

Minnesota Attorney General: Administrative Rules Proceedings

Copyright Notice:

This material may be protected by copyright law (U.S. Code, Title 17). Researchers are liable for any infringement. For more information, visit www.mnhs.org/copyright.

Version 3
August 20, 2018

Rule	HE #4 rec.	Bd #4 resp.
472 G, I, J, K, O	Amend as on p. 6	Agreed
474 B 2 f, 4	" " p. 7	App. agrs. * check rule as per top. p. 7
474 A 5	p. 11	X "
474 B	" " p. 12	Agreed
B 3	13	Agreed
481 B 2	" " 17 out p. 18	X Seems to agree - check rule twice if penalty deleted.
481 C	" " 18	Agreed
C 2	" " out p. 19	Agreed
487 A 1 a 3 e	out p. 24	Agreed
487 A 1 b 1	modify — p. 31-32	Agreed by elim.
487 A 1 b 5	modify — p. 33	Agreed
487 A 3	" p. 37	Justifies
487 A 4	" " p. 39	Agreed
487 c 1 e f	unreas. - reword p. 40-1	Done
504 H.	contra to stat. p. 44	Doesn't deal w/ - Deletes
509	modify p. 44-5	Agreed

TRANSMITTAL - MESSAGE SLI

TO Miller	LOCATION
DATE 5/23	TIME 11:50
FROM	LOCATION

TRANSMITTAL ACTION

- [ ] Review and see me
- [ ] Review and return
- [ ] Prepare reply for my sig.
- [ ] Reply and send me copy
- [ ] For your approval
- [ ] For your information
- [ ] For signature
- [ ] As we discussed
- [ ] As you requested
- [ ] Take appropriate action
- [ ] Notify staff

CALL OR VISIT

NAME Jack Brewin

FROM

PHONE NO. 5402

- [x] Called
- [ ] Was here to see you
- [x] Please call
- [ ] Will call again
- [ ] Returned your call

MESSAGE

Admin 1010 (Rev. 9-76) (55)

OVER

Adopted Ex III

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Proposed Rules for the
Minnesota Hospital Rate Review System

MHD 471 Scope.

A. All acute care hospitals licensed pursuant to Minnesota Statutes, Sections 144.50 to 144.58 are subject to the requirements of the Minnesota Hospital Rate Review System established by these rules.

B. Beds located in these hospitals, which are not licensed as acute care beds pursuant to Minnesota Statutes, Sections 144.50 to 144.58, are not subject to the requirements of the Minnesota Hospital Rate Review System. Where costs incurred through the operation of these beds are co-mingled with the costs of operation of acute care beds in a hospital subject to the system, associated revenue and expenses and other related data shall be separated in a manner consistent with the normal ~~step-down~~ requirements for allocation of costs as stated by 20 CFR 405.453 (Medicare).

C. Citations of Federal law or Federal regulations incorporated in these rules are for those laws and regulations then in effect on April 1, 1976.

MHD 472 Definitions. For the purposes of these rules, the following terms have the meanings given them:

A. "Accounting period" means the fiscal year of a hospital which is a period of twelve consecutive months established by the governing authority of a hospital for purposes of accounting.

B. "Admissions" means the number of patients accepted for inpatient services in beds licensed for inpatient hospital care.

C. "Applicant" means a voluntary nonprofit rate review organization which has applied to the board for approval or renewed approval of its reporting and review procedures.

D. "Auxiliary enterprises" means significant continuing revenue-producing activities which, while not related directly to the care of patients, are businesslike activities commonly found in health care institutions for the convenience of employees, physicians, patients and/or visitors:

1. An activity is significant if either its revenues or direct costs exceed $.20 per inpatient day;
2. An activity is businesslike if it has related direct costs equal to at least 25% of its revenues;
3. Irrespective of the above criteria, all parking lots, private physicians' offices, and retail operations are considered to be auxiliary enterprises.

E. "Beds" means the ~~average-number-of-beds-in-a-hospital~~

~~which-are-in-place-and-operating-with-staff-regularly assigned-to-them-during-an-accounting-period.--This-number-need-not-be-equivalent-to-the-licensed-or-constructed bed-capacity-but-it-shall-be-equivalent-to-the-average number-of-these-beds-commonly-considered-to-be-set-up and-staffed-during-an-accounting-period.~~ number of acute care beds licensed by the Minnesota Department of Health, pursuant to Minnesota Statutes, Sections 144.50 to 144.58.

F. "Burden of proof" means the burden of persuasion by the preponderance of the evidence.

G. "Charges" means the regular amounts charged to ~~both paying-patients-and-insurers-who-receive-services~~ patients and/or insurers, prepayment plans and self-insured groups on the patient's behalf, irrespective of any discounts, deductions, or other reductions in these charges which, by contract or other agreement, may be applicable. The terms "charges" and "rates" are synonymous for the purposes of these rules.

H. "Cost" means the amount, measured in money, of cash expended or other property transferred, services performed or liability incurred, in consideration of goods or services received or to be received.

I. "Emergency services" are those inpatient ~~hospital-services-and~~ or outpatient hospital ~~diagnostic~~ services

~~which~~ that are necessary to prevent ~~the death or serious impairment of the health of the individual, and which, because of the threat to life or health of the individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.~~ immediate loss of life or function due to the sudden onset of a severe medical condition.

J. "Emergency visit" means an ~~admission~~ acceptance of a patient ~~to~~ by a hospital ~~which maintains a distinct emergency service center for purposes of receiving emergency services.~~ for the purpose of providing emergency services in a distinct emergency service center.

K. "Expanded facility" means any expansion or alteration in the scope of service of an institution subject to the provisions of the Minnesota Certificate of Need Law, Minnesota Statutes §145.71 to 145.84, or Section 1122 of the Social Security Amendments of 1972, Public Law 92-603, according to the definitions contained in these laws and the current regulations sanctioned by them.

L. "Expense(s)" means costs that have been incurred in carrying on some activity and from which no benefit will extend beyond the period for which the expense is recorded.

M. "Fiscal year" means that period of twelve consecutive months established by the State for the conduct of its business.

N. "Inpatient hospital services" means the following items and services furnished by a hospital to an inpatient of such a hospital:

1. Bed and board;
2. Nursing services and other related services;
3. Use of hospital facilities;
4. Medical social services;
5. Drugs, biologicals, supplies, applicances and equipment;
6. Certain other diagnostic or therapeutic items or services; and
7. Medical or surgical services provided by certain residents-in-training.

O. "Loss" means the excess of all expenses over revenues for an accounting period or the excess of all or the appropriate portion of the ~~cost or~~ net book value of assets over related proceeds, if any, when items are sold, abandoned, or either wholly or partially destroyed by casualty or otherwise written off.

P. "Non-revenue center" means a service center which incurs direct operating expenses but which does not generate revenue directly from charges to patients for services. These centers, which rely on revenue from revenue centers to meet their expenses, may include such service centers of a hospital as:

1. General services, including:
   a. Dietary services;
   b. Plant operation and maintenance services;

c. Housekeeping services;

d. Laundry services; and

e. Other services.

2. Fiscal services;

3. Administrative services; and

4. Medical care evaluation services.

Q. "Outpatient services" mean those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and which are not inpatient services.

R. "Outpatient visit" means an ~~admission~~ acceptance of a patient ~~to~~ by a hospital ~~which maintains a distinct outpatient diagnostic service center for purposes of providing outpatient services.~~ for the purpose of providing outpatient services in a distinct outpatient service center.

S. "Program" means the reporting and review procedures proposed by an applicant.

T. "Quarter" means that period of the fiscal year corresponding to a three-month period of time for which the State regularly gathers information for the conduct of its business. For purposes of these rules, a fiscal year is composed of four quarters corresponding to the following groupings of months: a quarter is defined by the time period represented by the months of July, August and September; a quarter is defined by the time period

represented by the months of October, November and December; a quarter is defined by the time period represented by the months of January, February and March; and, a quarter is defined by the time period represented by the months of April, May and June.

U. "Rate" means ~~the average revenue for each inpatient admission~~ "charges" as defined in MHD 472 G.

$$\frac{\text{~~Total Revenue~~}}{\text{~~Number of Inpatient Admissions~~}}$$

~~for a full accounting period.~~ "~~Adjusted~~ Aggregate rate" means the average revenue ~~for each~~ per adjusted admission for a full accounting period determined by dividing total revenue by the number of adjusted admissions.

$$\frac{\text{Total Revenue}}{\text{Number of Adjusted Inpatient Admissions}}$$

Adjusted admissions are determined by:

$$\text{Number of Outpatient \& Emergency Visits} \times \frac{\text{Total Outpatient \& Emergency Revenue}}{\text{Number of Outpatient \& Emergency Visits}}$$

$$\times \frac{1}{\text{Inpatient Revenue Per Admission}} \quad \text{PLUS} \quad \text{The Number of Inpatient Admissions}$$

The aggregate rate for the budget year shall always be based upon annually projected admissions as stated in the rate revenue and expense report.

V. "Restricted funds" mean funds donated to the hospital

which are restricted for a specific purpose by the donor.

