institution to adopt a budget that the Commission deems reasonable.

In its deliberations the Commission may consider the necessary expenses of the institution or facility concerned, the effectiveness of its delivery of health care, the quality of available health care, the duplication of services in the area served, the community or regional need for any particular function or service, and any other factors the Commission may consider relevant.

(b) Review rate increases, except with respect to any rate increases provided for in the annual budget and resulting from the following:

(1) hospital increases in per diem per patient room rates or aggregate special services charges per patient by more than six percent over a 12 month period or ten percent over a 24 month period;

(2) more than a two-percent increase when a majority of the Commission feel such an increase to be unreasonable under the circumstances (this applies equally to nursing homes);

(3) nursing home increases in periodic room rates or aggregate special services charges per patient by more than four percent over a 12 month period or six percent over a 24 month period;

(4) introductions of additional services other than laboratory procedures or a social service that the Commission has exempted; and

(5) capital expenditures of $100,000 or more , or between $25,000 and $100,000 if a majority of the Commission feels such an expenditure is not reasonable under the circumstances.

Institutions may appeal Commission decisions to the Court of Common Pleas, and the Commission or Attorney General may enforce the Act by application to the Court of Common Pleas.

(To date no regulations have been approved in Connecticut.)

Special Provisions:

The Commission has the power to promulgate uniform accounting and reporting systems. Capital expenditure review provisions are incorporated into the statute.

A committee of the Commission is involved with regulating rates to be paid for state patients on the basis either of a percentage of operating expenses or of actual costs.

SUMMARY:

The Connecticut statute is aimed at containing hospital costs through an annual review of proposed hospital budgets and certain rate increases not included in the proposed annual budget. The act covers all hospitals and any other health care facility which the Commission requests to submit an annual budget. The program is administered by the Commission on Hospital and Health Care, an independent agency. All hospitals and health care facilities requested to do so by the Commission submit proposed operating and capital expenditures budgets 90 days in advance of each fiscal year. The Commission reviews these proposed budgets and informs the institutions of its decision within 45 days before the proposed adoption date. If agreement cannot be reached, the Commission may order the institutions to adopt a budget.

The act includes a certificate-of-need provision.

Third-party payers are not expressly covered by the statute, but in some instances Blue Cross uses the Commission's recommendations as a basis for its own rate-setting negotiations with hospitals.

The appeals procedure is judicial rather than administrative.

STATE: Massachusetts

Statute: Chapter 424 of the Acts of 1975

Date: July 3, 1975

Purpose: To stabilize hospital charges until the enactment and implementation of comprehensive legislation providing for a system to control the cost of purchasing hospital care in Massachusetts.

The act is an emergency law, effective only until January 31, 1977.

Agency: The Commonwealth of Massachusetts Rate Setting Commission. To administer the program, the statute utilizes the already existing independent Rate-Setting Commission (which currently reviews rates paid by state units, e.g., Department of Labor and Industry, and charges to be used by state institutions) consisting of a chairman, who has administrative experience and an advanced degree in the field of business administration, public administration or law, and two other members, one of whom is a CPA and one of whom is experienced in medical economics.

Parties: Any hospital that proposes to modify existing charges or establish new charges. Charges are defined as the amount to be billed or charged by a hospital to the general public for health supplies, care, services, and accommodations other than the differential between average weighted semiprivate room and board charges and private room and board charges.

Participation: Mandatory.

Rate-Setting Procedure: The method of approving rates is variable, depending on three situations:

1. Modification of Existing Charges: Any hospital wishing to modify its existing charges must submit an application for the Commission's approval at least 60 days prior to the implementation of the new rates. The application must include information supporting the proposed charge modification, including a budget (projected and actual costs), volume, and revenue data. The Commission then approves or disapproves the modification.

Requested modifications in charges must be supported by the reasonableness of the underlying costs. The basis for charge increase reviews will be set forth in regulations, Such factors as: (a) consistency with the rate of inflation as measured by a specific composite price index: (b) increases beyond that allowed by the index resulting from net increases in volume; and (c) the impact of cost increases beyond the control of the individual hospital must be considered. The Commission allows modification of the charges if the hospital's ratio of total patient-care costs to total patient-care charges for the applicable fiscal year exceeds 95%. Modification shall permit the hospital to

establish the ratio at 95%. If the ratio equals or is less than 95%, the Commission may not approve any requested modification in charges that would produce a ratio of total patient-care costs to total patient-care charges that is below the applicant's base-period of total patient-care costs to total patient-care charges. The Commission may consider changes in charges necessary to cover changes in intensity of services and changes in medical practice.

In developing regulations, the Commission consults with representatives of nonprofit hospital service corporations, the Massachusetts Hospital Association, and companies authorized to sell health and accident insurance.

2. Introduction of a New Charge: Any hospital that intends to introduce a new rate charge (i.e., a new service, etc.) shall submit an application for approval of the charge through a process similar to modification of an existing charge.

