

Abstracts of State Legislated Hospital Cost-Containment Programs

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This report summarizes State legislated efforts to control rising hospital costs and the status of these efforts in May 1982. The abstract for each of 17 State programs summarizes key legislative features and operating aspects. The States included in this report are: Arizona, California, Connecticut, Florida, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New York, Oregon, Rhode Island, Virginia, Washington, West Virginia, and Wisconsin. The abstracts focus on programs requiring the disclosure, review, or legislation of hospital rates and budgets.

Summary

As of May 1982, 17 States had legislation requiring the disclosure, review, or regulation of hospital rates or budgets.¹ Those programs which require hospitals both to participate in and comply with the results of a budget-review or rate-setting process are considered mandatory rate-setting programs. There are currently nine mandatory State rate-setting programs (Connecticut, Illinois, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington, and Wisconsin). The remaining eight programs solicit voluntary compliance with the results of the review processes or operate simply as disclosure programs.

There is a substantial amount of diversity in these programs. Some systems relate to revenues, others to costs. Some systems involve a review of each hospital's prospective year budget; others apply formulas to prior year costs. Some systems constrain the level of costs through penalties, others negotiate or deny costs identified by screens or by the application of statistical standards. Some systems constrain the rates of increase in costs through global budget approaches, others by guaranteeing inflation increases but scrutinizing all other requests in detail.

¹Since May 1982, major changes have taken place in California, Illinois, Massachusetts, and New York which are not reflected in this article. California passed legislation which authorizes the State to contract with a limited number of hospitals to provide Medicaid services. Both Massachusetts and New York passed authorizing legislation, and Medicare and Medicaid waivers have been granted to permit Statewide demonstrations of all payer prospective total revenue control systems. In Illinois, the legislature permitted the Illinois Health Finance Authority legislation to lapse as of October 1, 1982, and the agency has been disbanded.

Most of the programs are revenue-based and are concerned with the total financial needs of individual hospitals. The commission programs, in particular, attempt to limit the total revenue collected or received by a hospital to the individual hospital's total financial needs. This revenue limit is largely independent of whether or not payment rates are being set for all purchases of hospital services. For instance, the Connecticut program has direct control of only charges. However, when Connecticut hospitals set their charges they must consider third-party payer contractual allowances and the impact of those discounts on the total amount of revenue expected from Blue Cross, Medicare, and Medicaid. In contrast, all payer rates are directly controlled by the Maryland Commission under a demonstration program sponsored by Health Care Financing Administration (HCFA). However, Maryland hospitals also must consider the discounts on charges granted by the Commission to Blue Cross, Medicare, and Medicaid when setting their charges.

The cost-based systems are primarily used for establishing a reasonable payment rate for a hospital, given the cost of delivering care in the hospital (where cost is defined according to a payer's principles) and in other comparable hospitals. The cost-based systems are mainly Blue Cross and Medicaid; these prospective reimbursement programs use very similar definitions of hospital costs. However, these programs may apply to a total hospital budget as they do in Rhode Island. Further, if the payment unit is based on charges, the cost-based system, in effect, limits total revenue, because charges must be set consistently for all payers.

A major distinction is often drawn between budget-review systems and formula approaches to rate setting. But while hospital budgets continue to be the primary focus of most programs, the States have increasingly used formulas and statistical screens in their review procedures. In many cases, the characterization of a program as a budget-review program means only that a budget submission is required. It does not imply how or whether the budget may be reviewed. Budget screening devices were originally conceived and used to standardize the review process and to pinpoint those areas within a hospital's budget that needed further detailed review. Washington's budget-review program is the most frequently cited example of this screening process. Other budget-review programs use statistical screens to eliminate the budget review entirely, provided a hospital passes an overall test of reasonableness. That is, if a hospital's budget request is less than a specified rate of increase, then the budget review would be suspended.

Although these 17 States do not employ the same organizational structure and procedural criteria for reviewing budgets or setting payment levels, there are a number of basic features generic to each system. These elements include allowable cost definitions, interhospital comparisons, inflation adjustments, and volume adjustments.

The basis for determining the reasonableness of a budget request or for projecting a prospective rate in a future year is almost always the hospital's expenditures in a prior year. Those expenditures are routinely reported according to standardized definitions of allowable costs which follow Medicare definitions very closely. When differences occur, they normally are due to different policies on capital costs or other revenue considerations such as bad debt and charity.

Most of the programs rely heavily on interhospital comparisons to identify excess cost in the base year. The programs do use a broad range of characteristics and methods for group hospitals considered to be similar or peers, so that comparisons between hospital costs in most areas of operation are considered reasonable. For instance, the general feeling is that only hospitals of similar size and/or with similar teaching activities should be compared to each other.

Once hospital groups are established, indicators of a hospital's performance are compared with the performance of other hospitals in the group. These screens may be at the total hospital level such as cost per admission or at the departmental level such as cost per lab test. In order to determine whether the hospital exhibits inefficient behavior, a standard of comparison or screening level for the group is constructed. Screening values may be set at the average or mean for the group, at some value higher than the mean (for example, 110 percent of the mean), or at the median or higher percentile level (that is, the 75th percentile). The lower the screening parameters are set, the higher become the hospital costs that are identified as excessive. Depending on the type of program, the items of costs which are determined by the screening procedure to be potentially excessive are either subtracted from base costs or are questioned in subsequent hearings on a hospital's budget request.

One of the more critical aspects of a prospective reimbursement program is the rate of price increase allowed for the prospective year. These rates are used to project screened base year costs into prospective rates or prospective budgets. Thus, the selection of inflation indices and the projection or construction of the rate of increased allowance is extremely important to any prospective payment system. Hospitals with actual rates of increase exceeding the allowable rate will be subject to some or all of the risk associated with the difference.

In constructing inflation indices, some programs use national forecasts, some use regional or local forecasts, and others use a combination of both. In terms of accuracy of the inflation indices, it is becoming more and more common to adjust for differences between the forecasted and actual indices in order to minimize the risk due to misprojections for both the hospital and payers.

Most State programs make adjustments to reimbursement levels when volume varies. The volume adjustments incorporated in the programs determine the amount of additional revenue the hospital is allowed to keep when volumes increase, or lose when volumes decrease. The mandatory programs generally limit revenue increases due to volume increases both to provide for the marginal cost of the additional volume and to deter to some extent any unnecessary increases in volume. For instance, New York's volume adjustment varies depending on whether increased or decreased days are due to a change in the average length of stay or number of admissions.

The payment methods used by rate-setting programs have long been held to be extremely important because of the incentives they generate in hospitals. However, the review programs have substituted revenue control features which in many ways parallel the incentives which might be created by the payment methods themselves. In Connecticut, the total revenue budget approved for a hospital is controlled regardless of the payment unit. In Maryland, average revenue per diagnostic case or department specific average revenue per unit of service is controlled, and discounted charges are basically a method of apportioning costs to payers.

There are new payment methods also being used by State programs. In New Jersey, payment rates for diagnosis specific cases are being set and paid by all payers. The Office of Research and Demonstrations in HCFA is sponsoring demonstration programs and funding developmental activities in several States. These efforts include demonstrations that are testing the long-term effects of all payer systems (Maryland), area-wide budgeting (Rochester, New York), payment on a diagnosis-specific per-admission basis (New Jersey), and research to incorporate case-mix adjustments in reimbursement systems (New York).

The major characteristics of each of the 17 legislated programs are summarized in Table 1.

TABLE 1
State Legislated Hospital Cost-Containment Programs

	Responsible Agency	Type of System	Voluntary Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Arizona	Department of Health Services, local HSAs	budget/rate review	mandatory review, voluntary compliance	charge-based, including Blue Cross	total revenue	charges	prior to any rate change	not applicable	not applicable
California	California Health Facilities Commission	disclosure	mandatory disclosure	not applicable	not applicable	not applicable	annually	not applicable	not applicable
Connecticut	Commission on Hospitals and Health Care	budget/rate review and approval	mandatory	charge-based	total revenue	charges	annually	inflation, volume, unforeseen and material change in expense	public hearing before Commission
Florida	Hospital Cost-Containment Board, State Insurance Department	disclosure/rate review	mandatory disclosure, voluntary compliance	not applicable	not applicable	not applicable	annual disclosure; rate reviews as necessary	not applicable	not applicable
Illinois	Illinois Health Finance Authority	budget/rate review and approval	mandatory	all payers	total revenue	charges	annually and as necessary	inflation, volume, cost beyond control	public hearing before Authority
Maine	Health Facilities Cost Review Board: Voluntary Budget Review Organization	budget/rate review	mandatory review, voluntary compliance	charge-based	total revenue	charges	annually	not applicable	not applicable
Maryland	Health Services Cost Review Commission	budget/rate review and approval	mandatory	all payers	total revenue, departmental revenue, guaranteed revenue per case	charges	as necessary	inflation, volume, cost beyond control	public hearing before Commission

**TABLE 1 (continued)
State Legislated Hospital Cost-Containment Programs**

	Responsible Agency	Type of System	Voluntary Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
Massachusetts	Massachusetts Rate-Setting Commission	budget/rate review and approval	mandatory	charge-based	total revenue with cost limit	charges	annually	inflation, volume, cost beyond control	Division of Hearing Officers
		contract/cost/rate review and approval	mandatory	Blue Cross	cost-based	percent of approved budget	annually	Excess costs may be denied.	courts
		modified formula base	mandatory	Medicaid	cost-based with limits	per diem	annually	uncontrollable costs associated with change in government regulations	Division of Hearing Officers
Minnesota	Department of Health; Minnesota Hospital Association	budget/rate review	mandatory review, voluntary compliance	charge-based, including Blue Cross	total revenue	charges	annually and when requested during year	inflation, volume	Department of Health public hearing before independent hearing examiner; Minnesota Hospital Association-hearing before appeals panel
New Jersey	State Department of Health; New Jersey Hospital Rate-Setting Commission	budget/rate review and approval	mandatory	all payers	total revenue	rate per case and controlled charges	annually and when requested during the year	retroactive for volume, economic factor, pass-through items	formal appeal before Commission

TABLE 1 (continued)
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New York	State Department of Health	rate setting	mandatory	Medicaid and Blue Cross	cost-based	per diem	annually	retroactive for actual economic factor and volume	formal appeal before State hearing officer
		charge control	mandatory	charge-based	charge increase	charges	as necessary	actual economic factor	Appeals Board
Oregon	State Health Planning and Development Agency	budget rate review	mandatory review, voluntary compliance	charge-based, including Blue Cross	total revenue	charges	annually and when requested during year	not applicable	not applicable
Rhode Island	State Budget Office; Blue Cross of Rhode Island	negotiated budget/rate review and approval	mandatory	Medicaid and Blue Cross	total expenses/revenue	percent of charges	annually	retroactive volume	binding arbitration before independent mediation
Virginia	Virginia Health Services Cost Review Commission; voluntary cost review organization	budget/rate review	mandatory review, voluntary compliance	charge-based	departmental revenue	charges	annually and when requested	not applicable	not applicable
Washington	Washington State Hospital Commission	budget/rate review and approval	mandatory	charge-based, including Blue Cross	Total revenue; rates per unit of service by revenue center	charges	annually	volume	formal hearing before Commission or independent hearing officer

TABLE 1 (continued)
State Legislated Hospital Cost-Containment Programs

	Responsible Agency	Type of System	Voluntary Mandatory	Payers Covered	Revenue Control Method	Unit of Payment	Frequency of Review	Adjustments	Appeals
West Virginia	Department of Health	disclosure/ rate review	mandatory disclosure, voluntary compliance	not applicable	not applicable	not applicable	annual disclosure; rate reviews as necessary	not applicable	not applicable
Wisconsin	State Department of Health, Rate Review Committee	budget/rate review and approval	mandatory	charge-based, including Blue Cross	total revenue	charges	prior to any rate change, usually limited to one per year	none	hearing before independent appeals board

Arizona

The Arizona system of rate review involves mandatory participation and voluntary compliance by all hospitals. Applications for rate increases are reviewed by the State Department of Health Services and the local Health Systems Agencies.