W. "Revenue(s)" or "income(s)" means the value at the hospital's full established charges of all hospital services rendered to patients, regardless of the amounts actually paid to the hospital by or on behalf of patients.

X. "Revenue center" means a service center which incurs direct operating expenses and which generates revenue from patients on the basis of charges customarily made for services that center offers directly to patients. Revenue centers may include such service centers of a hospital as:

1. Daily patient services (routine services) including:
   a. Medical services;
   b. Surgical services;
   c. Pediatric services;
   d. Intensive care services;
   e. Psychiatric services;
   f. Obstetric-gynecological services;
   g. New born nursery services;
   h. Premature nursery services;
   i. Other routine services.
2. Other nursing services (special services), including:
   a. Operating room services;
   b. Recovery room services;
   c. Delivery and labor room services;
   d. Central services and supply services;

e. Intravenous therapy services;

f. Emergency services;

g. Other special services.

3. Other professional services (ancillary services), including:

a. Laboratories;

b. Blood bank;

c. Electrocardiology;

d. Radiology;

e. Pharmacy;

f. Anesthesia;

g. Physical therapy;

h. Other special services.

Y. "Service center" means an organizational unit of a hospital for which historical and projected statistical and financial information relating to revenues and expenses are accounted. A service center may be a routine, special, or ancillary service center. A service center may also be a revenue center or a non-revenue center.

Z. "System" means the Minnesota Hospital Rate Review System and any applicant approved to operate it or the board.

AA. "Third party payors" mean insurers, health maintenance organizations licensed pursuant to Minnesota Statutes, Chapter 62D, nonprofit service plan corporations, self-insured or self-funded plans, and governmental insurance programs, including the health insurance programs authorized by Title V, Title XVIII and Title XIX of the United States Social Security Act (Medicare and Medicaid).

BB. "Unrestricted funds"mean funds not restricted by the donor and funds designated by the governing authority of the hospital, not including revenues in excess of expenses.

MHD 473 The Minnesota Hospital Rate Review System. The Minnesota Hospital Rate Review System is established. This system shall be operated by the board ~~or~~ and any voluntary nonprofit rate review organization whose reporting and review procedures have been approved by the board, pursuant to MHD 496. The system shall consist of reports, administrative procedures, and standards.

MHD 474 Report Requirements. The system shall require annual financial information and rate revenue and expense, and interim increase reports.

A. Annual Financial Information Report. Each hospital shall submit an annual financial information report to the system. This report shall include:

1. a. A balance sheet detailing the assets, liabilities, and net worth of the hospital. This balance sheet should include information on:

(1) Current assets, including:

(a) Cash;

(b) Marketable securities;

(c) Accounts and notes receivable;

(d) Allowances for uncollectable receivables and third party contractuals;

(e) Receivables from third party payors;

(f) Pledges and other receivables;

(g) Due from other funds;

(h) Inventory; and

(i) Prepaid expenses.

(2) Plant capital allowances, including historical cost of, price level increments related to and accumulated depreciation related to:

(a) Land;

(b) Land improvements;

(c) Buildings;

(d) Leasehold improvements;

(e) Building equipment;

(f) Movable equipment; and

(g) Construction in progress.

(3) Deferred charges and other assets, including:

(a) Other assets;

(b) Investments in non-operating property, plant and equipment;

(c) Accumulated depreciation on investments in non-operating plant and equipment; and

(d) Other intangible assets (e.g., good will, unamortized borrowing costs).

(4) Current liabilities, including:

(a) Notes and loans payable;

(b) Accounts payable;

(c) Accrued compensation and related liabilities;

(d) Other accrued expenses;

(e) Advances from third party payors;

(f) Payable to third party payors;

(g) Due to other funds;

(h) Income taxes payable; and

(i) Other current liabilities.

(5) Deferred credits and other liabilities, including:

(a) Deferred income taxes;

(b) Deferred third party revenue;

(c) Long-term debt; and

(d) Fund balances~~.~~ (identifying donor restricted and unrestricted funds).

(6) In the case of hospitals owned by, operated by, affiliated with, or associated with an organization, corporation, or other hospital(s), a statement of the flow of funds between the hospital and that organization, corporation or other hospital(s). This statement shall detail all transactions between the hospital and the organization, corporation or other hospital(s).

b. In the event that a hospital maintains a balance sheet which includes information which differs from the information required by the balance sheet recommended by MHD 474 A.1.a., above, the hospital may substitute its balance sheet. This balance sheet shall include a narrative description of the scope

and type of differences between its balance sheet and that balance sheet recommended by MHD 474 A.1.a., above.

2. a. A detailed statement of income and expenses, including:

(1) Gross revenues from and expenses directly attributable to revenue centers;

(2) All operating revenues and expenses other than those directly associated with patient care;

(3) Reductions in gross revenues that result from charity care, ~~courtesy discounts,~~ contractual adjustments, administrative and policy adjustments, provision for bad debts, and other factors;

(4) Direct expenses incurred by the research and educational, general, fiscal, and administrative service centers;

(5) Direct revenue and expense received or incurred from non-hospital operations; and

(6) A statement of expenses by a natural classification of expenses for the hospital as a whole. The natural classification of expenses may include such factors as:

(a) Salaries and wages, including:

(i) Management and supervision;

(ii) Technicians and specialists;

(iii) Registered nurses;

(iv) Licensed practical nurses;

(v) Aides and orderlies;

(vi) Clerical and other administrative employees;

(vii) Environment and food service employees;

(viii) Physicians;

(ix) Non-physician medical practitioners;

(x) Vacation, holiday, sick pay, and other non-worked compensation.

(b) Employee benefits, including:

(i) F.I.C.A.;

(ii) State unemployment insurance and federal unemployment insurance;

(iii) Group health insurance;

(iv) Pension and retirement;

(v) Workmen's compensation insurance; and

(vi) Group life insurance.

(c) Professional fees-medical, including:

(i) Physicians' remuneration; and

(ii) Therapists and other non-physician.

(d) Other professional fees, including:

(i) Consulting and management services;

(ii) Legal services; ~~and~~

(iii) Auditing services~~.~~; and

(iv) Collection services.

(e) Special departmental supplies and materials.

(f) General supplies, including:

(i) Office and administrative supplies;

(ii) Employee wearing apparel;

(iii) Instruments and minor medical equipment which are non-depreciable;

(iv) Minor equipment which is non-depreciable; and

(v) Other supplies and materials.

(g) Purchased services, including:

(i) Medical - purchased services;

(ii) Repairs and maintenance - purchased services;

(iii) Medical school contracts - purchased services; and

~~(iv)--Management-services;~~

~~(v)--Collection-services;-and~~

~~(vi)~~ (iv) Other purchased services.

(h) Other direct expenses, including:

(i) Depreciation, amortization, and rental or lease expenses necessary to maintain an adequate plant capital fund, pursuant to MHD 487 A.1.b.;

(ii) Utilities - electricity;

(iii) Utilities - gas;

(iv) Utilities - water;

(v) Utilities - oil;

(vi) Other utilities;

(vii) Insurance - professional liability;

(viii) Insurance - other;

(ix) Licenses and taxes other than income taxes;

(x) Telephone and telegraph;

(xi) Dues and subscriptions;

(xii) Outside training sessions;

(xiii) Travel; and

(xiv) Other direct expenses.

b. In the event that a hospital maintains accounts which include information resulting in detailed statements of income and expense which differ from the information required by the statement of income and expense recommended by MHD 474 A.2.a., the hospital may substitute its statement of income and expenses. This statement shall include a narrative description of the scope and type of differences between its statement of income and expenses and that statement recommended by MHD 474 A.2.a.

3. An unaudited copy of the hospital's cost report filed pursuant to requirements of Title XVIII of the United States Social Security Act stated in 20 CFR 405.406 (b). This cost report shall correspond to the same accounting period as that used in the compilation of data for other

requirements for the report of annual financial information.

4. Attestation by the governing authority of the hospital or its designee that the contents of the report are true.

5. Attestation by a qualified, independent public accountant that the contents of the balance sheet and statement of income and expense ~~are true and conform to the bases for judging the reasonable use of finances in a hospital, as established by MHD 487 A.~~ have been audited.

B. Rate Revenue and Expense Report.

1. Each hospital shall submit a report of rate revenue and expense to the system on an annual basis. This report shall include statistical and financial information for:

   a. The hospital's last full and audited accounting period prior to the accounting period during which a hospital files this report with the system. This period shall be known as the prior year. Information for the prior year shall be actual.

   b. The hospital's full accounting period during which a hospital files this report with the system. This period shall be known as the current year. Information for the current year shall be actual and estimated according to the following:

(1) Information for at least the first ~~eight~~ six months shall be actual;

(2) Information for the ~~last four~~ remaining months may be estimated.

c. The hospital's next subsequent full accounting period following the accounting period during which the report is filed with the system. This period shall be known as the budget year. Information for the budget year shall be projected.