In reviewing the application, the Commission considers the relation of the proposed charge to the reasonable cost of providing the service, etc. provided that the Commission does not establish a charge that produces a ratio less than the hospital's base-period ratio.

3. Subsequent to April 15, 1975: Any hospital that modified existing charges or implemented new charges subsequent to April 15, 1975, and prior to the effective date of regulations had to file an application for approval of such modification in charges within 20 days of the effective date

of the regulations. This did not apply if the modification in charges was effective on or after April 15, but was filed with and approved by the Commission prior to that date.

In reviewing the application, the Commission shall use the same regulatory criteria established for 1 and 2 above. When agreement cannot be reached, the hospital adjusts its charges to the extent required by the Commission, provided that no adjustment results in charges less than those which were in effect on April 15, 1975.

All hospitals were required to file with the Commission within 15 days of the effective date of the act a complete listing of their charges in effect for the first day of the fiscal year commencing 1974. Each hospital, also, submitted a copy of its budget.

An initial appeal of a Commission's decision is heard by the Division of Hearings Officers of the State of Massachusetts. This is an administrative process. A second appeal may be made to the courts.

Special Provisions:

The penalty for failure to comply with the act is a fine of $1,000 per day.

Under the act, the Secretary of Human Services has to submit to the general court a proposal for a comprehensive system of controlling the costs of purchasing hospital care in the Commonwealth. In preparing his proposal, the Secretary is to consult with representatives of interested parties,

including the Massachusetts Hospital Association, nonprofit hospital service corporations, companies authorized to sell accident and health insurance, consumers, health professionals, the Federal Department of Health, Education, and Welfare, as well as State and regional planning agencies.

The act is effective for 2 years.

SUMMARY

The Massachusetts statute is fairly detailed and comprehensive, although much that is specified in other states' statutes is left to regulations in the Massachusetts statute. The statute uses a ratio-formula method of setting the maximum amount that charges can exceed patient-care costs. This is a unique legislative provision. The program is administered by the Rate-Setting Commission, an existing body with responsibility for setting rates and charges of state departments and institutions.

STATE LAWS PENDING
(As of August 1975)

(California, Delaware, Florida, Michigan, Pennsylvania, Vermont, Wisconsin.)

STATE: California

Bill: Senate Bill # 1107

Date: April 22, 1975

Purpose: The purposes of S.B. 1107 are (a) to encourage economy and efficiency among the purchasers of health services, and to enable and encourage all purchasers to take the information that will be required by the act into account to assist them in making informed decisions regarding the purchase of health care; (b) to reduce unwarranted rate increases for health care; and (c) to establish a single approval authority for the construction and expansion of health care facilities.

Agency: The California Health Facilities Commission.

The Commission, renamed from the California Hospital Commission, is an independent state commission of 13 members, an increase of six members from the California Hospital Commission. The Commission is composed of:

(a) one member who within the past 10 years had at least 5 years experience in the field of health insurance or in the administration of a health care service plan;

(b) one member experienced in the management of a comprehensive group-practice prepayment health care service plan;

(c) three executive officers of nonprofit general acute-hospitals, investor owned general acute-care hospitals, investor-owned, skilled-nursing facilities;

(d) one physician or surgeon; and

(e) seven public members.

An additional provision requires that members of the Commission shall be persons who, as a result of their training, experience or attainment, are exceptionally well-qualified to carry out the duties of the Commission.

The six Governor appointees are to hold staggered terms of 4 years. The Commission annually elects a chairperson, who must be selected from among the public representatives, and a vice-chairperson and other necessary officers. The Commission also appoints an executive director with administrative responsibilities, who must at least have 2 years experience as an administrator of a general acute-care hospital.

The Commission must meet at least three times annually, and is to prepare an annual report to the Governor and legislature of its operations and activities and expenses.

The Commission may appoint members from its membership and other individuals to assist it in carrying out its duties.

To assist the Commission, the bill creates two technical advisory boards, the Budget and Rate-Review Board and the Certificate of Need Board.

The Budget and Rate-Review Board is to advise the Commission on budgets and rates for health facilities and recommend appropriate policy regulations and guidelines to the Commission. It is to consist of the following 12 members:

(a) one representative of a governmental agency that purchases health services;

(b) one representative of a prepaid comprehensive group practice;

(c) four health-facility representatives from a nonprofit, long-term facility, and investor-owned hospital, and a nonprofit hospital;

(d) three practicing physicians;

(e) two representatives of third-party purchasers, one commercial and one nonprofit; and

(f) the Chairperson of the California Health Facilities Commission or his ex-officio representative.

The Certificate of Need Board is to advise the Commission on appropriate policy regulations and other guidelines for the certificate-of-need process. Its composition is identical to the Budget and Rate-Review Board, with the exception of: a representative of the Department of Health instead of a purchaser of governmental health services; three physicians, two of whom must be in the private practice of medicine; two of the twelve members must also serve on Health Systems Agencies boards.