Responsible Agency

State Department of Health Services and Local HSAs

The regulations governing reporting requirements are issued by the State's Department of Health Services (DHS). The local Health Systems Agencies (HSAs) and DHS both review and comment on proposed rate changes, but only the Director of DHS makes and issues the final decision.

The HSA's review process involves a citizens' panel which is selected by the chairman of the HSA project review committee. The DHS review process is performed by its Bureau of Health Economic and Planning Service (BHEPS). If disagreements regarding the final decision arise, BHEPS may convene an advisory committee, the Health Economics Committee (HEC), to conduct its own public hearing and advise the Director of DHS.

Payers/Facilities Covered

This system includes all charge-based payers (Blue Cross is charge-based) in all non-Federal hospitals and nursing care institutions.

Statute and Date

Arizona Revised Statutes: Title 36, Chapter 4, Article 3 and Title 36, Chapter 1, Article 1.1, 1971 and amendments in subsequent years.

Methodology of Current Program

The State Department of Health Services has implemented uniform accounting and annual reporting systems for hospitals. Hospitals and nursing care institutions may file for a change in rates at any time, although most file notices of rate increases which will be in effect at the beginning of their next fiscal year. These notices must be filed at least 60 days prior to the implementation date. The facilities must use DHS standard form number 301 (hospitals) or 302 (nursing care institutions) to supply financial and utilization data for their past, current, and budgeted years.

Both the local HSAs and BHEPS have the responsibility for rate review. The BHEPS and HSA staffs jointly determine completeness of the application. Although the requirements for filing are standard, there are no Statewide guidelines or methodologies for reviewing budgets or evaluating a proposed rate increase.

Some typical elements of the review include: 1) determining if the profit level is reasonable (4 to 7 percent of gross patient revenue), 2) examining 3-year trends in revenues and expenses, 3) checking the relationship between revenue and volume increases, and 4) analyzing 3-year trends in patient mix, length of stay, and admissions. Primary factors considered in the reviews are inflation (salaries, supplies, and utilities), volume changes, and the total financial needs of the institution. Different hospitals may be compared for a particular cost center or area.

The HSA staff analyzes the proposed rate increase and prepares summary information. Within 30 days after the filing date, the HSA holds a public hearing with a five-to-seven person citizens' panel. Meanwhile, the BHEPS conducts an independent staff analysis. The BHEPS analysis usually agrees with the HSA recommendations, although BHEPS uses a different method for assessing the proposed increases.

The final decision to approve or disapprove rate changes is vested with the Director of DHS who takes into consideration both the HSA and BHEPS findings and recommendations. Compliance with the decision is voluntary by the hospital. However, the hospital must wait until after the 60-day review cycle and post the new rates in a conspicuous place in its main facility prior to implementing the rate change. There are no financial risks or retroactive adjustments in the system.

BHEPS semi-annually publishes an in-depth, comparative study of the rates of all institutions.

Contact for Additional Information

Chief
Bureau of Health Economics
Division of Health Resources
Arizona Department of Health Services
1740 West Adams Street
Phoenix, Arizona 85007

California

The California disclosure system requires all hospitals to submit uniform cost and utilization data. The data are used to develop standards for hospital peer groups. These financial and statistical standards, plus the individual hospital data, are made public.

Responsible Agency

California Health Facilities Commission

The California Health Facilities Commission is an independent State agency charged with the implementation of the California Health Facilities Disclosure Act. The Commission consists of 15 members appointed by the Governor and confirmed by the Senate. The Chairperson of the Commission is elected by the Commission and must be a public member. The Commission is supported by a 70-member staff headed by an Executive Director who is appointed by the Commission.

The Commission has authority to require California health care facilities to publicly disclose financial and statistical information. In addition, the Commission is responsible for establishing and maintaining a system of uniform accounting and reports.

Payers/Facilities Covered

Payers are not involved in this disclosure system which includes all hospitals and long-term care facilities (skilled and intermediate care).

Statute and Date

Part 1.7 of the California Health and Safety Code, the California Health Facilities Disclosure Act: 1971.

Methodology of Current Program

This disclosure system has two components; one for hospitals and one for long-term care facilities. The hospital component involves three separate activities: annual financial and statistical reporting, quarterly financial and utilization reporting, and discharge data reporting.

Hospital Disclosure Program

HOSPITAL ANNUAL FINANCIAL AND STATISTICAL REPORTING

Hospitals are required to file a disclosure report containing financial and statistical information within four months of the close of their particular fiscal years. Each disclosure report contains information about the operation of the facility such as its ownership, costs, revenues, patient days, number of beds and services. Copies of this original report are made available for public viewing or purchase. The Accounting and Reporting Systems Branch then prepares the reports for entry into the Commission's data base. Data Systems prepares edit documents which indicate errors or problems with the reports. Corrections are made by the hospitals and incorporated into the data base.

Finally, a computer-generated disclosure report is prepared which performs major calculations for the hospitals such as allocating indirect costs, computing hourly wage rates, and determining costs per unit of service. This, together with a summary hospital report and "Hi-Lo Range" report (which indicates cost centers which are high or low compared to Statewide averages) is mailed to each hospital. The public may view or purchase these complete computer-generated reports.

All the information contained in these individual hospital reports is maintained in the Commission's comprehensive data base. From this data base the Commission produces annual summary reports on hospitals, including *Aggregate Hospital Data for California and Individual Hospital Data for California*. It also prepares special studies and research analyses including the *Economic Criteria for Health Planning Report* which presents expenditure estimates and standards of effectiveness for hospitals. The public may purchase special analyses of the data base on request.

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORTING

On January 1, 1981, the Commission initiated the collection and disclosure of quarterly summary data from each California hospital. Thirteen data items are collected, 12 of which are specified by law. The thirteenth, physicians' professional component expense, is requested by the Commission to facilitate adjustments that assure comparability of the data. Reports of both aggregate and individual hospital quarterly data are published each quarter. The purpose of these reports is to monitor the progress of the Voluntary Effort in California.

HOSPITAL DISCHARGE DATA REPORTING

The Commission is implementing a new program to collect data on the more than three million discharges from California hospitals which occur each year. The legislation establishing this reporting system specifies 12 data items to be reported on each discharge, namely: date of birth, sex, race, zip code, admission date, source of admission, type of admission, discharge date, principal diagnosis, principal procedure, disposition of patient, and expected source of payment.

It is anticipated that data will be available from this new system beginning in early 1983, covering the period of July 1, 1981 through June 30, 1982.

Long-Term Care Facility Annual Financial Reporting

The Commission annually collects and discloses a broad range of financial and service information on each skilled nursing and intermediate care facility in California. The Commission, working with the Department of Health Services, has integrated the Commission's disclosure report and Medi-Cal's cost report to reduce the reporting burden on long-term facilities. Each long-term care facility is required by law to submit a comprehensive report of its financial and service operations annually within four months of the end of its fiscal year.

These reports are subjected to the same kind of rigorous automated and manual review to assure completeness and accuracy as are the annual hospital disclosure reports. These data are available beginning with the first long-term care facility reporting period (fiscal years ending December 31, 1977 through December 30, 1978).

All the information contained in the individual long-term care facility reports is maintained in the Commission's comprehensive data base. From this data base, the Commission produces annual summary reports on long-term care facilities, including *Aggregate Long-Term Care Data for California* and *Individual Long-Term Care Data for California*. It also prepares special studies and research analyses including the *Economic Criteria for Health Planning Report* which presents expenditures estimates and standards of effectiveness for long-term facilities.

Hospitals or long-term care facilities may make appeals to the Appeals Committee of the Commission.

Contact for Additional Information

Executive Director
California Health Facilities Commission
State of California
717 K Street, Room 100
Sacramento, California 95814

Connecticut

Hospitals are required to annually submit financial data to the Commission on Hospitals and Health Care which establishes prospective revenue budgets for each hospital as well as rules on certificate-of-need requests. The purpose of the system is to lower health care costs throughout the State by encouraging efficiency in hospital management and coordination of use of facilities and services.

Responsible Agency

Commission on Hospitals and Health Care

The Commission on Hospitals and Health Care consists of three full-time members appointed by the Governor to represent the public, providers, and financial management respectively. The Commission has direct authority to review and approve hospital operating and capital expenditure budgets. In addition, the Commission may, at its discretion, review the budgets of other nongovernmental health care facilities and institutions. Further, the Commission grants certificates-of-need.

Payers/Facilities Covered

Participation and compliance by all nongovernmental hospitals in budget and rate review are mandatory. Participation and compliance by all health care facilities and institutions in certificate-of-need review are also mandatory.

The system includes all charge-based payers directly and other payers indirectly through revenue budget controls.

Statute and Date

Public Act 73-117 Connecticut GSA 19-73a through 73t, as amended, July 1973.

Methodology of Current Program

Hospitals are required to submit detailed cost, revenue, and statistical data for the past, current, and budget years, by using a uniform reporting system. The budget year reviewed begins October 1.

If a hospital's budget year expense per equivalent admission is less than its current year authorized expense per equivalent admission plus inflation plus 2 percent, the hospital is exempt from a detailed budget review. If the hospital fails the initial test, the review process then considers the overall financial requirements of the hospital to establish an approved net revenue figure. The process begins by applying an "overall reasonableness test" (ORT) screen to the hospital operating budget. To pass the screen, the hospital budget must meet five conditions defined by State regulations. In essence, the net revenue and

gross expenses for the budget year must not exceed the current year's net revenue by more than the hospital's inflation factor plus 2 percent, and the hospital's forecasted price increase cannot exceed its inflation factor. In addition, the Commission must be satisfied that the hospital meets the statutory criteria which the Commission must consider in reviewing budgets.