2. Statistical information for the rate revenue and expense report shall include:

a. The number of inpatient days for the hospital~~.~~ and each appropriate service center.

b. The number of admissions for the hospital and for each appropriate service center.

c. The average number of full-time-equivalent employees during each accounting period for the hospital and for each of its service centers. An employee or any combination of employees which are reimbursed by the hospital for 2080 hours of employment per year is a full-time-equivalent employee.

d. The number of beds ~~available for the hospital and for each appropriate routine service center.~~ (licensed), the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the

hospital and for each appropriate service center.

~~e.--The average annual occupancy rate for the hospital and for each appropriate routine service center.~~

~~f.~~ e. The number of outpatient clinic ~~admissions~~ (visits) for the hospital.

~~g.~~ f. The number of emergency ~~admissions~~ (visits) for the hospital.

~~h.~~ g. The number of units of service provided by each of the hospital's other service centers. The hospital shall select the statistic that best measures the level of activity for a particular function or service center and that, in addition, is compiled on a routine basis by the hospital to serve as the appropriate unit of service for each of its service centers.*

3. Financial information for the rate revenue and expense report shall include:

   a. An interim financial statement of the hospital which shall include an interim balance sheet and an interim income and expense statement for the current year only. The balance sheet and income and expense

---

* For example, although patient days might be used as the unit of service for daily patient services, treatments, procedures, visits, hours or other statistics would be the applicable measure of activity in other service centers.

statement shall conform to the requirements of MHD 474 A.1. and MHD 474 A.2. This financial statement shall contain a minimum of six months of actual information for the current year.

b. A statement of expenses for the hospital and for each of its service centers and a statement according to natural classifications of expenses as provided by MHD 474 A.2.a.(6).

c. A statement detailing the accounting method used to allocate expenses from among the non-revenue centers to revenue centers, which shall detail compliance with the offsets to costs and allocation of costs specified by the bases for judging stated by MHD 487 A.

d. A statement of total direct and indirect costs for the hospital and for each of its service centers before and after the ~~step-down~~ allocation of expenses.

e. A statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of ~~patient-days~~ day's charges outstanding at the end of each period.

f. A statement of changes in financial position showing the source and application of all funds for each period.

g. A statement of the capital budget of the hospital.

4. The report of rate revenue and expense shall also contain the following information:

   a. The pricing policy of the hospital which incorporates the overall pricing policy and financial objectives of the institution. This will be supplemented by a statement of budgeted increases in charges, revenue and aggregate rates for the budget year including these items:

      (1) Date(s) on which charges, revenue, and aggregate rates will be adjusted.

      (2) For each such date, the resulting aggregate dollar amount and weighted average percent of increase in budget year aggregate rates and gross charges for each revenue center.

      (3) For each such date, the resulting aggregate dollar and weighted average percent of increase in budget year total hospital revenues.

      (4) For each date, the resulting aggregate dollar amount and percent of increase in the budget year aggregate rate.

   b. Attestation by the hospital's governing authority or its designee that the rates are set equitably and without discrimination among insurers.

   c. In the case of a hospital with expanded facilities, a copy of the hospital's report used to obtain a

certificate of need for the expanded facility which projects the patient and service activity levels of the expanded facility for its first five years of operation.

C. Interim Increase Reports.

1. Each hospital desiring to amend or modify the aggregate rates for the budget year stated in the rate revenue and expense report then on file with the system to an extent exceeding the allowable increase limit prescribed according to MHD 504, shall submit an interim increase report.

2. In instances where changes in rates during the budget year are the result of legislative policy and appropriations to hospitals subject to these rules which are operated by the commissioner of public welfare, this report is not required.

3. The interim increase report shall include statistical and financial information for:

   a. The period of the budget year immediately preceding the effective date of amendments or modifications to the rates for the budget year which are stated in the rate revenue and expense report then on file with the system. Data for this period shall be actual for all expired months of the budget year, excepting the sixty-day period immediately preceding the filing of this report for which data may be projected.

b. The period immediately subsequent to and including the effective date of these amendments or modifications which terminates at the end of the last day of the budget year. Information for this period shall be projected on the basis of these rate amendments or modifications.

4. Statistical information for each period established by MHD 474 C.3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to MHD 474 B.2., which shall be recorded for each period stated by MHD 474 C.3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

5. Financial information for each period established by MHD 474 C.3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to MHD 474 B.3., which shall be recorded for each period stated by MHD 474 C.3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

6. This report shall also include a narrative statement describing the reason for amendments or modifications to the hospital's aggregate rates.

MHD 475-MHD 480 RESERVED FOR FUTURE USE

MHD 481 Administrative Procedures.

A. General Provisions for Filing of Reports.

1. Forms to be Specified. The system shall design and issue forms as necessary for meeting the requirements of reports established by these rules. These forms shall contain clear instructions for their completion.

2. All documents may be filed personally or by the United States Postal Service with the system at the system's official offices during normal business hours.

3. The system shall establish a method of ~~filing~~ record-keeping which shall insure that reports and other documents are ordered, ~~filed~~ stored, designated and dated in such a manner that facilitates easy public access to the contents of those reports, documents, and other information as required by these rules. These ~~files~~ records shall be open to the public inspection during normal business hours.

4. No report required by these rules shall be deemed to be filed until the system has ascertained the completeness of the report in accordance with the provisions of MHD 487 C.1.

B. Filing of Report of Annual Financial Information.

1. Each year, each hospital shall file a report of annual

financial information as required by MHD 474 A. with the system within 120 days after the close of that hospital's full accounting period. The cost report of the hospital filed pursuant to the requirements of Title XVIII of the United States Social Security Act (20 CFR 405.406(b)) may be filed separately from the other requirements for the report of annual financial information, provided:

a. It is filed no later than the time it is required to be filed with the Medicare Fiscal Intermediary as identified according to 20 CFR 405.651, et. seq. (Medicare). The hospital shall inform the system of this date when filing other information required by this report.

b. The report of annual financial information is considered incomplete until the receipt of the unaudited cost report, but the hospital is not considered in violation of rules until the date required by the Medicare Fiscal Intermediary for the submission of the unaudited Medicare cost report.

c. The audited Medicare cost report is submitted as soon as is practicable to substitute for the unaudited Medicare cost report. The submission of an audited Medicare cost report shall not affect the official filing date of a report of annual financial information.

2. Failure to File. Any hospital which fails to file the annual financial information report, and which has not requested an extension of time pursuant to MHD 481 G., to file that report shall be considered to be in violation of rules. The system shall notify the board, ~~and~~ the appropriate health systems agency and professional standards review organization to this effect. ~~Pursuant to Minnesota Statutes, §144.55, the board may consider this violation as cause to revoke, suspend or deny reissuance of that hospital's license to operate.~~

C. Filing of Report of Rate Revenue and Expense.

1. Each year, each hospital shall file a report of rate revenue and expense up to sixty days prior to the commencement of any accounting period of the hospital. No change in rates shall be made until sixty days have elapsed from the date of filing.

2. a. Failure to File. Any hospital which fails to file a report of rate revenue and expense, and which has not requested an extension of time, pursuant to MHD 481 G., to file that report shall be considered to be in violation of rules. The system shall notify the board, ~~and~~ the appropriate health systems agency and professional standards review organization to this effect. ~~Pursuant to Minnesota Statutes, §144.55, the board may consider this violation as cause to revoke, suspend or deny~~

~~reissuance of that hospital's license to operate.~~

b. A hospital which fails to file a report of rate revenue and expense, and which has requested an extension of time, pursuant to MHD 481 G., to file that report may be charged an additional late fee as authorized by MHD 509 C.

c. A hospital which fails to file a report of rate revenue and expense, and which has not requested an extension of time, pursuant to MHD 481 G., to file that report shall not amend or modify its rates until sixty days after that hospital files that report with the system.

D. Filing of Interim Increase Reports.

1. A hospital shall file an interim increase report sixty days prior to the effective date of any amendments or modifications to aggregate rates then on file with the system for the budget year if:

a. The proposed aggregate rate change exceeds the allowable increase limit established according to MHD 504.

b. Amendments or modifications to aggregate rates which are to become effective after the first day of the budget year and prior to the end of the last day of the budget year were not included in the report of rate revenue and expense then on file with the system.

~~c.--It-is-not-filed-within-ninety-(90)-days-of-any other-interim-increase-or-rate-revenue-and-expense report-filed-by-that-hospital.~~

~~d.--There-are-no-reports,-fees,-or-other-documents-or information-due-to-the-system-from-that-hospital.~~

~~e.--These-provisions-may-be-waived-by-the-system-if-the hospital-can-show-cause-why-they-should-be-waived.~~

2. Limitations. An interim increase report may not be filed within ninety (90) days of any other interim increase or rate revenue and expense report filed by that hospital or when there are any reports, fees or other documents due to the system from that hospital. This provision may be waived by the system if the hospital can show cause therefor.