All members of the technical advisory boards shall be appointed directly by the Commission and are to serve 3 year terms. Each board shall have a chairperson appointed by the Commission, a vice chairperson and a secretary elected by the Board, and is to meet at least two times a year.

Parties: All health facilities operating in the state, provided Federal and State governments agree to pay the rates approved by the Commission. All purchasers.

Participation: Mandatory

Rate-Setting Procedure: Each health facility or organization that operates a health facility must file with the Commission within 4 months of the close of their fiscal year the following reports:

(a) a balance sheet detailing the assets, liabilities, and net worth of the health facility;

(b) a statement of income, expenses, and operating surplus or deficit;

(c) a statement detailing the source and application of funds expended by the health facility for the period reported;

(d) a report of health facility expenditures allocating the costs of departments that produce no revenue to the other centers that they serve; and

(e) an annual summary budget of proposed expenditures and revenues for the following fiscal year and selected rates and changes to those rates as they occur.

The Commission is to review budgets and rates of all health facilities effective July 1, 1976, provided that the Federal and State governments agree to pay the approved rates. This review is to assure that necessary services to maintain quality of care will be offered. In determining the appropriateness of budgets and rate schedules the Commission shall consider the following:

(a) the overall budget and rates of the institution;

(b) equal payment for comparable services by all payers;

(c) occurrences beyond control of the facility;

(d) forthcoming capital expansion;

(e) working capital and cash flow needs;

(f) the cost of bad debts, charity, education, and research costs less income and grants or gifts for the above purposes; and

(g) the cost of complying with various regulatory requirements.

All health facilities are to comply with the budget and rate-review requirements of this act and may not increase rates for services unless such rates have been reviewed and approved by the Commission.

The Commission is to establish annual budget and rate guidelines.

Any decision rendered by the Commission may be appealed. The appeal is to be heard by a body composed of seven members of the Commission appointed by the chairman of the Commission. A second higher level appeal, if necessary, is available through the courts.

Special Provisions:

The Commission establishes uniform accounting and reporting systems for the hospitals and nursing facilities to report their financial position, with due consideration to accounting systems already in use by the institution. The Commission is to allow modifications in reporting requirements to correctly reflect differences in size, scope, type, or method of provisions of payment among the various institutions.

Specific reporting provisions are also to be established for health facilities that receive a preponderance of their revenue from associated comprehensive group-prepayment health care service plans. When such health facilities operate as units of coordinated group health facilities, they are to report as a group rather than individually.

A penalty of $100 per day is provided for failure to file under the bill. A certificate-of-need is required when a health facility adds new facilities or services, replaces or modernizes existing facilities, expands or reduces bed capacity or services, converts existing beds to a different licensure category, or makes capital expenditure for health facilities above $100,000.

All health facilities are assessed a special fee, of not more than .2% with respect to skilled-nursing facilities and intermediary-care facilities, and not more than .06% with respect to other health facilities of the facility's gross operating cost for the provision of health care services for its last fiscal year.

An incentive provision is included to recognize effective management and operation by allowing institutions to retain any surplus earned under approved rates and incur any deficits for exceeding approved rates.

The Commission's duty and responsibility to review rates is subject to the Federal and State governments' agreement to pay the health-facility rates approved by the Commission.

The Commission is to establish uniform billing practices for health facilities, acceptable to health facilities, insurance carriers, intermediaries, consumers, and the governmental interests. The Commission is to perform an economic-impact analysis of all bills introduced in the Legislature affecting health-facility costs.

SUMMARY: The Act provides for budget and rate review based on a uniform system of reporting and accounting developed by the California Health Facilities Commission. The accounting and reporting system is to reflect differences among institutions and year-to-year variances within individual institutions. The act covers all health facilities operating in the State and all purchasers of health-facility services. Two technical advisory boards, composed entirely of professionals, assist the Health Facilities Commission. The Commission is independent of other State agencies and is given fairly broad grants of power to carry out its duties. It is funded by an assessment fee against the health facility.

Each facility must file a detailed financial report with the Commission within 4 months of the close of the fiscal year. The Commission reviews the proposed budgets and rates of the health facilities. All health facilities must comply with the budget and rate review requirements of the Bill and may not increase rates for services unless the increases have been reviewed and approved by the Commission.

An incentive provision is included in the statute.

Also of note in the special provisions of this bill is the requirement that the Commission establish uniform billing practices that are acceptable to health facilities, insurance carriers, intermediaries, consumers, and governmental interests.

In addition, another bill, Senate Bill 1108, has been introduced that would authorize the California facilities Commission to contract with or receive a grant from the Department of Health Education and Welfare to carry out an experimental and/or demonstration project for a prospective payment system for health facilities.