Hospitals that fail the ORT are subject to more detailed review and analysis. The Commission first evaluates the reasonableness of the hospital's projected expenses by classifying hospitals into peer groups.

Within each peer group a hospital's base year (current year) costs are compared in three aggregations of cost centers: general services, routine services, and ancillary services. Units of services used to measure costs are: adjusted patient days for general services, patient days for routine services, and adjusted discharges for ancillary services. If a hospital's cluster costs exceed 105 percent of the median for the group, the individual cost centers within the cluster are also screened. Within each cost center, any amounts in excess of 105 percent of the median costs for the group are challenged. Reasonable base-year costs are then adjusted for inflation, volume, and non-volume changes to establish reasonable, prospective, budget-year expenses. The inflation factor is a composite index to predict the impact of inflation on the cost of hospital services. The index is based on proxies of actual hospital expense categories which are external, but comparable to the hospital industry. Certain types of expenses, such as depreciation, interest, and physicians' salaries, are individually evaluated.

Volume adjustments are calculated by distributing gross revenue across all revenue producing centers. For each revenue-producing center, the average revenue per unit of service for the center, that is, relative value unit (RVU), patient day, etc., are determined. Hospitals are entitled to 50 percent of the revenue attributed to increased units of service.

Non-volume changes consist primarily of new or expanded services. The adjusted budget-year expenses are then compared to the requested budget-year expenses. The operating expense budget base becomes the lower of the two.

In addition to the operating expense budget, the Commission also considers required working capital, bad debts, and other financial requirements, along with nonoperating income excluding philanthropic funds. Total revenue for working capital and bad debts may not be greater than 14 percent of the gross revenue budget.

The Commission then orders a net revenue budget and a capital expenditures budget for the hospital. The hospital's net revenue budget and the current portion of the approved capital expenditures budget are translated into a schedule of charges.

The facility is at risk for all revenues or expenses in excess of the approved level (adjusted for volume and inflation). Any excess or shortfall in revenue is applied to the next year's financial requirements.

The only retroactive adjustments are for changes in budgeted volume and for inflation. The facility may request an adjustment during the year, however, to meet unforeseen and material change in expenses.

The facility may informally review its requested budget with the Commission and attempt to work out a proposed negotiated settlement during its budget process. If the hospital disagrees with the initial Commission decision, it may request a public hearing of record before the Commission.

Contact for Additional Information

Chairman
Commission on Hospitals and Health Care
340 Capitol Avenue
Hartford, Connecticut 06115

Florida

The Florida cost review and disclosure system involves mandatory participation and voluntary compliance by all hospitals. The Hospital Cost Containment Board uses a screening methodology to identify high-cost hospitals which must undergo a budget/rate review at a public hearing.

Responsible Agency

Hospital Cost Containment Board (Department of Insurance)

The 1979 Florida Legislature enacted a law giving the State Insurance Commissioner the power to review individual hospital budgets and specify a uniform system of financial reporting based on a uniform chart of accounts.

The legislation located the nine-member Hospital Cost Containment Board in the Department of Insurance. The Board is composed of three major health care purchasers (including at least two representatives from the health insurance industry), three health care providers (including at least two representatives from the hospital industry and one member of the governing body of a major full-service general hospital), and three consumers (one of whom shall represent the elderly). The Insurance Commissioner, the President of the Senate, and the Speaker of the House of Representatives each make one appointment for each of the three categories, with the representatives from the sub-categories being selected by the President or the Speaker.

The Board members serve 4-year staggered terms. Members may be reappointed to succeeding terms. The Board meets as frequently as necessary but is required to meet at least quarterly.

Payers/Facilities Covered

The system does not directly involve payers, but it does include all hospitals.

Statute and Date

Florida Statutes, Chapter 395, Part II, Section 395.501-395.514, 1979.

Methodology of Current Program

The system is based on the theory that public disclosure of hospital costs encourages economy and efficiency and enables purchasers of care to make informed decisions. The legislation creating this program states that its purpose is to create a Hospital Cost Containment Board to advise the Legislature regarding health care costs, inflationary trends in health care costs, the impact of health care costs on

the State budget, the impact of hospital charges and third-party reimbursement mechanisms on health care costs, and the education of consumers and providers of health care services, in order to encourage price competition in the health care market place.

The Hospital Cost Containment Board is empowered to require the submission of hospital financial and accounting data (other than information relating to the costs of physicians' services, which are billed independently) and has specified a uniform system of financial reporting. The required data include, but are not limited to 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 the expected useful life of the property and equipment involved. Also required from each hospital is a current schedule of charges, as well as any subsequent amendments or modifications of the schedule. The legislation specifically prohibits the Board from adopting a uniform accounting system. Training sessions are being conducted to familiarize the hospitals with the reporting requirements.

In order to allow meaningful comparisons, hospitals are grouped according to characteristics including size, range of services, geographical differences, special services, cost centers, and duration of care.

The Board uses a budget-screening methodology to initiate reviews of hospitals' budgets, projected annual revenues, and the rates and charges proposed to generate those revenues. If a hospital's rates and charges or other statistical indicators (such as percentage increase in rates over the preceding year) are in the upper 20 percent of such indicators for a comparative group of hospitals, the Board is authorized to review the budget at a public hearing. In addition, the Board can review the extent to which a hospital's revenues exceed its expenses. The findings of any such hearing are published in the largest general circulation newspaper in the county in which the hospital is located.

The Board also is required to publish annually an in-depth study comparing the rates and charges and other relevant information of all hospitals, both State-wide and by county.

There is no appeal system because compliance is voluntary.

Contact for Additional Information

Information Officer
Hospital Cost Containment Board
Department of Insurance
350 Larson Building
Tallahassee, Florida 32301

Illinois

The Illinois prospective payment system will establish maximum aggregate revenue limits for each hospital. Emphasis will be upon monitoring the rate of increase in hospital revenues rather than upon examining past expenditure patterns. The purposes of the system are to ensure equity among payers and to contain the rise in hospital costs, while providing hospital administrators with maximum latitude in managing their institutions efficiently and effectively.

Responsible Agency

Illinois Health Finance Authority

In 1978, the Illinois Legislature enacted Public Act 80-1427, establishing the Illinois Health Finance Authority (IHFA), with five voting and five nonvoting members. The five voting members, no more than three of whom may be from the same political party, are four public members and one hospital trustee. The Director of Public Aid serves as an ex-officio, nonvoting member. The other four nonvoting members must be two hospital administrators and two representatives of third-party payers.

The IHFA has a full-time professional staff to develop, implement, and administer the prospective payment system.

Payers/Facilities Covered

The statute requires mandatory participation and compliance by all non-Federal hospitals provided all payers accept the rates. Medicare and Medicaid have agreed to participate on an experimental basis.

Statute and Date

Public Act 80-1427, 1978 (Illinois Rev. Stat. ch. 111 1/2, section 161 *et seq.*).

Methodology of Current Program

The IHFA's program is a dual-track system focusing on aggregate hospital revenue. Each year a hospital chooses to either accept a formula-generated aggregate revenue cap or submit to a detailed review of its proposed budget by the Authority. In the first year a hospital is on the program, the formula-generated revenue cap is derived from base-year costs. In subsequent years, the revenue cap is derived by applying the Authority's rules to the previous year's approved revenues. The budget-review track subjects the hospitals to a detailed comparison of costs with peer group hospitals. A hospital seeking a budget review may receive more or less than the

formula-generated revenue cap, whereas a hospital accepting the formula-generated revenue cap is guaranteed the amount and, hence, can calculate its revenues in advance.

The formula used to develop the first year revenue cap works from a hospital's base-year costs, as reported on the Authority's uniform cost report. These costs are trended forward, taking into account hospital market-basket inflation, changes in volume, and the growth of medical technology. Revenue allowances are then added to the costs. These account for capital expenditures, working capital, uncompensated care, and a mark-up to cover differentials and discounts that are approved by the Authority. In subsequent years, the trending starts from previously approved revenues, but adjusted retroactively to account for unanticipated inflation or volume. (The inflation adjustments are made solely on changes in exogenous indexes; the volume adjustment works on marginal costs so as to avoid incentives for unnecessary volume increases.)

Pending continuation of the Enabling Legislation currently scheduled to sunset on October 1, 1982, hospitals are to be phased into the system over a 36-month period starting December 1, 1982. The IHFA has established an effective date for each hospital corresponding to the hospital's fiscal year. Each hospital must submit its proposal for rate change at least 90 days prior to its effective date. The IHFA then has 60 days to issue a rate order unless the submitted data are insufficient. In such cases, the 60-day period is suspended until receipt of sufficient data. Upon receipt of the rate order, a hospital has 15 days to request a rate reconsideration. If the IHFA does not act upon the appeal request within 15 days, the request is considered denied.

In accordance with the IHFA's Enabling Legislation, all hospitals, purchasers, and third-party payers must recognize and accept the approved rates as payment in full. Five-year waivers of Medicare and Medicaid reimbursement principles have already been approved by the Health Care Financing Administration. Each hospital will retain any savings achieved within the approved rate and bear any deficits incurred in excess of that rate.

Contact for Additional Information

Executive Director
Illinois Health Finance Authority
123 W. Madison Street
9th Floor
Chicago, Illinois 60602

Maine

The current program in Maine mandates the submission and prospective review of all hospital budgets. The purpose of the system is to encourage voluntary cost containment among providers.

Responsible Agencies

Health Facilities Cost Review Board and the Voluntary Budget Review Organization

The Health Facilities Cost Review Board, a State agency, consists of 10 members. Of the 8 members appointed by the Governor, 5 are consumer representatives and 3 are industry or provider representatives. In addition, the Commissioner of Human Services or his/her designee serves as an *ex-officio* voting member. The Superintendent of Insurance or his/her designee is also an *ex-officio* nonvoting member.

The Board, in accordance with the statute, has designed the Voluntary Budget Review Organization (VBRO) as the organization approved to carry out the budget review provisions of this act. VBRO is a non-profit organization with 17 directors, the majority of which are public or payer representatives with the remainder from providers. In turn, the VBRO Directors appoint a Hospital Budget Review Panel which issues the final ruling on the reasonableness of a hospital's proposed budget.

Payers/Facilities Covered

Participation is mandatory and compliance is voluntary by all non-Federal hospitals.

Statute and Date

Section 1.22 MRSA, Chapter 105, Health Facilities Information Disclosure Act, April 1978. The Maine Legislature recently approved the continuation of the Act to July 1, 1983. The Act had previously been scheduled to sunset on July 1, 1982.