~~2.~~ 3. Failure to File.

a. A hospital which fails to file an interim increase report with the system when it is required to file such a report pursuant to MHD 474 C., shall be considered in violation of these rules.

b. If this violation is discovered by the system during the budget year, the system may require a hospital so violating these rules to adjust its aggregate rates to be consistent with the allowable increase limits until sixty days after the hospital properly files an interim increase report.

c. If this violation is discovered by the system subsequent to the expiration of the budget year during which the violation occurred, the system may investigate this violation, pursuant to MHD 487 B., in order to determine the effect of this violation upon the aggregate rates of the hospital. The system may recommend a reduction in the rates of the hospital and require that the hospital submit interim increase reports for every increase in aggregate rates, irrespective of the allowable increase limits, for the next two subsequent full accounting periods following the discovery of the violation.

d. In making any retrospective assessment of a hospital's compliance with requirements to file interim increase reports, the system shall recognize that the actual aggregate rates for the budget year may exceed the projected aggregate rates for that budget year by a reasonable amount due to slight variations from projected information contained in the rate revenue and expense report then on file with the system. A reasonable amount may vary with the financial and statistical composition of each hospital but, it should never exceed one and one-tenth times the allowable increase limit for the accounting period in question.

~~3.~~ 4. Allowable Increase Limits: Hospital Calculation. In order for a hospital to determine the extent to which it may increase its aggregate rates during the budget year before it is required to submit an interim increase report, the hospital shall:

a. Add the four quarterly allowable increase limits established by the board, pursuant to MHD 504, which are appropriate for the budget year of the rate revenue and expense report then on file with the system. This calculation provides the hospital with an allowable increase limit for the budget year stated in percentage terms; then,

b. Subtract from the allowable increase limit for the budget year the percentage of the aggregate rate increase for the hospital, if any, from the current year to the budget year, as stated in the rate revenue and expense report then on file with the system. To the extent that the remainder from this calculation is positive, the hospital may increase its aggregate rates for the hospital by this amount at any time during the budget year. Cumulative increases in the aggregate rates of the hospital over the budget year up to this amount do not require the submission of an interim increase report. The system should be advised by the hospital at the time that rates are being so increased, stating the

reason for and general scope of such an increase. The next subsequent rate revenue and expense report of the hospital should detail these increases.

c. Amendments or modifications which do not exceed the allowable increase limit or provide for aggregate rate decreases may take effect immediately upon determination by the hospital's governing authority or its designee. Notice of the amendments or modifications at the time they become effective shall be given to the board. These amendments or modifications shall also be noted in the hospital's next subsequent rate revenue and expense report.

~~E.--Application-for-Variance-in-Rate-Determination. If-a-hospital-desires-to-adopt-an-alternative-method-of-accounting,-cost-control,-rate-determination-or-payment-which-may-affect-the-way-in-which-the-system-proceeds-in-its-assessment-of-that-hospital's-rates,-it-shall-notify-the-system-sixty-days-in-advance-of-the-effective-date-of-this-new-method. Such-notification-shall-detail-the-new-method,-including-expected-impacts-upon-hospital-revenues,-expenses-and-rates-as-well-as-the-impact-of-the-new-method-on-the-equity-with-which-rates-are-set.~~

~~F.~~ E. Filing of Reports: Multi-Hospital Corporations and Other Organizations Operating More Than One Hospital. The system requires the filing of all reports for each individually licensed acute care hospital, as provided by MHD 474.

A multi-hospital corporation or organization operating more than one hospital may act as the reporting organization for the hospital to the system. This reporting organization shall provide all information separately for each hospital it operates. The reporting organization shall also provide with this information, a statement detailing the financial relationship between each hospital it operates and the reporting organization, as required by MHD 474 A.1.a.(6), for the annual financial information report.

~~6.~~ F. Filing of Reports: Extensions. Upon reasonable cause being shown by a hospital, the system may extend any period of time established for the submittal of any report or other information, or any period of time established for the performance of any other act permitted or prescribed by these rules, for an additional and specified period of time.

MHD 482-MHD 486 RESERVED FOR FUTURE USE

MHD 487 Investigations, Analysis and Review Standards. The system shall investigate, analyze and review all reports and other information it receives relating to hospital rates according to the following standards:

A. Bases for Judging the Reasonable Use of Finances in a Hospital. In all investigations, analyses, and reviews conducted pursuant to Minnesota ~~Laws 1976, Chapter 296,~~

~~Article-II,-Sections-1-through-9,~~ Statutes, §§144.695-144.703, and these rules, the system shall recognize that rates must supply the financial resources necessary to meet the financial requirements of a hospital. In meeting the reporting requirements of these rules, hospitals shall address the contents of their reports to and indicate their compliance with these financial requirements and to the other stated bases for judging the reasonable use of finances in a hospital. The system shall then conduct investigations, analyses and reviews following these established bases.

1. Financial Requirements of Hospitals. The rates charged to patients or their insurers by a hospital must be adequate to maintain the solvency of the hospital. Rates should provide adequate money to meet expenses incurred in the following specific categories:

   a. Current Operating Needs Related to Patient Care. In meeting the needs of a hospital to provide health care services, rates should provide finances necessary to meet expenses incurred by:

      (1) Direct Patient Care.

         (a) Rates should provide finances to meet expenses in this category which may include salaries, wages, employee fringe benefits, services, supplies,

normal maintenance, minor building modification and any applicable taxes.

(b) The monetary value of services provided by members of religious orders, other organized religious or social service groups or organizations or by a unit of government, such as a county, may be included in rates, provided:

(i) That value does not exceed the amount that would have been paid to regular salaried hospital employees for the provision of the same services;

(ii) The maximum value for non-governmental services is the cash payment to the order, group or organization from the hospital;

(iii) That value is reduced by the expense incurred by the hospital for the provision of any room and/or board without charge to members of those orders, groups, or organizations.

(2) Interest Expense.

(a) Rates should provide the finances necessary to recover costs incurred

by the hospital due to necessary and proper interest on funds borrowed for operating and plant capital needs.

(b) Interest on funds borrowed for operating needs is the cost incurred for funds borrowed for a relatively short term. This interest is usually attributable to funds borrowed for such purposes as working capital for normal operating expenses.

(c) Interest on funds borrowed for plant capital needs is the cost incurred for funds borrowed for plant capital purposes, such as the acquisition of facilities and equipment, and capital improvements. These borrowed funds are usually long-term loans.

(d) Interest is necessary if it is:

(i) Incurred on a loan made to satisfy a financial need of the hospital. Loans which result in excess funds or investments should not be considered necessary;

(ii) Incurred on a loan made for a purpose reasonably related to patient care. ~~Loans made to~~

~~finance-that-portion-of-the-cost of-acquisition-of-a-facility-that exceeds-historical-cost-and-which has-been-determined-to-have-excess-capacity,-pursuant-to-MHD 487-A.4.,-or-whose-services-have been-determined-to-be-inappropriate,-pursuant-to-Public-Law 93-641,-§1523-(a)(6)-(National Health-Planning-and-Resources Development-Act-of-1974),-are-not considered-to-be-for-a-purpose reasonably-related-to-patient-care.~~ Loans made for the following are not to be considered to be for a purpose reasonably related to patient care: to expand facilities that have been determined to have excess capacity, pursuant to MHD 487 A.4.

(e) Interest is proper if it is incurred at a rate not in excess of what a prudent borrower would have to pay in the money market existing at the time the loan was made.

(3) Educational Program Expenses.

(a) Rates should provide the finances necessary to recover the net cost to the

hospital of providing educational activities which:

(i) Are approved educational activities and can be demonstrated to directly contribute to the care of patients who are in hospitals during the time the cost is incurred; ~~and~~ or

(ii) Can be demonstrated to contribute to the preventive health education of the population of areas of patient origin which the hospital serves.

(b) "Approved educational activities" means formally organized or planned programs of study usually engaged in by hospitals in order to enhance the quality of patient care in a hospital. These activities shall be licensed where required by State law. Where licensing is not required, the hospital shall be able to demonstrate that it has received approval for its activity from a recognized national professional organization for the particular activity. Approved educational activities include those programs defined

as approved by 20 CFR 405.116(f) (Medicare) and 20 CFR 405.421(e) (Medicare).

(c) "Net cost" means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursement from grants, tuition and specific donations. Non-inpatient revenue sources, including fees from those receiving educational benefits, should be investigated and utilized prior to the inclusion of the cost of community preventive health education in financial requirements.

(d) "Orientation" and "on-the-job training" costs are recognized as normal operating costs of hospitals for employees of the hospital.

(e) The extent of costs incurred for the provision of educational activities contributing to the preventive health education of the population of the hospital's areas of patient origin should not exceed that amount necessary to provide activities recommended

appropriate for hospitals by the State Health Planning and Development Agency, and appropriate health systems agency, pursuant to Public Law 93-641, §1523 ~~(a)(6)~~ and §1513, respectively. ~~In any instance, these costs should not include any payments in excess of the normal salary or remuneration to professional employees of the hospital or health professionals who maintain consultative, contractual, or patient relationships with that hospital.~~

(4) Research Program Expenses. Rates should provide finances necessary to meet costs incurred by a hospital due to research programs which directly relate to daily patient care to the extent that non-patient revenue of the hospital is unavailable to offset these research costs. Rates should not provide finances necessary to meet costs incurred by a hospital due to research purposes, over and above usual patient care.

(5) Bad Debt, Charity Allowances, ~~Courtesy Discount Allowances,~~ and Contractual Allowances ~~Expenses~~.

(a) Rates should provide finances necessary to recover losses in revenue due to bad debts, charity allowances, ~~courtesy-discount-allowances,~~ and contractual allowances.