STATE:	Delaware
Statute:	Senate Bill 294 (H.B. 370) Pending
Purpose:	Approval of contracts between Health Service Corporations and hospitals and physicians.
Agency:	A committee consisting of the Secretary of Health and Social Services, the Insurance Commissioner and the State Auditor. The Secretary of Health and Social Services shall serve as committee chairman.
Parties:	Participating hospitals, physicians, and other providers of health services. Hospital Service Corporations.
Participation:	Mandatory
Rate-Setting Procedure:	No procedure is provided for in the bill. The bill states only that changes or renewals of contracts between health service corporations and participating hospitals shall require the approval of a majority of the Committee.
Special Provisions:	None
SUMMARY:	This pending bill is a model of simplicity; presumably extensive regulations and guidelines will be adopted upon passage.

STATE: Florida

Bill: House Bill 1705. Patient Protection Act of 1976. Pending.

Purpose: To provide strong economic incentives that will enable and motivate health care facilities to provide services efficiently and economically to all citizens, to create a State commission with authority over financial disclosure and budget and prospective rate review, and to aid purchasers of health care to make informed purchase decisions. The Commission's purposes are to provide reasonable and appropriate safeguards to ensure that the total cost of hospital and nursing home services is reasonably related to the total services offered by such facilities, that the aggregate rates of facilities are reasonably related to their aggregate costs, and that rates charged by facilities are uniform for all purchasers of services.

Agency: Florida Health Care Cost Commission.

The Commission is to be located within the Department of Health and Rehabilitative Services. The Secretary of the Department of Health and Rehabilitative Services shall be a permanent member of the Commission. Additional members are to be appointed by the Governor and confirmed by the Senate and are to consist of the following:

(a) one practicing hospital and one practicing nursing home administrator;

(b) one representative from the health insurance industry;

(c) one practicing physician;

(d) one representative of a hospital service plan; and

(e) three consumers of health care.

The Commissioners are to serve 4 year, staggered terms. Meetings are to be held as frequently as duties require, but no less than four times a year.

The Commission is to report annually, each March 1, to the Governor and the Legislature on its operation and activities for the preceding year.

The Commission is to be furnished the staff necessary to fulfill its responsibilities and duties by the State health planning agency. The Commission is to have the power to contract with third parties for services necessary to carry out its activities, and may create committees from its own membership and ad hoc advisory committees in specialized fields as necessary.

Parties: All hospitals and nursing homes operating in the state. All purchasers of services.

Participation: Mandatory

Rate-Setting Procedure: Health care facilities are to report within 120 days of the end of their fiscal years. The report shall include, but

not be limited to:

(a) a statement of operations;

(b) a statement of, receipts and disbursements, of revenues and expenses including, but not limited to, salaries and benefits, operating expenses, equipment and supplies, fixed capital outlay, and all other direct and indirect disbursements allocated to each account classification;

(c) a statement of assets and liabilities, including reserves, depreciation, special or other funds;

(d) the location of any real property owned by the institution;

(e) a statement of loans and investments, interest, rents, and profits from the investments of the hospital or nursing home;

(f) a statement of payment or advances such as, salaries, loans, gifts, bonuses, etc. by or to persons or entities that is directly or indirectly controlled by an officer, director, trustee or stockholder of the facility;

(g) all reports and schedules must be certified as to their accuracy.

Not more than 12 months after the adoption of the uniform system of financial reporting required by the bill, the commission is to have the authority to initiate reviews or investigations to assure all purchasers of services that the total costs of services are reasonably related to the total services offered by the facility, that a

facility's aggregate revenue as expressed by rates is reasonably related to the facility's aggregate costs; and that rates are set equitably among all purchasers or classes of purchasers of services. A declaratory provision requires that facilities have the ability to meet their total financial requirements from operating revenues.

To discharge its obligations, the commission will have full power to review, at least annually, projected annual revenues and to approve the rates proposed to generate the revenue projected by any hospital. No hospital may charge for services at rates other than those established in accordance with the procedures established under the bill.

Rates that are in force in hospitals and nursing homes as of January 1, 1976 shall be known as the base rate. The commission shall review for appropriateness incremental changes in the base rate. When making its reviews the commission shall consider:

(a) the need for increasing operating efficiencies;

(b) the need for closing and/or converting to other uses excess beds; and

(c) the degree of duplication of services in a given community.

The commission must, also, obtain an impact statement from the appropriate Health Systems Agency constituted

under P.L. 93-641. The statement shall include the projected effects of the proposed rate change upon health care costs and delivery in the area served by the health care facility.

Special Provisions:

The commission is to specify a uniform system of financial reporting by which hospitals are to record their revenues, expenses, other income and outlays, assets, liabilities, units of service and utilization of services for each fiscal year.

An incentive provision is included that encourages programs in which hospital employees receive a share of the savings from efficient operation. In addition, the bill has an incentive provision allowing hospitals to retain savings from operating at a cost below the prospectively approved rates.

An assessment of not more than .04% of each hospital's operating costs for its prior fiscal year is to be levied to finance commission operations.

A penalty of $10,000 per day is to be imposed upon hospitals and nursing home facilities that knowingly violate provisions of the act.

SUMMARY:

The Florida bill is comprehensive in that it covers most aspects of prospective rate setting. All hospitals and nursing homes operating within the State and all purchasers of services are covered by the bill. The program is

administered by the Florida Health Care Costs Commission, and is to be located within the Department of Health and Rehabilitative Services.