Methodology of Current Program

Hospitals are required to annually submit a prospective budget to the VBRO 90 days prior to their new budget year. The formal budget review process consists of comparison of various expense and revenue reference values calculated for each hospital. Comparisons are performed according to hospital peer groups determined by service costliness indices, bed size, cluster analysis, etc.

The first reference value considered is the percent change target (PCT). Each calendar quarter, the VBRO publishes a PCT based on an economic projection of the market-basket inflation rate. A hospital's percent change (budget year over current year) in total operating revenue per adjusted admission is compared to the predetermined PCT. Budgets that are within 10 percent of the PCT are then subject to the revenue screen, which is based upon the lowest quartile value of the peer group for net patient revenue per adjusted admission.

If a budget does not meet the PCT test, or if it fails the revenue screen, it is subjected to an expense screen which is based upon the median value of the peer group for total operating expenses per adjusted admission. If a hospital's value is greater than the peer group value, a detailed budget review is undertaken.

If a hospital is not included in a peer group because of unique characteristics, or if the budget failed the expense screen, the hospital is subjected to a detailed analysis to determine the reasonableness of the budgeted operating expenses.

In addition to the comparison of reference values and/or detailed budget review, each hospital's budgeted operating margin (other financial requirements) is reviewed for reasonableness. The other financial requirements such as capital, working capital, and bad debt expense are considered on an individual hospital basis.

When the analysis of the complete proposed budget is finished, staff findings are prepared in a draft which is reviewed with the hospital.

A finalized staff report is then sent to the hospital and to the members of the Hospital Budget Review Panel approximately 15 days before the panel is to meet on the hospital's budget submission. Approximately 30 days before the beginning of the budget period, the panel reviews the budget submission for reasonableness. All panel meetings are closed; however, hospital representatives are invited to attend to answer questions or to provide additional information.

The Hospital Budget Review Panel, after completion of its review and meeting with the hospital, prepares and issues a letter setting forth its opinion as to the reasonableness of the proposed budget. This letter is sent to the hospital within 3 days of the meeting. A copy of the opinion letter and the budget executive summary is sent to the Health Facilities Cost Review Board (State Board) within 30 days of the review meeting.

Contact for Additional Information

President
Voluntary Budget Review Organization of Maine
One Memorial Circle, Box 8
Augusta, Maine 04330

Maryland

The Maryland rate-setting system uses a quasi-public utility approach to hospital rate regulation in which rates are set and then adjusted for such items as inflation, volume changes, and pass-through costs.

Responsible Agency

Health Services Cost Review Commission

The Health Services Cost Review Commission is a seven-member independent commission appointed by the Governor. A majority of the Commission must not have any connection with the management or policy development of any hospital or related institution.

Prospective rates are developed by a full-time professional staff operating under regulations issued by the Commission. In addition to promulgating reimbursement rates, the Commission has the authority to hold public hearings, conduct investigations, and require the submission of data relevant to the cost of hospital services.

Payers/Facilities Covered

The system includes all payers in all non-Federal hospitals. Medicare and Medicaid participate on an experimental basis.

Statute and Date

Article 43, Section 568H through 568Y, Annotated Code of Maryland, July 1973, with subsequent amendments.

Methodology of Current Program

Hospital rate-setting in Maryland currently consists of three systems: rate review, inflation adjustment, and the Guaranteed Inpatient Revenue System.

A rate-review system is used to develop an initial set of rates per unit of service in the various revenue producing departments. Under this system, all hospitals are required to submit data annually on base and budgeted years, using a uniform accounting and reporting system. The total approved revenues are based on four component parts: direct and allocated indirect departmental expenses, other financial considerations (including bad debt, charity and working

capital), a payer differential, and a capital facilities allowance for buildings and equipment. The capital facilities allowance is used in place of historical cost depreciation to allow hospitals to be paid for equipment used at a level which allows replacement at current market prices. It also provides for a down payment for buildings at 20 percent of current market prices for those hospitals which are used effectively, or it provides payment of the hospital's mortgage payment, whichever is higher. The rate-review system is applied relatively infrequently because most hospitals now receive rate increases under the Inflation Adjustment System; however, the hospital, at its option, can request a new schedule of rates under the system.

The Inflation Adjustment System was instituted to allow hospitals reasonable rate increases while avoiding the administrative burden of full rate-review. It considers inflation adjustments, volume adjustments, changes in payer and case mixes, and certain pass-through costs.

Inflation adjustments are made for: 1) salaries and fringe benefits, and 2) food, supplies, utilities, and other expenses. The inflation adjustment system has three components. First, the retroactive provision compensates the hospital for the past year if actual inflation was greater than the projected rate. (Conversely, if the actual rate is lower than the projected rate, then a deduction will be made in the budget-year rate.) Second, if a correction needs to be made, a price-leveling adjustment brings the rates to the level where they would have been if the inflation rate had been projected accurately. Finally, the provision for future inflation is established at a level equal to the most recent changes in inflation.

Volume for the prospective year is established at a level equal to the actual volume for the current year. Different fixed-variable cost proportions have been established for the routine and ancillary areas as well as for different magnitudes of volume changes.

Costs are considered pass-through if they fall into one of two categories. The first category is costs mandated by the State or Federal government that affect all hospitals. Past examples of this type have included increases in the minimum wage law and changes in the FICA tax rate. The second category includes increases in costs greater than the CPI that affect the hospital industry more than other industries. For example, the Commission would approve an amount to be included in the hospital's rates for increases in FICA taxes associated with a change in Federal regulation on FICA tax on sick pay.

The Commission instituted the Guaranteed Inpatient Revenue (GIR) System because of concern that the present system, based on rates per units of service, was leading to increased volume and overuse of hospital services. The GIR system, currently installed in 21 hospitals, seeks to control the volume of ancillaries and lengths of stay. It guarantees payment for each case treated by the hospital. The GIR system determines the average charge for each diagnosis for each type of payer. The average charge is adjusted for inflation and a 1 percent factor for growth and technology. The total GIR payment is the product of discharges (by diagnosis and payer) and adjusted charges. At year's end, the GIR payment is compared to the revenue from the Commission-approved rates charged by the hospital during the year. If the revenue from rates is less than the GIR payment, the hospitals will receive the variable cost portion of the savings. However, if the revenues exceed the GIR payment, the Commission will recoup the additional funds from the hospitals in the following year.

If the facility is not satisfied with its initial rates, it may request a detailed budget review. If dissatisfied with the outcome of the budget review, it may request a hearing before the Commissioners. If still dissatisfied with the decision of the Commissioners, its recourse is to the courts.

Contact for Additional Information

Executive Director
Health Services Cost Review Commission
201 West Preston Street
First Floor
Baltimore, Maryland 21201

Massachusetts

The Massachusetts budget/rate review system uses different methodologies for Medicaid, Blue Cross, and charge-based payers. Medicaid uses a formula method to set a *per diem* which is trended forward for inflation. Blue Cross reimburses on the basis of prospectively determined maximum allowable cost. The charge-based payers pay approved charges which cover financial needs.

Responsible Agency

Massachusetts Rate Setting Commission

The Massachusetts Rate Setting Commission consists of three Commissioners and a full-time professional staff. The staff is supported by an Advisory Council, consisting of representatives from the public and the health care industry. In addition, a Hospital Policy Review Board oversees activities related to hospital charges and budget reviews. The Board's authority is limited to review and comment on proposed rules and regulations.

Payers/Facilities Covered

The system includes all charge-based payers in all non-Federal hospitals. Rates also are set separately for Medicaid, using a prospective methodology. The Commission approves the Blue Cross contract with hospitals and conducts Blue Cross and Medicaid audits.

Statute and Date

Blue Cross: MLG c. 176A, s. 5. Public Assistance (including Medicaid): MGL c. 6A, ss. 31-48. Charge Payers: Chapter 409 of the Acts of 1976; Chapter 432 of the Acts of 1981.

Methodology of Current Program

The Massachusetts Commission is unique in that it uses different methodologies to determine the reimbursement rates for different payers.

Medicaid

The Medicaid prospective rate system is a formula system that sets an inpatient *per diem* rate. Hospitals are required annually to submit historical costs by using uniform reporting. A 2-year base is used in the prospective rate system, and the base-year operational costs cannot exceed the cost of the prior year by more than an approved inflation index. Allowable

base-year costs are defined in Rate Setting Commission regulations which closely relate to Medicare definitions of allowable cost and are verified with audited data.

The Medicaid inpatient rate is established, in simple terms, by dividing total allowable patient care costs in a completed "base" year by total acute inpatient days in that year. The resulting "per diem" rate is projected forward 2 years to the "rate" year by applying a composite, industry-wide inflation factor to it. The inflation factor is based on inflation rates in certain proxy variables (for example, X-ray films, purchased services, etc.) drawn from the general economy. The basic aim is to hold the increase in hospital costs per day to rates consistent with general inflation experience.

Volume adjustments, with the exception of minimum occupancy levels, are recognized only through changes in the volume of patient days. Minimum occupancy levels vary according to type of services and type of hospital (teaching and nonteaching). In addition, routine costs (bed and board) are subjected to Medicare routine *per diem* limitations. Administratively necessary days are reimbursed at a rate, determined for each hospital, which more closely reflects the level of care mandated by Federal and State statutes, with a provision for adjustment if adequate patient placement efforts are documented.

While there are no retroactive adjustments, revisions for cost beyond control, for audit adjustments, and for various other administrative reasons are permitted during the year. The facility is at risk for any overexpenditure, and keeps any profits resulting from cost savings until these lower costs are reflected in the base year.

Charge Payers

Under Chapter 409, hospitals are required annually to submit past, current, and prospective year costs so the Commission can review individual budgets. The hospital submits these budgets to the Commission 60 days before the beginning of its fiscal year. The Commission has adopted a uniform reporting manual. Hospitals also report case-mix data on magnetic tapes according to the Uniform Hospital Discharge Data Set (UHDDS) format. In general, the approval process determines reasonable financial requirements for a hospital and then approves a set of charges to cover them. In October 1978, the Commission adopted a definition of "total patient care cost" which reflects the reasonable financial requirements of an individual hospital for providing patient care. The requirements are comprised of three parts: 1) operating requirements, 2) capital requirements, and 3) working-capital requirements. To determine the operating requirement for the budget year, base-year costs are adjusted for inflation, volume, costs beyond control, and new services. The inflation index is comprised of 79 cost categories of trended historical

data. The cost categories are paired with an economic change indicator. Prior to the start of each hospital's fiscal year, the Commission projects values for the rate of increase in each indicator. The Commission also develops a separate index for each category for the intermediate and budget years. The inflation factors for the intermediate year are based on both actual data and projections, while the budget year index is forecasted. The base-year costs in each category are indexed forward to the budget year.