(i) "Bad debts" mean amounts considered to be uncollectable from accounts and notes receivable which were created or acquired in providing services. Accounts receivable and notes receivable are designations for claims arising from the rendering of services, and are collectable in money in the near future. These amounts should not include any amount attributable to a reclassification of any expenses incurred due to the provision of charity care. Income reductions due to charity allowances, ~~courtesy-discount allowances~~ and contractual allowances should be recorded as such in the records of a hospital and not as bad debts.

(ii) "Charity allowances" mean the provision of care at no charge to patients determined to be qualified for care according to 42 CFR 53.111(f) and (g), in hospitals required to provide free care, pursuant to 49 U.S.C. §291, et. seq. (The Hill-Burton Act). The annual amount of charity care shall be no greater than the amount of the Hill-Burton grant or Hill-Burton guaranteed loan amortized in equal installments over the life of the hospital's Hill-Burton free care obligation.

(iii) "Contractual allowances" ~~and "courtesy-discounts" are those governmental contract adjustments to or other cost justified discounts or differentials from the established charges of a hospital.~~ , "Cost justified Discounts" and "Non-cost justified Discounts."

(aa) "Governmental contract adjustments" are those discounts from the established

charges required due to governmental reimbursement practices established pursuant to regulations authorized by such governmental programs as those created by Title V, Title XVIII and Title XIX of the United States Social Security Act.

(bb) "Cost justified discounts" or "differentials" mean those cash, trade, or quantity discounts or differentials from the established charges. ~~granted to certain patients, groups of patients, or third-party payers at the time services are paid for.~~ In order to include the amount of these discounts or differentials in rates, hospitals shall demonstrate that the value, as measured in money, of services or other benefits for an accounting period provided by

certain patients, groups of patients, or third party payors to the hospital is equal to or greater than the aggregated amount, as measured in money, of the differential or discount granted to certain patients, groups of patients or third party payors for that same accounting period.

(cc) Discounts or differentials which are not cost justified in a manner consistent with MHD 487 A.1.a.(5)(a)(iii)(bb), above, shall not be included in rates but shall be treated as reductions in revenue and recorded by the hospital as such.

(b) These losses in revenues due to bad debts, charity allowances, ~~courtesy discount allowances,~~ and contractual allowances should be offset by available and applicable income from sources other than patients, as identified by

MHD 487 A.2., before these losses are included in rates. Such offsets should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs.

b. Plant Capital Needs. Rates should provide the finances necessary for various plant capital needs. ~~Plant capital needs must be funded to be included in the rates.~~ In order to include plant capital needs in rates, the hospital must fund the plant capital requirement and be in receipt of a certificate of need as required by Minnesota Statutes §145.71-§145.84. Funding of depreciation shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund.

(1) Finances which relate to land, land improvements, building and building equipment and movable equipment shall be placed in *an identifiable* fund. The use of the fund shall be restricted to debt principal retirement, new plant and equipment (with certificate of need approval if necessary), major repairs, and replacement of capital equipment (with certificate of need approval if necessary). The annual increment to this fund

should be:

(a) ~~The greater of:~~

~~(i) The annual debt principal repayment on buildings, building equipment and movable equipment. This principal repayment should be computed as though it were a level payment over the life of the debt instrument, or~~

~~(ii)~~ The annual straight-line depreciation expense on land improvements, buildings, building equipment and movable equipment.

(b) Plus inflation factors, annually determined and consistent with the established useful lives of land improvements, buildings, building equipment, and movable equipment. These inflation factors shall be determined by the *system* on the basis of a price level adjustment index recognized by independent public appraisers as expressing the annual price level adjustment from historical cost of hospital land improvements, buildings, hospital building equipment and movable equipment.

The system shall derive these factors from any of the most current indices then available to the system which give specific recognition to the following factors:

(i) The effect of inflation upon the replacement cost of existing land improvements, buildings, building equipment, and movable equipment, based upon their historical cost; and

(ii) The effect of inflation upon funds necessary for the modification of or addition to hospital buildings, land improvements, building equipment, and movable equipment.

(2) 100 percent of the inflation factors should be included by the hospital as the annual inflation factor unless the hospital has been determined to have excess capacity, as provided by MHD 487 A.4., or by the appropriate health systems agency, professional standards review organization and State Health Planning and Development Agency. In instances where excess capacity exists, the annual inflation factor and the level of

debt principal payment in excess of the depreciation allowance permitted by MHD 487 A.1.b.(1) should be reduced by the proportion of facilities determined to be in excess.

(3) The fund may not be sufficient to retire existing debt.

(4) The annual interest income earned from an investment of this fund annually should be used to reduce the inflation factor requirements for plant capital needs which are included in rates. In addition, the annual increment to the plant capital fund, when projected over the lives of the depreciable assets of the hospital using the current year's experience, should be evaluated with regard to the individual hospital's capital needs in relationship to the appropriate health systems agency's areawide health plan and the State Health Planning and Development Agency's State Health Plan.

(5) In the event that sufficient financial resources are not available in this fund to meet plant capital needs (including the need for the replacement of existing facilities and the need for expansion of the scope of

services to accommodate advances in medical technology, where either or both of these needs have received certificate of need approval when required), the additional financial resources should be acquired from:

(a) Income from appropriate sources other than patients;

(b) Borrowed funds or leases ~~when~~ to the extent income from sources other than patients can be demonstrated to be inadequate; or

(c) Approved inclusion in rates~~,-when-the hospital~~ to the extent it can demonstrate that insufficient resources exist ~~in-(i)-or-(ii)~~ from (a)and (b) above, ~~or-when-a-hospital-can-demonstrate~~ and that inclusion in rates will result in a lower cost to current patients than would result from the borrowing of funds or leasing of plant capital assets. Approval of inclusion in rates shall be by the system upon demonstration by the hospital of ~~either~~ ~~or~~ both of the conditions herein stated. Once approved, the inclusion in rates of these additional financial requirements may be considered reasonable.

Any portion of the annual equal amortized historical cost of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated.

(6) If a hospital can demonstrate that an emergency exists, then the hospital may, with certificate of need approval, include the cost of the emergency plant capital needs directly in its rates in a manner consistent with the previous financial practices of that hospital.

(7) If a hospital can demonstrate that the ~~inclusion-in-the-fund~~ assumption of any specific capital debt will result in a greater cost to current patients than depreciation or retirement of that debt under consistent financial practices of that hospital which differ from the ~~funding~~ determination of plant capital needs as stated by these rules, then a hospital may choose ~~not-to-fund-the-specific-capital-debt.~~ an alternative method of meeting its plant capital needs. In this instance, the hospital

should provide complete information to the system regarding the precise method which will be used to meet such a plant capital need. Direct inclusion of plant capital needs in rates requires approval by the system as provided by MHD 487 A.1.b., above.

c. Incremental Operating Cash Needs. Rates should provide finances to maintain a reasonable working capital allowance.

(1) The working capital allowance which may be included in rates is determined by the annual incremental difference between (net accounts receivable and inventories and prepaid expenses) and (salaries payable and other net payables) at the end of an accounting period. Any increases in working capital over the prior year, as stated in the first report of annual financial information submitted to the system by a hospital shall form the initial basis for the system's assessment of the reasonableness of the working capital allowance.

(2) The amount of working capital is dependent upon the number of days charges in accounts receivable for the hospital. These days charges should be stated in aggregate for an accounting period. ~~and a~~ A statement of

accounts receivable by payor must also be provided.

(a) Payors may include:

(i) Third party payors, including:

(aa) Medicare;

(bb) Medicaid;

(cc) Blue Cross;

(dd) Health maintenance organizations;

(ee) Other insurers; and

(ii) Paying patients.

(b) The number of days charges in accounts receivable for the hospital is determined by:

$$\frac{\text{Total Net Accounts Receivable At The End Of An Accounting Period}}{\text{Total Patient Charges For The Same Accounting Period}} \Big/ \text{Actual Number of Calendar Days In That Same Accounting Period}$$

(3) "Net accounts receivable" means the dollar amount accounts receivable at the end of an accounting period less estimated discounts and differentials and reserve for uncollectables.

(a) To the extent that the number of days charges in accounts receivable for a hospital increases from one accounting period to another subsequent accounting

period, the hospital may increase rates to maintain its working capital allowance.

(b) To the extent that the number of days charges in accounts receivable for a hospital which is attributable to a particular payor or category of payors decreases, the working capital allowance should be reduced by that amount.

(4) "Inventories" means the dollar amount in inventories at the end of an accounting period. The dollar amount in inventories should not increase from one accounting period to another subsequent accounting period unless the hospital can justify such an increase as due to inflation, alterations in scope or volume of services offered.

(5) "Other net payables" means total payables at the end of an accounting period less all liabilities owed to third party payors and less the current portion of plant capital expenditure from the plant capital fund.

(6) The reasonableness of the working capital allowance depends upon factors including:

(a) The number of days charges in accounts

receivable for a hospital compared with the number of days charges in accounts receivable for toher hospitals determined by the system to share common characteristics. This number may be compared for hospitals in total;

(b) The amount of bad debts accrued by a hospital during an accounting period; and

(c) The amount of finances a hospital may hold in reserve funds.