The Commission is composed of 9 members, three of whom have backgrounds in the health field, two representing the health care insurance industry, three members representing the public interest, and the Secretary of the Department of Health and Rehabilitative Services.

The Commission specifies a uniform system of financial reporting by which hospitals file annual reports of their fiscal condition. The Commission then reviews the projected budget and the proposed rates.

An incentive provision encourages the introduction of programs that will permit hospital employees to receive all or part of any savings in operating costs that result from efficient program operations.

STATE: Michigan

Statute: Senate Bill Number 765. Pending

Purpose: To create the Health Services Cost Review Commission, that will regulate the rates charged by hospitals and related institutions, and require certain disclosures.

Agency: Health Services Cost Review Commission.

The seven-member Commission is an autonomous body within the Department of Public Health. The sole statutory requirement for membership is that those appointed should be persons that are interested in health care problems, and that four shall have no connection with the management or policy of a hospital or related institution. The members serve 4 year, staggered terms. The Governor annually selects a chairman, who selects a vice-chairman. The Commission, with the Governor's approval, appoints an executive director. The Commission is empowered to create committees from its membership and appoint advisory committees, which may include individuals and representatives of interested public and private groups and organizations as members. Meetings of the Commission are to be held as frequently as its duties require, but no fewer than six meetings per year are to be held.

The Commission is to prepare and transmit to the Governor, the director of the Department of Public Health, and each member of the legislature an annual report of its operations and activities for the preceding fiscal year.

Parties: All hospitals and health care institutions, and operations licensed by the Department of Health.
All purchasers.

Participation: Mandatory

Rate-Setting Procedure: Each institution within the Commission's jurisdiction is to file at least annually:

(a) a balance sheet detailing the assets, liabilities, and net worth of the institution for the fiscal year;

(b) a statement of income and expenses for the fiscal year; and

(c) such other reports of the cost incurred in rendering services as the Commission may prescribe.

The Commission is to have the power to initiate reviews or investigations as necessary to ensure all purchasers of health care hospital services that the total costs of the hospital are reasonably related to the total services offered, that a hospital's rates are reasonably related to the hospitals costs in the aggregate; and that rates are set equitably among all purchasers or classes of purchasers of services.

When the Commission is conducting its review of hospital rates it should consider necessary operating expenses, appropriate expenses incurred for rendering services to patients who cannot or do not pay, all properly incurred interest charges, and reasonable depreciation expenses based on expected useful life of the property and equipment involved. A broad declaratory provision states that the Commission is to allow institutions to charge rates that will permit them to render an efficient service while retaining solvency.

A hospital shall not charge for services at rates other than those established in accordance with the provisions of the bill, nor shall a hospital change or amend its schedule of rates without prior approval of the Commission.

Special Provisions:

The Commission, after consultation with the appropriate advisory committees, is to specify a uniform system of accounting and financial reporting, including such cost-allocation methods as it may prescribe, by which hospitals must record their revenues, expenses, other income and other outlays, assets, liabilities, and units of services for the fiscal year. The Commission may allow and provide for modifications in the accounting and the reporting system in order to reflect differences in scope or type of services and financial structure between the various categories, sizes, or type of institutions subject to the bill.

Michigan

A penalty provision provides that a willful failure to report as required by the bill is a misdemeanor punishable by a fine of not more than $500. This bill also has a conflict of interest disclosure provision covering trustees, directors, or officers of hospitals and their interests in business firms which contract with the hospital in amounts of $10,000 or more.

SUMMARY: The Michigan bill is an almost word-for-word duplicate of the Maryland bill. The program is administered by a seven-member Health Services Cost Review Commission, an independent commission within the Department of Public Health. It covers all hospitals and other health care institutions and all purchasers of health services. The Commission formulates a uniform system of accounting and financial reporting, by which all covered institutions file at least annually a statement of their fiscal situation. The Commission then reviews the information received and determines the reasonableness of the rates proposed. No institution may charge for services at rates other than those established in accordance with the procedures in the bill.

The bill includes a penalty provision and a conflict-of-interest provision.

STATE: Pennsylvania

Bill: Senate Bill 10 (H.B. 853) Comprehensive Health Care Act. Pending

Purpose: To enhance the public health by ensuring that health care is available to everyone at a fair and reasonable cost, that the health care delivery system is responsive and adequate to the needs of all the citizens, that health care services are efficiently and effectively used, that cost inflation is limited, that unnecessary duplication, fragmentation, and dehumanization of health care services and facilities are minimized, and that health care services meet quality standards.

Agency: The Department of Health.

The department has the supervisory responsibility for administering the statute. The department makes final decisions on rate approval, issuance of certificates-of-need, and issuance of licenses. It, also, has the final responsibility to adopt regulations governing rates, certificates-of-need, and licenses, after consultation with the Health Care Policy Board.