The second major adjustment is for changes in volume. Hospitals receive marginal cost adjustments calculated as direct costs using a 60:40 fixed/variable split with a 2-percent downside corridor. The volume statistics are overhead-adjusted patient days, routine-patient days, ancillary department's statistics, and outpatient visits.

The operating requirement for the budget year is adjusted for two other factors: costs beyond control and new services. Costs beyond control are cost increases which are "beyond the reasonable control of the individual hospital" and are not adjusted by inflation and changes in volume. These costs (including approved certificate-of-need projects) are added to the intermediate and budget year operating costs. New services, which are defined as new cost centers, are approved as part of the budget year operating costs if they meet planning approval and if the net patient revenue from the new service is less than or equal to the reasonable financial requirements of the new services.

The other reasonable financial requirements are the capital and working-capital requirements which, together with the hospital's operating requirement, yield the total reasonable financial requirements for a hospital. The capital requirements consist of 1) building and fixed equipment historical cost depreciation for the budget year, 2) interest expense for the budget year, and 3) the return on investment for proprietary hospitals. The working-capital requirement is an allowance sufficient to finance the increase in accounts receivable due to inflation, taking into account the expected growth in accounts payable.

In July 1980, interim provisions to the charge control act were enacted in C.540 which placed an 11-1/2 percent inflation cap on charge increases for Fiscal Year 1981. This cap was succeeded in FY 1982 by C.432 which included a 1-1/2 percent "productivity" offset against inflation and used approved FY 1981 revenues as a base for calculating allowable FY 1982 revenues. The 1982 cap incorporates a voluntary review by regional hospital councils to comply with the inflation cap on a regional basis, if the overall cap is exceeded at the State level. This voluntary review was backed up by the authority of the Commission to adjust hospital charge increases in those instances where the voluntary rule was not effective.

The Massachusetts Rate Setting Commission is developing changes to charge control regulations so as to replace the use of actual costs as a base for future budgets with hospitals' most recently approved maximum allowable base-year operating cost.

Blue Cross

Until FY 1982, all Blue Cross contracts were based on methodologies which were essentially similar to Medicare cost-based reimbursement, with the additional elements of price-level depreciation on all assets, working capital allotments, and coverage of bad debt and charity expenses.

Blue Cross and the hospitals entered into a new prospective reimbursement agreement for FY 1982-FY 1984. This contract uses an inflation system which is very similar to the C.409 methodology, with additions to the base year for items such as vacant nursing positions and annualizations for costs not in place the entire year, and the provision that labor cost inflation projections are adjusted if they prove to be low but not if they are high. Volume is recognized through formulas that strongly encourage reductions in patient days and ancillary tests, and increases in outpatient visits. The ancillary volume adjustment guarantees hospitals a small incremental amount to cover increased intensity, but penalizes hospitals which exceed this intensity level. Capital costs are settled on a reasonable-cost basis outside the "maximum allowable cost" (MAC) limitation which governs most operating cost increases. Certain other costs (bad debt and free care expenses, etc.) are settled outside the MAC provisions. Audits are used to determine the reasonable cost of all items settled outside the MAC. A number of committees have been established to review such issues as utilization appropriateness, disputes and proposed experiments with cost-saving projects, etc.

Under the State's administrative procedures act, facilities have the right to appeal non-Blue Cross decisions made by the Commission to the Division of Hearing Officers. If dissatisfied with the outcome at that level, they have recourse to the courts. Blue Cross decisions can be appealed directly to the courts.

Contact for Additional Information

Chairman
The Commonwealth of Massachusetts
Rate Setting Commission
One Ashburton Place
Boston, Massachusetts 02108

Minnesota

The Minnesota rate/cost review and disclosure system involves mandatory participation and voluntary compliance. The Minnesota Hospital Association reviews cost data and rates for peer groups of non-governmental hospitals, and the State Department of Health reviews State hospitals.

Responsible Agencies

State Department of Health and Minnesota Hospital Association

The Commissioner of Health establishes rules and regulations governing the review of hospital budgets and reviews and comments on the reasonableness of the hospital rates. In addition, the Commissioner may certify a program of budget review and comment which is operated by a nonprofit corporation having systems and procedures substantially equivalent to those adopted by the State. Hospitals may choose to be reviewed by the State or any of the certified alternative programs. The Minnesota Hospital Association (MHA) has been designated to administer the Minnesota Rate Review Program (MRRP), and all but the State hospitals have chosen it as the agency that reviews their rates.

Payers/Facilities Covered

The system includes all charge-based payers (Blue Cross is charge-based) in all non-Federal hospitals.

Statute and Date

Minnesota Statute Sections 144.695 through 144.703.

Methodology of Current Program

Hospitals participating in the MRRP are reviewed by a rate-review panel at the beginning of each hospital's fiscal year or at any time a rate increase is requested during the year. Hospitals are required to submit cost and statistical data for past, current, and prospective budget years before the beginning of their fiscal year and at least 60 days before any rate changes go into effect. A hospital may request exemption from review by the panel, based on the submitted data. There is no uniform accounting and reporting system.

The MHA conducts a budget/rate review process to provide information to the rate-review panels. The review process includes an initial desk audit, peer group screens, and an examination of the prospective year's overall expense percentage increase over the current year's projected expenses. The extent to which the hospital complied with the rate-review

panel's prior recommendation also is evaluated. Peer groupings are established by the State through a cluster analysis of 100 characteristics such as types of services, facilities, location, teaching status, and so forth. Within groups, hospital costs are analyzed for variance from the average cost per adjusted admission. The other peer group screens compare the budget year expenses in 15 functional cost categories to the peer group means. The hospital must explain any variances from peer group means.

The MHA convenes the rate-review panels which consist of two hospital representatives, one third-party payer representative, and two consumer representatives. These panels are ultimately responsible for reviewing and commenting on hospital rate requests. Rates must be sufficient to supply the financial resources necessary to meet the hospital's financial requirements.

The projected inflation factor is obtained from the State Department of Health. It is composed of a Statewide inflation factor for each of the various cost categories. The State estimates these inflation factors using monthly forecasts from Data Resources, Incorporated.

Depreciation is indexed forward from historical cost to reflect the impact of inflation, and the need for replacement beds is considered. In addition to analysis of the operating budget, the capital-expenditure budget and projected working-capital needs are reviewed to establish the overall reasonable financial needs of the facility.

There are retroactive adjustments based on changes in volume and actual inflation. A fixed/variable cost ratio has not been established; changes in costs are figured to be directly proportional to changes in volume. An attempt is made to consider the difference in fixed and variable costs in a subjective manner during rate reviews. A facility also may request an interim adjustment at any time during the year.

There are no direct incentives or risks because there is voluntary compliance. However, the Blue Cross contract limits reimbursement to approved rates and performs a compliance review. Revenues in excess of financial needs must be applied against next year's needs, unless the hospital can demonstrate that the revenues were generated through productivity gains. Justified losses also may be offset in the next year's revenue.

The system of hearings and appeals is different for hospitals reviewed by the MHA and those hospitals reviewed by the State.

Minnesota Hospital Association

After informal discussions are held between staff and the facilities, a seven-member review panel (four consumer members, three provider members) examines and rules on all issues. If the facility is dissatisfied with the ruling, it may request another hearing before an appeals panel.

Department of Health

If points of difference cannot be resolved by informal discussions between staff and the facility, a public hearing is held which is presided over by an independent hearing examiner. The findings of the hearing examiner are reviewed by the Commissioner of Health. The final decision is made by the Commissioner, with the advice and consent of the Attorney General.

Contact for Additional Information

For State Hospitals:

Director of Rate Review
Minnesota Department of Health
717 Delaware Street, S.E.
Minneapolis, Minnesota 55440

For Nongovernmental Hospitals:

Director, Rate Review
Minnesota Hospital Association
2333 University Avenue, S.E.
Minneapolis, Minnesota 55414

New Jersey

The New Jersey prospective case-mix-based reimbursement system establishes a fixed payment rate per type of case. Participation and compliance are mandatory. The purpose of the system is to encourage the efficient delivery of health care services of the highest quality through provision of financial incentives and promotion of proper utilization.

Responsible Agency

New Jersey State Department of Health, New Jersey Hospital Rate Setting Commission

Under regulations promulgated by the Health Care Administration Board, the five-member New Jersey Hospital Rate Setting Commission approves or adjusts prospective hospital rates proposed by the Commissioner of Health. The Health Care Administration Board consists of the Commissioners of Health and Insurance (ex-officio) plus 11 additional members appointed by the Governor and confirmed by the State Senate—representing both the public and the hospital industry.

The New Jersey Hospital Rate Setting Commission is an objective, adjudicative organization established within the State Department of Health. The Commissioners of Health and Insurance serve on the Commission ex-officio. Two consumer representatives and one representative experienced in hospital administration or finance are appointed by the Governor, with the advice and consent of the Senate. The Commission selects its own executive secretary and additional staff is provided by the Department of Health. Decisions of the Commission are effected by a majority vote of the full membership.

Payers/Facilities Covered

Participation and compliance by all short-term acute care hospitals are mandatory. All purchasers of hospital services (including Medicare and Medicaid) are under a demonstration waiver.

Statute and Date

New Jersey Health Care Facilities Planning Act, P.L. 1971, Chapter 136 and; 1978 Amendments (Senate Bill 446), P.L. 1978, Chapter 83, 1971 and 1978.

Methodology of Current Program

Since 1976 the New Jersey State Department of Health has been engaged in a contract with the Health Care Financing Administration to develop a hospital prospective rate-setting experiment based on patient case-mix. In 1978, the New Jersey Legislature enacted Senate Bill 446, authorizing the establishment of a new hospital payment system applying to

all providers and purchasers of hospital and related health services. The case-mix system was implemented in 1980 with an initial group of 26 hospitals with all hospitals to be on the system by December 31, 1983.

The system establishes a per case rate of payment specific to each type of patient. Patient types are defined according to the diagnosis related group (DRG) patient classification method—a technique for categorizing hospital inpatients into 467 groups that are both medically meaningful and similar in consumption of hospital resources. The 467 DRGs, a complete refinement of the 383 DRGs originally used, were developed by a national committee in conjunction with a Health Care Financing Administration grant to Yale University.

The rates per case are calculated using three data sets; medical discharge abstracts, patient billing records, and uniform hospital financial and statistical reports. The medical discharge abstract is linked to the patient billing record for the same patient. Starting in 1981, a uniform billing report became mandatory. Each patient is assigned to a DRG according to six variables; principal diagnosis, secondary diagnosis, surgical procedure, age, discharge status, and sex. Financial and statistical data for a base-year come from the Standard Hospital Accounting and Rate Evaluation forms. Cost centers are clustered into direct patient care costs, indirect or institutional costs, and general service costs categories. General service costs (medical records, dietary, housekeeping, laundry and linen, central and sterile supply, and non-drug pharmacy costs) are then allocated to direct patient care costs and indirect cost centers using standard step-down procedures.