2. Income From Sources Other Than Patients. In all investigations, analyses, and reviews conducted pursuant to these rules, the system shall recognize that hospitals have sources of income other than patients which are intended to be or may be used for the reduction of its rates. In meeting the reporting requirements of these rules, hospitals shall disclose the extent to which this income is used to offset costs and to provide service in such a manner as to reduce rates charged patients. This income includes:

a. Restricted Endowment Funds, Specific Purpose Funds, and Gifts.

(1) Income from endowment funds or gifts restricted by donors to provide for services

for designated patients should be used to reduce the payment for those services.

(2) Income from endowment funds or gifts restricted by donors to provide for buildings and movable equipment should be used to reduce the designated building and movable equipment capital needs, as appropriate.

(3) If a hospital has restricted funds which could be used for a building or equipment purchase but chooses instead to use borrowed money, all costs associated with paying off the incurred debt should not be considered reasonable unless the hospital demonstrates that the financing method used was to the economic benefit of patients then utilizing that building or equipment.

(4) If funds are restricted to a particular type of plant capital project, which is not a replacement of a previous or existing project, these funds should not be used until the hospital has obtained a certificate of need, if required, for that type of plant capital project.

~~(5)--If-funds-or-the-income-therefrom-are-restricted-to-the-provision-of-charity-care,~~

~~these-funds-or-their-income-should-be-annually-budgeted-to-offset-charity-care-requirements-prior-to-the-budgeting-of-the-use of-any-patient-generated-revenue-for-charity care-for-any-accounting-period.~~

~~(6)~~ (5) Funds restricted to research should be used if needed and available to offset any research costs. Patient revenues from revenue cost centers should not be used to provide matching monies for non-patient-care related research.

b. Unrestricted Funds from Non-Patient Sources. Unrestricted funds from non-patient sources should be used to reduce the total financial requirements of a hospital. Exceptions to this rule may be granted if the hospital can show that alternative uses of these funds are to the economic benefit of current patients and/or in the best interests of the community served.

c. Auxiliary Enterprises. Profits from such enterprises operated by hospitals should be used primarily to offset the financial requirements of a hospital. Such enterprises should be self-sufficient and profitable. Any losses incurred by the hospital due to such an enterprise which can be demonstrated to be a fringe benefit to

hospital employees or of direct economic benefit to patients receiving care during the period of incurred loss may be included in rates.

d. Special Projects Income. Income received to finance special projects or salaries paid to special project employees should be deducted from financial requirements before determining the amount of payment to be made for patient services. Income to the hospital from the special projects in excess of the projects' financial requirements should be used to offset the hospital's financial requirements.

e. Income from sources other than patients used as offsets to rates should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs. If such a condition should result, the offsets should be adjusted to that portion which would not cause this condition.

3. Variations From Budgeted Volumes of Activity and Service. Changes in the aggregate rates may be necessary due to variations from budgeted volumes of activity and service. The financial requirements of a hospital for a budget year should reflect adjustments in volumes of activity and service realized during the prior and current years.

a. If a hospital over-projects its volume in a service center, in the next year its financial requirements should be increased by an amount equal to the ~~percentage~~ ratio of ~~(~~fixed~~)~~ to total costs for that service center ~~and~~ multiplied by the income loss due to unrealized activity.

b. If a hospital under-projects its volume in a service center, in the next year its financial requirements should be reduced by the ~~percentage~~ ratio of ~~(~~fixed~~)~~ to total costs of that service center ~~and~~ multiplied by the difference between the actual and budgeted income of that service center.

c. The system proposes three alternative procedures for identifying the costs related to increased volume or reduction in expenses anticipated resulting from decreases in volume as compared to original budget forecast.

(1) Alternative 1. The system will establish different fixed to variable expense ratios for different peer groups of hospitals. The ratios will vary from 80%/20% to 60%/40% and shall be applied to hospitals in a manner consistent with the hospital's size and complexity of services.

The fixed to variable expense ratio will be applied to total patient admissions adjusted for outpatient activity, with the adjustment based on the ratio of outpatient revenues to inpatient revenues.

(2) Alternative 2. In the event that an individual hospital identifies that its fixed to variable expense ratio differs significantly in aggregate total from that established by the system, that hospital may submit supporting data to the system requesting a fixed to variable ratio different than that adopted for its peer group. In such cases, the system may approve a fixed to variable expense ratio other than that established under MHD 487 A.3.c.(1). Under this alternative, the fixed to variable ratio would represent an aggregate average hospital-wide experience and would be applied to adjusted patient admissions, with the adjustment based on the ratio of outpatient revenues to inpatient revenues.

Revenue and rate adjustment based on volume variance within the provisions of Alternatives 1 and 2 can be made on aggregate

average annual rates per adjusted patient admissions. These rates, based on total approved budget, are identified at the time of the budget review.

(3) Alternative 3. In the event that a hospital has identified that its operating expenses by service center depart drastically from the fixed to variable expense ratio at the aggregate level, such a hospital may submit supporting data to the system establishing a different fixed to variable expense ratio for each service center. In such instances, the volume variances would be measured according to the unit of service established for each service center, and the expense adjustment allowance would be based on the ratio of fixed to variable expenses for each service center, rather than on the aggregate overall average expenses and per adjusted admission.

4. Excess Capacity. For hospitals with occupancy rates, based upon staffed and set up beds, below the average occupancy rate of other hospitals determined by the system to share common characteristics, the aggregate rates set on the basis of costs may produce

unreasonable charges to patients. The system may assess the aggregate rates of such hospitals where the criteria of need for beds shall be consistent with the demand for beds as indicated on a hospital or a service center level by occupancy rates. In cases where low occupancy appears to affect the aggregate hospital rates, the hospital shall be considered to have excess capacity.

a. Prior to any determination by the system that excess capacity exists in a hospital, the system shall submit its preliminary determination to the appropriate health systems agency and to the State Health Planning and Development Agency, both of which are identified according to Public Law 93-641,§§1515 and 1521~~.~~, as well as the appropriate professional standards review organization. These agencies may comment to the system regarding the consistency of this preliminary determination with health ~~planning~~ care standards regarding occupancy rates~~.~~ in their areas of expertise.

b. If these agencies comment that this preliminary determination is consistent with health planning standards and, if applicable, the declarations of an appropriateness review, then the system may determine a hospital to have excess capacity.

This determination shall state in quantitative terms the extent of any determination of excess capacity and the basis for the determination.

c. In hospitals where excess capacity exists, the annual inflation factor and any debt principal payment to the plant capital fund which relates to beds, in excess of the depreciation allowance permitted by MHD 487 A.1.b.(1), should be reduced by the proportion of excess beds to total beds available.

B. Investigations.

1. The system may investigate any or all hospital rates, rate components or rate structures established by a hospital or common to more than one hospital. Such investigations shall be supplemental to and not in place of review of reports of rate revenue and expense or interim increase reports as authorized by MHD 487 C.2.

2. The system shall investigate the basis of existing rates as contained in the rate revenue and expense reports of hospitals in an effort to assess whether or not current rates are reasonable, equitable, and non-discriminatory among insurers.

3. The system shall notify any hospital or hospitals whose rates, rate components or rate structures are to be

investigated, as provided by (1) or (2) above, and shall state the objective of such an investigation.

4. Investigations and subsequent reports shall analyze rates, rate components and rate structures in accordance with the bases for judging established by MHD 487 A.

5. Investigative Report. Subsequent to an investigation, the system shall issue an investigative report which shall detail its findings. The findings of an investigative report shall be considered in the review of any interim increase or rate revenue and expense report subsequently submitted by an investigated hospital.

C. Review of Reports.

1. General Provisions: Completeness.

a. Each report required by these rules shall be reviewed by the system in order to ascertain that the report is complete. A report shall be deemed to be filed when the system has ascertained that the report is complete. Complete means that the report contains adequate data for the system to commence its review in a form determined to be acceptable by the system pursuant to MHD 474 A., MHD 474 B., and MHD 474 C., as appropriate.

b. If the system has not responded to the hospital within ten working days after the receipt of a report by the system, the report is deemed to be

complete and filed as of the initial day of receipt by the system. The system may stipulate any additional time it may need to ascertain a report's completeness in which case, the ten working day period does not apply. Such stipulated additional time shall not exceed thirty days after the day of the initial receipt of a report by the system. If a report is not found to be incomplete during such additional period, it shall be deemed to be complete and filed as of the initial day of receipt by the system.

c. A report determined by the system to be incomplete shall be returned immediately by the system to the hospital ~~stating the need for more data.~~ with a statement describing the report's deficiencies. The hospital shall resubmit an amended report to the system. Such a return and resubmittal shall be recorded in that hospital's file as maintained by the system. If the resubmitted report is determined to be complete by the system, then it shall be deemed to be filed on the date the resubmitted report is received by the system.

d. Reports filed with the system by hospitals prior to the effective date of this rule shall be deemed to be temporarily complete. Subsequent to the

effective date of these rules, the system may require hospitals to amend these reports to conform with the requirements of these rules.

e. If a hospital discovers any error in its statements or calculations in any of its submitted reports ascertained by the system to be complete, it shall inform the system of the error and submit an amendment to a report.