The Health Care Policy Board shall conduct studies and make investigations and then recommend rules and regulations for implementation of the statute to the Department of Health. The Board is composed of 19 members:

(a) four members from the general public who qualify as consumers;

(b) two representatives from organized labor;

(c) two members from the business community;

(d) two third-party contract payers;

(e) one third-party payer who is not a third-party contract payer;

(f) one physician;

(g) one nonphysician member from the healing arts;

(h) two representatives from hospital management;

(i) one representative from nursing homes;

(j) one representative from other classes of providers;

(k) two from any class of provider.

Members serve 4 year staggered terms. The Governor designates a chairman. The Board reports annually to the Governor, the General Assembly and the public on the regulation of health care facilities in Pennsylvania.

Parties: All hospitals, which includes general tuberculosis, mental, chronic disease, and other types of hospitals excluding Federal facilities and state mental hospitals; and skilled- or intermediate- nursing facilities (unless the nursing facility provides care exclusively to the clergy or other religious professionals). Third-party contract

payers' and governmental agencies' rate setting procedures are specifically covered. All rates charged by health care facilities are covered by the bill.

Participation: Mandatory

Rate-Setting Procedure: Financial reports are to be submitted on forms provided by the Department at specified intervals, but at least annually, and must include the following information:

(a) a balance sheet detailing all assets, liabilities, and the net worth of the institution;

(b) a statement of income and expenses for the fiscal year; and

(c) such other reporting as the Department may prescribe.

After consultation with the Board, the Department shall classify hospitals according to size, geography, regional economic factors, type of facility, teaching programs related to patient care, and scope of services provided.

The Department is to review and analyze the information it receives and to develop cost comparisons for each class of facility covered by the bill. Based on these comparisons, the Department may identify those providers whose financial operations deviate significantly from the

statistical norms or from other providers within the same classification. The Department may require any provider so identified to justify the reasonableness of the deviation and upon failure to do so may require the adoption and implementation of an appropriate cost-containment program.

Within 2 years from the enactment of the bill, all contracts and contract rates between providers and third-party contract payers for the rendering of health care services and all other rates to be paid to providers, are to be approved by the Department.

Following negotiations with the hospital provider, the third-party contract payer must file an application with the Department for approval of a proposed contract or modifications to an existing contract. Within 60 days the Department will approve, deny, or approve the application in part.

The bill has a declaratory provision that states that rates contained in the contracts must be reasonably related to the cost projected or incurred by providers for the efficient production of services. To assure this, the Department shall take into consideration the various factors used in determining classification of hospitals. Rates paid to providers that are not covered by the above method will nevertheless require the approval of the Department.

Third-party contract payers may exclude as costs the expenses for research and education not directly related to patient care in contract negotiations with providers.

To facilitate rate approval, the Department may establish maximum rate changes for providers; rates filed that fall within the maximum will be deemed to be approved.

Prior to the approval of any rate or contract rate by the Department, the provider and any person interested as a consumer or third-party is entitled to a hearing on the reasonableness of such rates. No provider may charge for services at rates other than those approved by the Department. If the provider does so, the Department may order compensatory adjustments in rates for subsequent years.

Special Provisions:

After consultation with the Health Care Policy Board, the Department of Health is to prescribe a uniform system of accounting and financial reporting. In developing the accounting system the Department must consider the accounting principles established by the American Institute of Certified Public Accountants, the chart of accounts established by the American Hospital Association, and any other appropriate standards utilized by health care providers. The Department may allow for modification in accounting and reporting systems to reflect differences between various categories of institutions and size, and type of services provided. Within 2 years of the enactment of the bill,

every provider is to maintain a set of accounts in accordance with the accounting system prescribed by the Department.

The Department may promote and approve alternative methods of rate determination or payment of an experimental or innovative nature. The Department may require providers' proposed budgets to be submitted in support of the providers rates or contract rates.

A retroactive adjustment provision provides for exceptions from rates or contract rates approved by the Department for good cause shown by a petition. The appeals process is directly through the courts.

The bill includes a certificate-of-need provision, a licensure provision, and a clause that encourages incentive plans.

A penalty provision provides for a fine of not more than $300 and/or imprisonment for not less than 10 days and not more than 30 days for failure to comply with the bill. Each day of noncompliance constitutes a separate offense.

SUMMARY: The bill provides for prospective rate setting primarily through contract negotiations between hospitals and third-party payers. The contracts are subject to the approval of the Department of Health, which gathers budgetary information on all hospitals through uniform accounting and financial reporting systems. Unlike many other statutes, by which the administering agency takes an active part

in rate setting, in Pennsylvania the Department of Health's function is to monitor the rate-setting process to assure that rates are reasonably related to costs and reflect economical, geographical, and patient-mix differences among hospitals. To facilitate rate approval, the Department has the power to establish permissible maximum changes in rates for providers; rates that fall within this maximum are deemed to be approved. The Department of Health is assisted in its duties by a Health Care Policy Board, a 19 member group that recommends rules and regulations for implementing the bill to the Department.