Direct-patient-care costs include nursing, ancillary services, and other routine services. Nursing costs are apportioned based on the inpatient days spent by patients of a DRG in different types of nursing units; medical/surgical, intensive care, and newborn nursery. However, starting in 1984, a methodology with a nursing-relative-intensity measure will be used. Inpatient ancillary costs are apportioned to DRGs on the basis of the ratio of charges to charges applied to costs (RCCAC). Outpatient direct costs are prorated on the basis of charges.

Although direct-patient-care costs had been assumed to have been totally variable, a cost/volume adjustment methodology will be introduced in 1982 in recognition of the fact that shifts in volume and/or case-mix are not realistically accompanied by a corresponding shift in costs. The cost/volume adjustment, calculated on trends in case-mix revenue and in volume, will leave compensation costs fixed but all other direct-patient-care costs variable. In 1983, the cost/volume adjustment will be incorporated into the prospective rates.

The direct-patient-care cost per DRG (with ancillary physicians' costs deducted and regional wage differences equalized) is averaged separately across all patients in teaching, in minor teaching, and in non-teaching hospitals to serve as an "incentive standard" for each hospital group. A hospital's base payment rate for the DRG is a "blend" of its own direct-patient-care costs and its group incentive standard, according to a coefficient of variation formula. (As the variability of the cost within a DRG increases among peer hospitals, more of an individual hospital's costs and less of the incentive standard are included in the hospital's base rate for the DRG.)

The resulting figure (with ancillary physicians' costs added back and wage equalization reversed) is then adjusted by a hospital "economic factor" derived from fluctuations in a composite index of economic indicators approximating the inflation in hospital costs for the base-year through the rate-year. This becomes the rate-year's direct-patient-care cost for the DRG. It is multiplied by the hospital-projected, commission-approved patient volume expected during the rate-year for the DRG and is summed with the other similarly calculated DRG costs to yield the total reasonable patient-care costs for inpatients. (Inpatients with lengths of stay above or below certain range limits called trim points, patients who leave against medical advice, patients with unusual clinical conditions, and deaths, are termed outliers. These patients have atypical resource consumption and will pay charges for actual services received instead of DRG-determined rates.)

Outpatient costs are categorized into seven groups: ambulatory surgery, same day psychiatry, home renal dialysis, referred private patients, emergency room services, clinics, and home health. With the exception of referred private patients who pay itemized charges, each category's overhead or routine costs are divided by the number of visits to determine the direct unit cost as a base-rate. These figures are inflated by the hospital economic factor and multiplied by the projected outpatient volumes for the rate-year, to yield the reasonable direct-patient-care costs for outpatients. The ancillary costs for outpatients are treated similarly to outlier costs.

Indirect or institutional costs include operating costs for managerial, educational, and facilities maintenance services. They are considered fixed and not subject to variation because of changes in case-mix or volume. The indirect costs of each hospital are divided by its direct-patient-care costs, resulting in an indirect to direct cost ratio. These ratios for participating hospitals are ranked separately for teaching, minor teaching, and nonteaching institutions. The portion of any hospital's ratio in excess of 110 percent of the median ratio is excluded from the allowable cost base. The indirect costs that pass the screening process as inflated by the hospital's economic factor become the reasonable indirect costs.

Reasonable direct-patient-care and indirect costs are combined with other financial elements (uncompensated care, working capital needs, capital facilities allowance, and personal health allowances) to derive the rate-year's preliminary cost-base (PCB).

To develop a hospital revenue budget from the PCB, reasonable direct-patient-care costs are reaggregated into revenue-producing centers. Reasonable indirect costs and other financial elements are added, and volume projections are applied to yield an estimated revenue budget. The hospital uses this budget to structure its charges and determine the amount that must be billed to patients in the different DRGs so that the revenue collected at the end of the rate-year equals the PCB, adjusted for actual patient volume and case-mix. The charge schedule for any cost center may not deviate from approved costs by more than 50 percent for the first year the hospital is on the system and by 25 percent thereafter.

At the end of the rate-year, a final reconciliation will be derived from patients' uniform bills and audited hospital financial statements to determine differences between the revenue actually collected and the approved revenue budget, adjusted for actual volume and case-mix. For 1982, a volume variability adjustment is included for volume changes that are less than 10 percent between base and rate-years. Any over or under collection, plus interest determined according to the treasury bill rate will be included in the next year's rates.

After rates are set, a hospital is notified of its schedule of rates and receives a complete rate package. Within 30 days, the hospital must: 1) accept the rates, which allow the hospital the right to appeal certain specific items; or 2) not accept the rates. With respect to any appealed exception, the hospital forwards an appeal document, and the Department and the hospital conduct a detailed review. Based on the review and any additional documentation required, the State Commissioner of Health submits a report to the Commission. The hospital may petition the Commission regarding this report. The Commission may render a decision on the merit of the documents to approve the rates, to modify the rates, to hold a hearing, or to refer the appeal to a State Administrative Law Judge.

Contact for Additional Information

Assistant Commissioner
Division of Health Planning and Resource Development
New Jersey State Department of Health
John Fitch Plaza
CN 360
Trenton, New Jersey 08625

New York

The prospective reimbursement system in New York determines maximum allowable revenue per hospital by screening cost and facility utilization patterns. The purpose of the system is to encourage efficiency in hospital management by disallowing high or unnecessary costs. Compliance with the findings of the Department of Health is mandatory.

Responsible Agency

Department of Health

The Commissioner of the Department of Health certifies that proposed rates are reasonably related to the costs of delivering efficient health care services. Rates for Medicaid are certified to the Director of the Budget, rates for Blue Cross are certified to the Superintendent of Insurance, and rates for Worker's Compensation are certified to the chairperson of the Worker's Compensation Board. Rates for Medicaid are developed by the staff of the Department of Health under regulations approved by the State Hospital Review and Planning Council. Blue Cross rates are developed separately by Blue Cross plans by using procedures approved by the Department of Health which are "not inconsistent" with the regulations passed by the Council. The Department of Health reviews the rates developed by the Blue Cross plans before certifying them.

Payers/Facilities Covered

Medicaid, Blue Cross, Worker's Compensation, no-fault insurance, and charge-based payers.

Participation and compliance are mandatory for all non-Federal hospitals.

Statute and Date

Public Health Law Sections 2800 through 2807, 1969 and amendments in subsequent years.

Methodology of Current Program

New York State is striving for a uniform system of reimbursement to include all payers. In New York, the Blue Cross, Worker's Compensation, and Medicaid methodologies are now virtually identical. All three payers use a common grouping system, and all have length-of-stay and minimum-utilization penalties. The Department of Health administers the Medicaid system for all hospitals in the State. Blue Cross rates are set using the same basic system for the downstate New York area and the six separate upstate plan areas. In addition, a charge control law was passed in 1978. This law, effective January 1979, established a panel of health economists who determine the inflation factor methodology for charges. Charges to

charge-paying patients can increase only by the lower of the established inflation factor or the actual increase in costs. Appeals to the charge control limitation can be made to an Appeals Board for significant volume changes or a change in types of services.

Under the 1981 reimbursement system, rates were established on the basis of an average *per diem* cost and trended forward to account for inflation for a particular rate-period. In 1982, the method for allocating cost was changed to a ratio of cost to charges (RCC). This approach apportions the costs of hospital services on the basis of relative consumption of resources, measured in part by charges, for different third-party beneficiaries. RCC produces a closer alignment between the services actually provided to third-party beneficiaries and the actual cost of those services. Final RCC relationships for 1982 will be based on payer utilization information for the full year 1982.

To facilitate the transition from an average cost methodology to an RCC methodology, the rate changes produced by the RCC for each facility were limited to a maximum rate increase of 6 percent above average allowable inpatient cost per day or a maximum rate decrease of 12 percent below average allowable inpatient cost per day for Medicaid and Blue Cross. In addition, hospitals received a minimum rate, such that the combined revenues produced by the RCC rates for Blue Cross and Medicaid were not less than those that would have been received under the average allowable inpatient cost reimbursement methodology for 1982.

For each system, hospitals are required to file a uniform cost report with the State and respective Blue Cross plan within 120 days of the close of the fiscal year. They must use the Uniform Financial Reporting System (UFR, USR), which includes both financial and statistical data. In addition, supplemental data must be filed for both Blue Cross and Medicaid, accounting for differences in coverage.

Medicaid System

The Medicaid formula establishes a *per diem* rate based on actual cost incurred in a base year. Base-year costs are analyzed through inter-hospital group comparisons. An innovative grouping methodology referred to as "seed cluster" grouping was introduced upstate beginning in 1980. Under this approach, a statistical method establishes each hospital as the center of its own group and gathers around that hospital all other facilities which are most similar, as measured by least distances. This method produces a group for every hospital and has the benefit of not excluding any hospitals from consideration in more than one group.

Routine costs are screened against an adjusted group average *per diem* with a 5 percent corridor (105 percent of the group average), and ancillary costs are screened against an adjusted group average per discharge with a 5 percent corridor (105 percent of the

group average). In addition, each hospital's ceiling is further adjusted by the hospital's case-mix. This adjustment is accomplished using diagnosis related groups (DRGs). Those costs in excess of the case-mix adjusted ceiling are disallowed. Next, an excessive length of stay penalty (equal to routine *per diem* times the number of excess days) is applied if appropriate. New York State's length-of-stay (LOS) standard is hospital-specific, taking into account each hospital's unique case-mix. This is done with an age/diagnostic classification system, where a separate LOS standard is developed for each of the resulting 542 different types of patients.

Once the standards are developed, a unique overall standard is developed for each hospital by relating its case-mix to the broader standards (normalization). New York uses four separate sets of standards—upstate teaching, upstate nonteaching, downstate teaching, and downstate nonteaching. The standards for each set were determined by taking the hospitals in each category and averaging the lengths of stay for each type of patient. It should also be noted that a 1-day corridor is added to the length-of-stay standard calculated for a facility.

The base-year costs, exclusive of capital costs and historical cost depreciation (which are pass-through costs), are indexed forward to the prospective budget year. The inflation factor in New York, called a trend factor, comprises labor and nonlabor inflation rates. Hospitals are grouped according to size, geographic location, and type. Each hospital then receives its group's specific wage inflation rate. This rate is derived from the weighted average of inflation rates for hospital and other wages. Under the charge control legislation of 1978, collective bargaining agreements must be considered in determining the wage inflation rate. The second part of the trend factor, the nonlabor rate, is computed in a similar manner by using appropriate inflation indices weighted by the percentage of total expenditures represented by each item.