(1) In the case of an interim increase report or a rate revenue and expense report, the submittal of an amended report by a hospital to the system shall not affect the date of filing or the sixty-day period required, providing:

(a) The hospital informs the system of any errors ~~within thirty calendar days of the initial filing of a report;~~ prior to the system's public comments on the reasonableness of the hospital's aggregate rate; and

(b) The ~~amendment to the report is submitted to the system by a date determined by the hospital and the system to be acceptable.~~ errors are not of such great magnitude as to affect the system's ability to make a fair comment.

(2) An amended rate revenue and expense report or interim increase report not meeting the conditions established by MHD 487 C.1.e.(1), above, shall be refiled as if it were a new report.

f. If the system discovers an error in the statements or calculations in a report filed with it which the system determines will have a noticeable impact upon its ability to render a fair comment on the report, it may:

~~(1)--If the discovery occurs within thirty calendar days after the date of filing of the report,~~ require the hospital to amend and resubmit the report by a date determined by the system ~~and the hospital to be acceptable.~~ to be reasonable. The initial filing date is not affected ~~in this instance.~~ if the hospital resubmits the report by the determined date. If the hospital fails to resubmit the amended report by that date, the date of filing shall be the date the system receives the resubmission.

~~(2)--If the discovery occurs thirty calendar days or more after the date of filing of the report, require that the hospital resubmit a new report. The date of filing shall then be the date when the new report is submitted to the system, pending the determination by the system that the new report is complete.~~

2. Review of Rate Revenue and Expense Reports and Interim Increase Reports.

a. These reports shall be reviewed on a basis of the rate and cost history of each hospital on an institutional and a service center basis. Statistical and financial information available for a hospital as a whole institution may be compared with the same type of information for other peer hospitals which share common characteristics. In instances where service centers among hospitals sharing common characteristics themselves share common characteristics, hospitals may be compared on a service center basis. Common characteristics may include:

(1) Similarity in available number of beds and related occupancy rates;

(2) Similarity in composition of areas of patient origin;

(3) Similarity in composition of patient services;

(4) The status of a hospital as a teaching or non-teaching institution;

(5) Similarity in size and composition of full-time-equivalent staff of the hospital and ratios of that staff to patient admissions; and

(6) Other data determined by the system to be appropriate which may be available pursuant

to annual licensing report requirements as established pursuant to MHD 78(d)(1).

b. Comment. The system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the board and the public prior to the implementation of proposed budgets or rates. The comment shall state that a hospital's existing and proposed rates are reasonable or are in question.

(1) Bases which may be used to comment that a hospital's existing and prospective rates are reasonable, include:

(a) Rates are similar to the average of the aggregate rates then in effect for other hospitals in a peer group;

(b) Prospective aggregate rates represent a minimal increase which is consistent with the principles of the bases for judging established by MHD 487 A.;

(c) Aggregate Rrates have been demonstrated by the hospital to be necessary and consistent with the principles of the bases for judging established by MHD 487 A.

(2) Bases which may be used to comment that a hospital's existing and prospective rates are in question include:

(a) Rates deviate from the average of the rates then in effect for other hospitals in a peer group;

~~(b)--Rates-provide-revenue-which-is-in-excess-of-expenses-which-deviate-from-the-past-financial-practices-of-that-hospital,-of-hospitals-sharing-common-characteristics,-or-which-deviate-from-the-principles-of-the-bases-for-judging-established-by-MHD-487-A.;~~

~~(c)~~ (b) Rates have not been demonstrated by the hospital to be necessary and consistent with the bases for judging established by MHD 487 A.

D. Public Meetings. All official meetings of the system, including executive sessions, which occur for any purpose related to completion of an investigation, release of results of an analysis, or issuance of comment upon review of reports pursuant to these rules shall be open to the public. Public notice shall be given one week in advance of any official meetings of the system where the results of investigations, analyses or reviews are to be discussed or acted upon.

E. Burden of Proof. In all matters relating to the review of interim increase reports or rate revenue and expense reports or other analyses or investigations, the burden

of proof of the reasonableness, equity and lack of discrimination of established or proposed rates under review shall rest with the hospital.

F. Consolidation. When two or more investigations, analyses or reviews involve common questions of fact, the system may address the common questions of fact and make comments applicable to all hospitals under consideration.

MHD 488-MHD 495 RESERVED FOR FUTURE USE

MHD 496 Approval for Operation of the System. The board may approve the operation of the system by any voluntary, nonprofit rate review organization.

A. Application. Such an organization desiring this approval may apply for approval by the following procedure:

1. Open Application Period. A voluntary, nonprofit rate review organization may apply for approval of its reporting and review procedures after January 1 and before March 31 of a fiscal year, or within ninety days after the effective date of these rules, for operation of the Minnesota Hospital Rate Review System during the next subsequent fiscal year.

2. Contents of Application. An application for approval shall include:

a. A detailed statement of the type of reports and administrative procedures proposed by the applicant

which shall demonstrate that, in all instances, the reports and procedures are substantially equivalent to those established by the system, pursuant to MHD 474, MHD 481, and MHD 487.

b. A statement that all reports determined to be complete and information filed with the applicant from its participating hospitals shall be available for inspection by the board and the public within five working days after completeness of reports is proposed to be determined and at least prior to the proposed date of issuance of any findings and comments.

c. Provisions establishing a proposed enrollment period for hospitals which shall not extend beyond March 31 of any fiscal year, or beyond ninety days after the effective date of these rules in the first instance, for any eligible hospital that wishes to participate in the proposed program of the applicant for the next three subsequent fiscal years.

d. Provisions establishing any proposed criteria whereby a hospital may be judged by the applicant to be eligible for participation in its proposed program.

e. Any additional statements or information which is necessary to insure that the proposed reporting and review procedures of the applicant are substantially equivalent to all the rules established for the system, pursuant to MHD 474, MHD 481, and MHD 487.

B. Review of Application.

1. Within forty-five calendar days of the receipt of an application for approval by a voluntary, nonprofit rate review organization, the board shall issue its decision that the procedures for reporting and review proposed by the applicant are approved or disapproved. Approval by the board shall take effect immediately.

2. Disapproval. The board may disapprove any application on demonstration that the reporting and review procedures of any voluntary, nonprofit rate review organization are not substantially equivalent to those established by the board.

3. Reapplication. An organization whose application has been disapproved by the board may submit a new or amended application to the board within fifteen calendar days after disapproval of the initial application. An organization may only reapply for approval on one occasion during any fiscal year.

C. Annual Review of Applicant.

1. By March 31 of each year, any voluntary, nonprofit rate review organization whose reporting and review procedures have been approved by the board for the fiscal year then in progress which desires to continue operation of the system shall submit an annual review statement of its reporting and review procedures.

2. The annual review statement shall include:

   a. Attestation by the applicant that no amendments or modifications of practice contrary to the initially approved application have occurred; or,

   b. Details of any amendments or modifications to the initially approved application, which shall include justifications for those amendments or modifications.

3. The board may require additional information from the applicant supporting that the applicant's reports and procedures are substantially equivalent to those established for the system.

4. Forty-five days from the receipt of the annual review statement, the board shall issue its decision that the applicant has renewed approval or that the applicant has been denied renewed approval. Renewed approval shall be immediately effective.

5. Denial of Renewed Approval. The board may deny renewed approval on the demonstration that the reporting and review procedures of any applicant are no longer substantially equivalent to those established for the system.

6. Reapplication. An applicant whose renewed approval has been denied by the board may submit a new or an amended annual review statement to the board within fifteen calendar days after denial of the initial statement. An applicant may only reapply on one occasion during the fiscal year.

7. A hospital enrolled with an applicant whose renewed approval has been denied and which has not enrolled with any other applicant whose reporting and review procedures have been approved by the board shall become subject to the system as operated by the board for the next three subsequent fiscal years.

D. Revocation of Approval. The board may revoke its approval of any applicant's reporting and review procedures at any time upon demonstration that the reporting and review procedures of that organization are no longer substantially equivalent to those required by the system.

MHD 497-MHD 503 RESERVED FOR FUTURE USE

MHD 504 Board Determination of Allowable Increase Limit.

A. The board maintains the authority to establish allowable increase limits. Increases in rates which have minimal impact upon the average charges per patient admission for the hospital are allowed to meet expenses incurred by a hospital due to inflation. Increases are determined to have minimal impact if they do not exceed, for any projected accounting period or portion thereof, a cumulative total of the appropriate quarterly allowable increase limits established by the board.

B. During the quarter of the first fiscal year that these rules are effective, the board shall establish a quarterly allowable increase limit:

1. For each of the full quarter(s) of its current fiscal year which remain unexpired at the time rules are promulgated; and
2. For each quarter of its next subsequent fiscal years necessary to result in a total of six quarterly allowable increase limits corresponding to the next six quarters of the current and next subsequent fiscal years occurring immediately after the implementation of these rules.

C. At the beginning of each quarter subsequent to the effective date of these rules, the board shall establish a quarterly allowable increase limit for the sixth subsequent quarter.