The bill includes a certificate-of-need provision and a licensure provision.

STATE: Vermont

Statute: Senate Bill 142. Pending for consideration in adjourned session January - April, 1976.

Purpose: To promote the economical delivery of high quality and effective hospital services by establishing a Health Care Cost Commission with authority over financial disclosure, budget approval, facility review, and other related fiscal matters. This Commission will assure all purchasers of hospital services that hospital costs are reasonably related to services, that rates are reasonably related to aggregate costs and financial requirements of hospitals, and that rates are set equitably among all purchasers of these services.

Agency: The Health Care Cost Commission.

A newly created independent Commission of nine members appointed by the Governor and confirmed by the Senate as follows:

(a) five public members concerned with the delivery of quality health care, who represent a geographical balance within the state;

(b) one person appointed from a list of three names submitted by the Vermont Hospital Association;

(c) the Commissioner of Banking and Insurance, ex-officio;

(d) one person appointed from a list of three names submitted by the Vermont State Medical society;

(e) the Secretary of the agency of administration, ex-officio.

Members serve staggered 4 year terms. The Governor is to appoint a chairman and vice-chairman from among the public members of the Commission to serve 2 year terms. The Commission is to appoint a full-time executive director with administrative duties. The Commission is to meet as its duties require.

The Commission is to report annually to the Governor and the General Assembly its findings, recommendations and proposals for improving efficiency, lowering health care costs and coordinating use of hospital facilities and services.

Parties: All hospitals, except those operated by the First Church of Christ, Boston, Massachusetts.
All purchasers.

Participation: Mandatory

Rate-Setting Procedure: Each hospital is required annually to file with the Commission after the close of its fiscal year:

(a) a balance sheet detailing the assets, liabilities, and net worth of the hospital;

(b) a statement of income and expenses for the fiscal year; and

(c) such other reports as the Commission may prescribe.

Each year every hospital is to submit to the Commission its proposed operating and capital expenditure budget for the next fiscal year, at least 90 days prior to the adoption of the budget. The Commission is to review the budget and notify the hospital of its approval, denial or modification of such budget, not later than 45 days before the proposed adoption date. If the Commission denies or modifies a budget, it must hold a hearing within ten days. Representatives of the hospital shall be present, to consider and evaluate relevant information. Within 15 days the Comission is to recommend a budget it deems to be reasonable. If agreement on the budget cannot be reached by the Commission and the hospital within 15 days of the proposed adoption date, the Commission is to order the hospital to adopt a budget that the Commission deems reasonable for the upcoming fiscal year. The Commission is to review projected annual revenue and approve the reasonableness of rates proposed to generate revenue determined to be just and reasonable.

In the event of unforeseen and material changes in circumstances beyond the control of the hospital in any fiscal year, the hospital may submit a revised budget to the Commission and request a change in rate schedules.

No hospital may charge rates other than those determined in accordance with the procedures laid out in the bill.

The bill has a broad declaratory provision charging the Commission with the responsibility to set rates that will allow the hospital to render high-quality services while allowing the hospital to generate sufficient revenue to meet its financial obligations.

Judicial enforcement and review is available to both the Commission and persons aggrieved by the Commission's determination.

Special Provisions:

The Commission is to adopt a uniform system of accounting, financial, and statistical reporting, including such cost-allocation methods as it may prescribe. In establishing the uniform accounting procedures the Commission will consider existing systems utilized by the hospitals, differences among hospitals according to size, type, financial structure, scope, and method of services, and other pertinent distinguishing factors, then modify its requirements to reflect these differences.

The accounting system is to reflect differences between patient-oriented hospitals and hospitals that are not primarily patient oriented.

A unique provision of this bill is the Commission's power when reviewing hospital rates to maximize the ability of hospitals to continue attracting gifts. The statute also includes an incentive provision prohibiting retroactive increases or decreases in rates as a result of unforeseen patient costs, or efficient operations. However,

gains accruing to the hospital as a result of modification of patient services, operating requirements, or of changes in price-level indices are subject to a downward adjustment at the end of the year.

A certificate-of-need provision is incorporated into the bill.

The Commission is financed by an assessment against insurance companies and hospital service corporations, based on their gross premiums. The total sum assessed may not exceed $200,000 less grants and gifts received by the Commission from the public and private entities.

Failure to comply with the reporting requirements may incur a fine of not more than $500 and suspension of business for not more than 6 months.

A conflict-of-interest provision requires disclosure of transactions over $10,000 between hospitals and business entities by a trustee, director or officer of the hospital who has a financial interest in the business entity.

SUMMARY:

The Vermont bill sets rates prospectively for all hospitals and covers all purchasers. The program is administered by an independent Health Care Cost Commission. The Commission is to adopt a uniform system of accounting, financial, and statistical reporting by which each hospital will annually file after the close of its fiscal year. Each hospital

also submits annually to the Commission its proposed operating and capital expenditures budgets for the next fiscal year at least 90 days prior to the adoption of the budget. The Commission reviews it and informs the hospital of its decision. If agreement cannot be reached, the Commission orders the hospital to adopt a budget that the Commission deems reasonable for the upcoming fiscal year. No hospital may charge rates other than those determined in accordance with the procedures laid out in the bill. The Commission is funded by an assessment against insurance companies and hospital service corporations.