Capital and depreciation costs are added to the inflation-adjusted base costs to establish the total allowable inpatient cost for the prospective year. This total inpatient cost is divided by patient days (ad-

justed for minimum occupancy levels by service) to determine the *per diem* rate. If the hospital's occupancy rate for a service is below the service's minimum occupancy level, expected patient days at the minimum occupancy levels will lower the hospital's *per diem* rate. New York currently has a volume adjustment which is applied to Blue Cross, Medicaid, and Worker's Compensation rates of payment according to the same rules. Under the rules, operating costs are adjusted for charges in patient days attributed to a change in average length of stay and for charges in the number of discharges. For increases, the variable portion of operating costs is increased. For decreases, the fixed portion of operating costs is reduced.

The facility is at risk for any overexpenditure and may keep any profit resulting from underexpenditure. Each system allows for a retroactive adjustment for actual variance in the economic factors.

Blue Cross System

Over time, the Blue Cross system has become very similar to the Medicaid system. The major difference in the two is that in the calculation of its inpatient *per diem*, Blue Cross recognizes an allowance for the net loss incurred by a voluntary hospital in rendering ambulatory and emergency services.

Hospitals have 120 days to file an appeal with the State, specifying why they believe their rate is inadequate. The State then reviews the hospital's submission and makes a recommendation to the Commissioner of Health. If the facility is dissatisfied, it may request a formal appeal before a State hearing officer. If still dissatisfied, recourse is to the courts.

Contact for Additional Information

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Office of Health Systems Management
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Albany, New York 12237

Oregon

The Oregon rate review and disclosure system involves mandatory participation and voluntary compliance by most hospitals. The State Health Planning and Development Agency reviews cost and volume budgets for the total hospital and for individual cost centers to determine the reasonableness of charge increases. A determination that rates are unreasonable may be made public.

Responsible Agency

State Health Planning and Development Agency

The Oregon State Health Planning and Development Agency (SHPDA) is responsible for reviewing and commenting on existing and proposed hospital rates. The SHPDA has no enforcement powers; but it reviews the rates, determines their reasonableness, and publicizes those deemed unreasonable. The Director of the SHPDA is appointed by and serves at the pleasure of the governor.

The Oregon Statewide Health Coordinating Council (SHCC) serves as an advisory council to the SHPDA on general policymaking issues; however, it is not involved in rate review. The SHPDA has created a special technical advisory committee, the Cost Containment Advisory Committee, for rate review matters. The Cost Containment Advisory Committee is composed of representatives of hospitals, physicians, payers, consumers, and a public agency.

Payers/Facilities Covered

The system does not involve payers directly, but it does include governmental hospitals with the exception of those operated by health maintenance organizations.

Statute and Date

ORS Chapter 442, Sections 400 through 450, August 1981.

Methodology of Current Program

A hospital may give notice of a change in rates at any time during the year provided the State agency is notified of the proposed increase 30 days prior to the effective date of the new rates. There is no provision for retroactive adjustments unless the statutory 30-day advance notice of rate increases has not been given. When advance notice of rate increases has not been given, rates must be rolled back to the last filed rate. Any charges to patients in excess of the last properly filed rates shall, at the discretion of SHPDA, either be refunded to those persons overcharged or offset against future rate increases in lieu of refunding.

At least 30 days prior to the effective date of rate increases, hospitals are required to submit supporting budget data to the SHPDA. Additionally, prospective budgets are required at the beginning of each fiscal year. Financial statements are filed with SHPDA within 120 days after the hospitals' fiscal year end. Operating and fiscal data are reported monthly via the American Hospital Association's Monitrend system. There are no standard accounting forms, but the monthly Monitrend reporting is done on a standardized form for computer processing. Failure to perform as required by statute and rules may result in imposition of a civil penalty not to exceed \$100 per day of violation, depending on the severity of the violation.

SHPDA staff reviews interim budget data supporting rate increases, annual capital and operating budgets, annual financial statements and Monitrend reports, considering such factors as inflation and volume changes, to determine the reasonableness of rates being charged. Any rates which are found to be unreasonable may be brought to the attention of the public via the press. A determination as to the unreasonableness of rates may be appealed. Hospitals, however, are not prohibited from charging unreasonable rates. On the other hand, failure to file rates can result in a civil penalty.

Contact for Additional Information

Financial Analyst
Health Economics and Facilities Review Section
State Health Planning and Development Agency
3886 Beverly Street, N.E., Suite 19
Salem, Oregon 97305

Rhode Island

The Rhode Island rate-review program prospectively establishes a Statewide limit on hospital expenditures. This limit, known as the Maxicap, is a negotiated maximum percentage increase in total hospital expenditures allowed in the State during the coming year. Blue Cross, the State, and the individual hospitals then negotiate the final operating expense budget upon which the Blue Cross and Medicaid prospective payment rates are based.

Responsible Agencies

Blue Cross, State Budget Office

The staffs of Blue Cross, the State Budget Office, and the Hospital Association of Rhode Island set the Maxicap. Subsequently, the staffs of Blue Cross and the State Budget Office (jointly referred to as the third parties) and the hospitals conduct hospital budget negotiations. The State has not issued specific regulations defining the rate-review process. Instead, the hospitals, Blue Cross, and the State Budget Office establish the process in a contractual agreement.

Payers/Facilities Covered

Blue Cross, Medicaid. Participation and compliance are mandatory for all non-Federal hospitals.

Statute and Date

Chapter 208, Title 27 of the General Laws, July 1971.

Methodology of Current Program

A Maxicap is set annually by negotiation. Hospitals subsequently submit cost data on their current and prospective budget years using a uniform reporting system. The budget-review process focuses on the incremental changes from current to prospective years. These changes are reviewed on both a global and cost-center level. Hospitals are grouped, but inter-hospital comparisons are limited.

In assessing the increment from the base-year, the Blue Cross and Budget Office staffs consider inflation, volume changes, and the provisions of new and expanded services. The inflation adjustment or Maxicap is negotiated using a market-basket approach to evaluate price increases. Volume changes are projected based upon historical patterns at the respective institutions. A Statewide medical program review and priority process are used to determine the appropriateness of new or expanded services. Funding of such services is based upon both need and affordability.

After total operating expenses and volume changes have been negotiated, the hospital establishes a schedule of charges. Blue Cross and the State Budget Office review this schedule for accuracy of revenue calculations. The schedule of charges is then used by Blue Cross and Medicaid to establish aggregate cost to charge ratios for inpatient and outpatient services. These ratios, adjusted for cost and benefit differences between the two payers, are applied to charges to determine the actual payment rate.

If the third parties and a hospital cannot reach agreement, negotiations end and a two-phase review process begins. First, both sides are brought together for formal mediation. This process differs from normal negotiations by involving members of the hospital's governing board and officials of third parties. If mediation does not result in agreement, unresolved issues go before an independent arbitrator for binding arbitration. The arbitrator must choose one of the two positions and is not free to consider any modifications of positions which might have occurred during mediation.

Contact for Additional Information

Director of Reimbursement
Blue Cross of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Supervisory Budget Analyst
State Budget Office
Room 100
State House
Providence, Rhode Island 02903

Virginia

The Virginia budget/rate review system involves mandatory participation and voluntary compliance. Through an annual review of revenues and expenditures, the Virginia Health Services Cost Review Commission makes determinations regarding the reasonableness of aggregate charges in relation to aggregate costs.

Responsible Agency

Virginia Health Services Cost Review Commission

The Virginia Health Services Cost Review Commission is an 11-member commission, the members of which are appointed by the Governor and approved by the General Assembly. The 11 members, who serve for a 3-year term, are comprised of 3 hospital administrators, 1 Blue Cross representative, 1 commercial insurance representative, 5 consumer representatives, and 1 *ex officio* member, the Commissioner of Health. The Commission is staffed by a staff director and a secretary.

The Commission has contracted with the Virginia Hospital Rate Review Program as a consulting service for data and analyses. The staff includes a director, 2 assistant directors, a secretary, and 5 budget analysts.

Payers/Facilities Covered

The system includes all charge-based payers in all general, psychiatric, and outpatient surgical hospitals.

Statute and Date

Code of Virginia, Title 9, Chapter 26, April 1978.

Methodology of Current Program

The present program, enacted by the General Assembly in 1978, mandates that hospitals use the uniform financial reporting system established by the Commission. Each hospital must submit an annual budget of revenues, expenditures, and volumes no later than 60 days prior to the beginning of their respective fiscal years. Hospitals also must file, no later than 10 days after the beginning of their fiscal years, a schedule of charges in effect on the first day of the fiscal year. Any subsequent amendment to the schedule of charges must be filed at least 60 days prior to its effective date.

The hospital budgeted rate structure is to be based on Commission guidelines which define the elements of the hospital's total financial requirements. The elements of financial requirements are: 1) current operating requirements: consisting of patient care costs, bad debt and charity costs, and educational and research costs; 2) operating margin: consisting of work-

ing capital and capital requirements for major renovations, repairs, plant and equipment replacement, and expansion and new technology; and 3) taxes and return on equity (for investor-owned institutions).

A major concept of the rate-review process is the use of screens as standard values for various elements of operating cost. Hospital budgeted and historical expenses are compared to the screen values to determine their reasonableness. The screen values were developed to highlight exceptional cost but are not applied as ceilings. Judgment and the step-by-step comparison of hospital expenses to screen values are used to assess reasonableness. Total hospital operating expenses are compared to a global screen based on the increase in cost per adjusted admission. If a hospital's budgeted or incurred expenses pass the global screen, they are presumed to be reasonable. However, all hospitals still are subject to screening on a departmental basis.

The Commission has contracted with the Virginia Hospital Rate Review Program to review budgets, proposed rates, and/or historical data by performing the following technical functions: 1) reviewing hospital-wide and departmental indicators (overall measures of activity) to gain a general understanding of the hospital's operations; 2) reviewing the current operating needs by screening departmental direct costs and productivity and hospital-wide costs; 3) reviewing capital needs by evaluating plant capital needs, working capital needs, and return on investment needs and by performing the overall capital needs test based on percent return on assets; 4) allocating all hospital-wide expenses, working capital needs and return on investment requirements into revenue producing departments using the single step-down apportionment method; 5) allocating capital needs to all departments; 6) reviewing revenue projections; 7) analyzing relationship of charges to cost; and 8) preparing a report to the Commission.

The results are reviewed and decided upon by the Commission at regular monthly meetings. Hospital representatives may attend these meetings to ask questions or appeal decisions. Compliance with Commission decisions is voluntary.

Each hospital also submits an annual summary report no later than 120 days after the end of the hospital's fiscal year. The report is submitted on a Year End Summary Financial and Statistical Data Form, together with a copy of an audited financial statement/audit report and Schedule B-1 (Statistical Page) of the Medicare Cost Report. The Commission uses these data for future budget-review purposes and for a historical data program.