The bill includes a conflict-of-interest provision.

STATE: Wisconsin

Bill: Assembly Bill 374. Pending

Recommended for passage by Committee on Health and Social Services.

Purpose: To assure all purchasers of hospital services that the financial requirements of the hospital are reasonably related to the cost of total services offered by the hospital, that in the aggregate a hospital's rates are reasonably related to the hospital's financial requirements, and that rates are set equitably among all purchasers of services while recognizing that costs incurred by an institution in obtaining reimbursement may not be the same among purchasers.

Agency: State Health Planning and Development Agency.

To assist the agency, the bill authorizes the creation of a 15 member Hospital Rate Review and Approval Committee which recommends to the agency approval, partial approval, conditional approval or disapproval of hospital budgets and rate-increase requests. The members, who are appointed by the Governor and serve staggered 3 year terms, include:

(a) three representatives from the Wisconsin Hospital Association;

(b) one representative from a domestic insurance company;

(c) two representatives from a hospital service corporation;

(d) three representatives from State and local government;

(e) one representative from the Wisconsin Medical Society; and

(f) five consumer members from the Health Policy Council.

The agency is to submit an annual report of its activities and decisions to the Legislature.

Parties: All hospitals. All purchasers.

Participation: Mandatory

Rate-Setting Procedure: The agency is to establish guidelines for the evaluation of hospital budgets and proposed increases in rates charged to purchasers of services. No rate can be put into effect until it has received agency approval. In evaluating budgets the agency is to consider:

(a) budget similarities and differences with institutions providing services of similar scope and quality;

(b) the soundness of a hospital's current capital expenditure plan;

(c) a hospital's efforts to obtain prompt payment for services rendered; and

(d) the accuracy of a hospital's past budget projections.

Prior to making a determination of rate-increase requests, the agency is to consult with the Health Systems Agency in the area where the institution is located on the need for and the utilization of the hospital's services and the appropriateness of its capital-expenditure plan.

The agency shall also take into consideration the following as elements of a hospital's rates:

(a) patient related operating expenses;

(b) bad debts, charity care, third-party allowances and uncollectables;

(c) interest on indebtedness;

(d) unreimbursed educational expenses;

(e) unreimbursed patient care related research;

(f) depreciation on building and equipment (either historical cost or price level adjusted);

(g) amortization of capital indebtedness;

(h) working capital;

(i) expenses related to 1122 capital expenditure projects; and

(j) income from grants, gifts and nonhealth sources, whether it be restricted or nonrestricted, is not required to be offset against the above mentioned expenses.

When seeking approval of a budget including rate increases, a hospital must apply to the agency on forms provided by the agency. When no rate increase is requested, the filing is to be on forms provided by the agency, but for informational purposes only. An application for a rate

increase must be submitted to the agency at least 30 days prior to the beginning of a hospital's fiscal year.

A hospital may request a rate increase only once a year, except in cases where unforeseen factors beyond the control of the hospital cause increases that necessitate a rate increase to meet the financial requirements of the hospital.

The appeals procedure is not set out in the bill. Instead the bill authorizes the agency to adopt appeal procedures for hospitals requesting rate increases. The process will be administrative in nature rather than judicial.

Special Provisions:

The agency is to prescribe a system for hospital financial reporting.

A penalty provision in the bill states that a hospital that increases its rates without agency approval may be required to refund to payers the unapproved increase and to roll back rates to the previously approved level, or may be required to forefeit not less than $100 nor more than $1,000 per day.

In contrast to some other statutes that deal with rate review, this bill states that income from unrestricted gifts and nonhealth services may not be used to reduce payment for services.

An assessment to cover 50% of the program costs is levied against institutions in the form of filing fees. Such fees may not exceed .01% of an institution's total annual revenue.

SUMMARY: The bill provides for the review of budgets and proposed increases in rates. All hospitals and all purchasers of health services are covered. The State Health Planning and Development Agency is responsible for the overall administration of the program; however, to assist the agency, the bill creates the Hospital Rate-Review and Approval Committee, which is responsible for the reviewing of hospital budgets and rate-increase requests. The committee is to recommend approval, partial approval, or disapproval of budgets and rates to the agency.

A system for hospital financial reporting is to be prescribed by the agency for use by the hospitals. An application for a rate increase must be submitted to the agency at least 30 days prior to the beginning of each hospital's fiscal year. When no rate increase is requested, the filing shall be for informational purposes only. Much of the hospital's financial reporting requirements is left to regulation. The bill does, however, specify several expense items and methods for calculating them that are to be considered in evaluating a hospital's budget.

Fifty percent of the cost of the program is financed by assessments against the hospitals.

DATE DUE