Contact for Additional Information

Staff Director
Virginia Health Services Cost Review Commission
Room 417
2015 Staples Mill Road
Richmond, Virginia 23230

Washington

The Washington rate-review system is a mandatory budget review system, with payment rates calculated for all payers except Medicare and Medicaid. The emphasis of the budget-review process is on identifying high-cost operations and disallowing costs exceeding certain screens.

Responsible Agency

Washington State Hospital Commission

The Washington State Hospital Commission is a five-member independent commission appointed by the Governor and confirmed by the Senate. It comprises representatives of labor, business, and hospitals, as well as consumers. No more than two members may have a fiduciary duty to a health facility or agency, or a financial interest in rendering health services. Rules and regulations for rate-setting are issued under the direct authority of the Commission. The Commission is assisted in its activities by an 11-member technical advisory committee also appointed by the Governor. The advisory committee consults and makes recommendations to the Commission on matters of policy, rules, and regulations, as requested by the Commission.

Payers/Facilities Covered

The system includes charge-based payers directly (including Blue Cross) and other payers indirectly through revenue budget-controls in all non-Federal hospitals.

Statute and Date

RCW Title 70, Chapter 39 (Chapter 5 Laws of 1973, First Ex. Sess.) March 1973.

Methodology of Current Program

At least 60 days before a new fiscal year, each hospital is required to submit detailed information on its costs, statistics, and charges for its past, current, and budgeted fiscal years by using a uniform accounting and reporting system. These data are used to develop screens for budget-review. The next month

is spent reviewing the hospital's budget, that is, desk profile analysis, volume analysis, and comparison with established screens. The initial step is an examination of the budget to determine any significant changes, such as new beds or services, which could affect the budget. Next, a volume analysis is performed to determine if the hospital's volume projections are reasonable. The Commission uses guidelines to adjust for changes in operating expenses related to changes in volume. Changes in volume are assigned a fixed/variable relationship which may range from 80 percent fixed to 20 percent variable cost for small institutions, to 60 percent fixed to 40 percent variable for larger institutions.

The hospital's operating budget is then screened twice. Hospitals are clustered into peer groupings which are developed after considering: size, teaching level, case-mix, geographic location, and other variables. The operating budget is first reviewed on a global level using primary screens. To pass the primary screens, a hospital must demonstrate that adjusted operating expenses (which exclude depreciation and interest on long-term debt) per equivalent admission are at or below the 50th percentile, and that the percent change from base-year approved and base-year estimated are at or below the 70th percentile. If it fails any one screen, a second screening process is initiated. The secondary screening consists of a review of each cost center to measure intensity, input prices, and productivity. To pass a secondary screen, the facility must be at or below the 70th percentile for its peer group. If a cost center passes a screen, no further review is required. If it fails a screen, the staff performs a detailed analysis of that cost center by classifying expenses and considering inflation, changes in volume, and uncontrollable cost.

Deductions from revenues are allowable costs. These deductions are 1) cost associated with contractual allowances from Medicare and Medicaid, and 2) charity and bad debt.

The Planned Capital and Service Component, which is not subject to peer group review, is added to the approved operating budget amount. It consists of the following: 1) net increases in working capital; 2) prior debt commitments; and 3) expansion and acquisition of new equipment. This component is reviewed by staff for appropriateness and adequacy, while considering the facility's overall financial needs and sources available to meet those needs.

A revenue-to-expense ratio analysis is then performed on the proposed rates to satisfy the statutory requirement that rates be reasonably related to costs. After consideration of all of the above, the Commission recommends the amount of total rate-setting revenue which will allow the facility to meet its financial needs.

Approximately 30 days before the rates go into effect, the staff issues a report to the hospitals, the Commission, the Health Systems Agencies, and third-party payers on the findings and recommendations. Prior to the beginning of the hospital's fiscal year, a public hearing is held before the Commission. At this time, Commission members review recommendations by the staff and may query the hospital on any area of hospital operations. Also, at this time, the hospital may argue for certain areas of operation in which the staff has recommended a budget cut. Finally, the Commission votes on the staff recommendations and the final approved budgeted revenue. A formal Decision and Order (D&O) detailing the final approved revenue is then issued by the Commission within 30 days following the hearing.

The facility uses the approved rates in establishing its list of charges. About 4 months after the year ends, the Commission receives actual audited data from each hospital. Year-end compliance is then assessed, and this compliance is incorporated into the following year's allowable revenue. If a hospital is dissatisfied with its approved budget, it may request reconsideration and present additional information in an informal hearing, request an amendment to its approved budget during the year, or petition for a formal hearing. If a hospital is dissatisfied with the decision of the Commission after the informal hearing, it may appeal to the Commission for a formal hearing of record. This formal hearing is conducted by either a member of the Commission or an independent hearing officer, at the Commission's option. If the facility is dissatisfied with the results of the formal hearing, it has recourse to the courts.

Contact for Additional Information

Executive Director
Washington State Hospital Commission
206 Evergreen Plaza Building
711 South Capitol Way, FJ-21
Olympia, Washington 98504

West Virginia

The current program in West Virginia mandates the public disclosure of each hospital's financial position. The purpose of the program is to initiate reviews to determine whether hospital charges are economically justified.

Responsible Agency

Department of Health

In 1979, the West Virginia legislature enacted the Health Care Facilities Financial Disclosure Law which requires hospitals to file financial reports with the Director of Health and publish a financial statement in a local newspaper. The Director of Health may determine whether the rates charged by a hospital are economically justified.

Payers/Facilities Covered

The system does not directly involve payers but does include all non-Federal hospitals with over 15 beds.

Statute and Date

Chapter 16, Article 5-F of the West Virginia Code, 1979.

Methodology of Current Program

By statute, within 120 days of the end of its fiscal year each hospital must file financial and statistical reports with the Director of Health, and publish as a legal advertisement in a local newspaper an annual report prepared by the facility's auditor or an independent public accountant. The published report must contain a complete statement of the facility's

assets and liabilities, income and expenses, and profit or loss, as well as a statement of ownership for persons owning more than 5 percent of the capital stock.

Reports filed with the Director of Health include: 1) a statement of services available and services rendered; 2) a statement of the facility's total financial needs and resources available to meet those needs, that is, a budget; 3) a schedule of its then current rates; 4) a copy of the cost reports filed with the Health Care Financing Administration and the State Medicaid Agency; and 5) statements of all charges, fees, or salaries paid in excess of \$55,000, and all charges, fees, or other sums in excess of \$55,000 collected by the covered facility on behalf of any other person, firm, or partnership. All documents filed must be made available for public inspection.

Although there is no formal budget-review process, the Director of Health may carry out analyses and studies related to health care costs and the financial status of any hospital and make determinations as to whether the rates charged by a hospital are economically justified. To date, the Director has published three statistical reports outlining hospital expenses, revenues, and profits during the first year of the program. The emphasis of those reports is upon providing a Statewide perspective as opposed to specific hospital reviews.

A financial penalty may be imposed upon any hospital failing to provide the required documents within the specified period of time. However, compliance with the Director of Health's findings is voluntary. There is no appeal mechanism.

Contact for Additional Information

Director
Office of Health Planning and Evaluation
West Virginia Department of Health
1800 Washington Street East
Charleston, West Virginia 25305

Wisconsin

The Wisconsin prospective reimbursement system is designed to contain hospital costs in the State by reviewing all requests for rate increases. The reasonableness of the requests is determined by analyzing various financial and statistical ratios highlighting variations from each hospital's past experience and from similar institutions. Compliance with the rate-review findings is mandatory by agreement.

Responsible Agency

Wisconsin Hospital Rate Review Committee

By statute, prospective rates may be established directly by the Department of Health and Social Services or through a mutual agreement with the Wisconsin Hospital Association and Blue Cross of Wisconsin. The State has chosen the latter approach.

Under the three-party agreement, an independent Rate Review Committee was established. It is composed of 20 members; 6 appointed by the Governor, 6 appointed by the hospital association, 6 appointed by Blue Cross, and 2 appointed jointly by the State and the hospital association. Authority to decide on the reasonableness of rates rests with the Rate Review Committee. Blue Cross performs the actual budget analysis and the Department of Health and Social Services provides technical support for developing methodology.

Payers/Facilities Covered

The system includes all payers except Medicare and Medicaid. Participation and compliance by all non-Federal hospitals is mandatory by agreement.

Statute and Date

Section 49.45, Section 146.60 Wisconsin Statute; Chapter 39, Wisconsin Laws of 1975, Chapter 224 Wisconsin Laws of 1976; Chapter 323, Wisconsin Laws of 1981.

Methodology of Current Program

The rate-review process begins when a hospital submits a request for a rate increase. The request must be submitted 60 days prior to the proposed implementation date. Data supporting the need for the increase must be submitted no later than 45 days prior to the implementation date. Hospitals are limited to one rate increase per fiscal year, unless extenuating circumstances exist. They are encouraged to time their requests to coincide with the beginning of their fiscal years.

Supporting data include, but are not limited to the following: budgets (operating and capital, current and/or prospective), interim financial statements, audited and certified annual financial statements, Title XVIII and XIX cost reports, and standardized re-

porting forms. A uniform accounting and reporting system is not used. Instead, the Blue Cross staff transfers the hospital data to its own format for internal analysis.

The data analysis consists of two comparisons. First and most important, a hospital's current request is compared with its prior experience. Second, a hospital's current request is compared with the experience of a group of similar hospitals. The hospital groups used in the analysis are based on geographic location, size, and teaching activity. The items that are analyzed in both comparisons are: percent of occupancy, length of stay, employees per patient day, average salary per employee, days of revenue in accounts receivable, days of cost in inventory revenue *per diem*, financial requirements *per diem*, total revenue *per diem*, operating expenses *per diem*, charge per admission, and *per diem* cost of research and educational programs. Deviations determined during the comparisons do not necessarily result in an adverse action. The facility has the opportunity to justify any above average costs.

Based on their analysis, the staff presents the Rate Review Committee with a recommendation to approve, disapprove, modify, or defer the requested rate increase. If a hospital disagrees with the recommendation of the staff, it may present its position before the Committee. If the Committee decides to modify or disapprove, it must specify which elements in the hospital's budget are considered unreasonable. The amount of reduction in each element and how it applies to each payer must also be specified by the Committee.

A hospital, the Wisconsin Hospital Association, Blue Cross of Wisconsin, or the State of Wisconsin may appeal a decision of the Rate Review Committee. Appeals must be brought before a seven-member board which is selected from the total Appeals Board membership of 21, within 10 calendar days of the Committee's decision. The board considers cases on alleged violation of due process and questions of fact. The appealing party has the right to be present at the appeal and to be represented by legal counsel. The board can uphold the Committee's decision or reverse it and require the Committee to redetermine the hospital's rate. The board's decision is final.

Contact for Additional Information

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