D. The board shall provide each hospital and each approved applicant with information concerning the quarterly allowable increase limits on each occasion that the board does establish such a limit.

E. Form. The quarterly allowable increase limit is a single percentage figure which is applicable to the average charges per inpatient admission for the hospital.

F. Basis. This single percentage figure is based upon the averaged monthly Consumer Price Index, as published by the Division of Labor Statistics, U.S. Department of Commerce, stated as percent changes, for relevant previous quarters preceding the establishment of a quarterly allowable increase limit.

G. Compensation. Should quarterly allowable increase limits prospectively established by the board according to these rules allow increases in aggregate rates in excess or less than any actual increases in the Consumer Price Index, the board may compensate for this excess by:

1. Measuring the difference between the prospective quarterly allowable increase limits and the actual changes in the Consumer Price Index for expired quarters; and,

2. Adding or reducing by a reasonable proportion of that difference the next quarterly allowable increase limit to be established by the board.

~~H.--Exceptions.--Increases directly attributable to any of the following causes are allowable, providing the hospital notifies the system by letter at the time of such increases and the exception category under wiich the increase qualifies and the hospital documents any of these as the causes for increase in rates in its next subsequent report of rate revenue and expense:~~

~~1.--The base cost and dollar amount of increased costs of malpractice insurance.--The hospital shall provide information indicating the effective date of any related premium increases.~~

~~2.--The increased cost of any government mandated pension funding requirements.--The hospital shall indicate the effective date of the related cost increase.~~

~~3.--The increased cost of salaries, wages, or fringe benefits to employees resulting from labor negotiations.~~

~~The hospital shall indicate the extent of increased costs.~~

~~4.--Changes in Federal or State law or regulation which cause uncontrollable increases in cost.--The hospital shall indicate the law or regulation causing change and the nature of the effect of the change upon rates.~~

~~5.--Changes in rates in acute care beds in hospitals operated by the commissioner of public welfare due to legislative action.~~

MHD 505-MHD 508 RESERVED FOR FUTURE USE

MHD 509 Fees. Hospitals whose rates are reviewed by the ~~system as operated by the~~ board, as distinct from a voluntary, nonprofit rate review organization, shall submit filing fees with rate revenue and expense reports and interim increase reports which are submitted to the board. These fees are based on the cost of reviews and the number of beds licensed as acute care beds in a hospital, pursuant to Minnesota Statutes, §§144.50 to 144.58.

A. Rate Revenue and Expense Report Fee. On each occasion which a hospital submits a rate revenue and expense report to the ~~system as operated by the~~ board, as distinct from a voluntary, nonprofit rate review organization, it shall accompany this report with a filing fee based upon the following schedules which shall be annually adjusted to reflect the impact of inflation upon these fees, providing the report is timely:

If the Number of Licensed Acute Care Beds of the Hospital Is:	Then the Filing Fee Is:
6 to 24	$ 385.00
25 to 49	$ 495.00
50 to 99	$ 710.00
100 to 149	$ 930.00
150 to 199	$1,150.00
200 to 249	$1,370.00
250 to 299	$1,590.00
300 to 349	$1.810.00
350 to 399	$2,025.00
400 to 449	$2,250.00
450 to 499	$2,470.00
500 or over	$2,685.00

B. Interim Increase Report Fee. On each occasion which a hospital submits an interim increase report to the ~~system-as-operated-by-the~~ board, as distinct from the voluntary, nonprofit rate review organization, it shall accompany this report with a filing fee. This fee shall be one-half of the rate revenue and expense report fee, as established by MHD 509 A., providing the report is timely.

C. "Timely" means that each report has been submitted within the time prescribed by MHD 481 C.1. or MHD 481 D.1., as appropriate, that an extension of these reporting times, as permitted by MHD 481 G., has not been

necessary, and that the report has been determined to be complete, pursuant to MHD 487 C.1. If a report does not meet these standards, the board may require the submission of an additional late fee according to the following late fee schedule:

1. A report submitted after the reporting times established by MHD 481 C.1. or MHD 481 D.1., as appropriate, for which an extension in time has been permitted, pursuant to MHD 481 G., shall be liable for a late fee in addition to the filing fee established by MHD 509 A. or MHD 509 B., above, as appropriate. This late fee shall be ten percent of the filing fee established by MHD 509 A. or MHD 509 B., above and as appropriate for that hospital.
2. A report submitted by a hospital which is determined not to be complete, pursuant to MHD 487 C.1., shall be liable for a late fee for each occasion on which a resubmission as provided by MHD 487 C.1. occurs. This late fee shall be, for each such occasion of resubmission, five percent of the filing fee paid on submission of the initial report to the board by the hospital as established by MHD 509 A. or MHD 509 B., above.
3. Reports not submitted or submitted after the reporting times established by MHD 481 C.1. or MHD 481 D.1.,

as appropriate, for which an extension has not been requested or permitted, pursuant to MHD 481 G., shall be liable for the cost of a full audit by an independent public accountant, as necessary for the completion of the report in addition to the filing fee established by MHD 509 A. or MHD 509 B., above, as appropriate.

D. The board may suspend all or any portion of the filing fees and late fees herein established upon cause being shown by a hospital. Such cause may consider such factors as:

1. The inability of a hospital to pay the fees without directly affecting the rates.
2. The occurrence of any emergency financial condition of a hospital, including natural disasters or difficulties associated with completion of reports related to sicknesses or other absences of related hospital employees or other administrative complications resulting in delay in the completion of reports.
3. Other factors which relate to the economic condition or administrative condition of a hospital.

MHD 510 Official Offices. For purposes of these rules, the official offices of the board are:

Minnesota State Board of Health
717 Delaware Street, Southeast
Minneapolis, Minnesota 55440

MHD 511 Severability. If any section or provision of these rules is declared unconstitutional or void by any court of competent jurisdiction, or its applicability to any person or circumstances is held invalid, the constitutionality or validity of the remainder of the rules and the applicability to other persons and circumstances are not affected, and to this end, the sections and provisions of these rules are declared to be severable.

MHD 512-MHD 520 RESERVED FOR FUTURE USE

APPROVED AS TO FORM AND LEGALITY
MAY 23 1977 19
WARREN SPANNAUS, ATTORNEY GENERAL
BY /s/ Michael B. Miller
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
MAY 23 1977 4:05 P.M.
Joan Anderson Growe
Secretary of State

315

John A. Breviu
Special Assistant
Attorney General

May 27, 1977

- Minnesota Department of Health Rules-
Chapter 28-Rules for the Minnesota Hospital Rate Review System

CERTIFICATE OF BOARD'S

ADOPTION OF RULES RESOLUTION

I, Warren R. Lawson, M.D., do hereby certify that I am the Secretary and Executive Officer of the Minnesota State Board of Health, a board duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of a resolution adopted at a meeting of the said Board of Health duly and properly called and held on the 10th day of March, 1977; that a quorum was present at said meeting; that a majority of those present voted for the resolution; that said resolution is set forth in the minutes of said meeting and has not been rescinded or modified.

RESOLVED, that the rules relating to "In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System" identified as MHD 471-511 which were considered at a public hearing held on the 5th and 6th days of January, 1977, are found to be reasonable, necessary and supported by the evidence contained in the record, and are hereby approved and adopted, pursuant to authority vested in the State Board of Health by Minn. Laws 1976, ch. 296, art. II § 1-9 and that Warren R. Lawson, M.D., Secretary and Executive Officer of the Board, be and hereby is authorized to sign an order adopting those rules.

BE IT FURTHER RESOLVED that the Report of Hearing Examiner be and hereby is adopted by the Board of Health as its own with the following changes:

1. Section 6 (p. 3) - Delete the last two sentences.
2. Section 15 (p. 8) - Amend the last sentence in the first full paragraph to read: "The point is well-taken, and the rule will be modified accordingly."
3. Section 15 (p. 8) - Amend the wording of rule MHD 472 U. to read as follows:

"U. 'Rate' means 'charges' as defined in MHD 472 G. 'Aggregate rate' means the average revenue per adjusted admission for a full accounting period determined by dividing total revenue by the number of adjusted admissions.

$$\frac{\text{Total Revenue}}{\text{Number of Adjusted Inpatient Admissions}}$$

Adjusted admissions are determined by the following formula:

$$\text{Number of Outpatient and Emergency Visits} \times \frac{\text{Total Outpatient and Emergency Revenue}}{\text{Number of Outpatient and Emergency Visits}} \times \frac{1}{\text{Inpatient Revenue Per Admission}} \text{ Plus The Number of Inpatient Admissions}$$

"The aggregate rate for the budget year shall always be based upon annually projected admissions as stated in the rate revenue and expense report."

4. Section 19 (p. 10) - Delete the last sentence in the final paragraph.

5. Section 22 (p. 11) - Delete the last three sentences in this section. Insert instead, "The MHA suggestion has merit and the rule will be accordingly modified."

6. Section 23 (p. 12) - Amend the final sentence in this section to read: "This figure appears to be reasonable and the rule will be so modified."

7. Section 24 (p. 12) - Amend the fifth sentence in this section to read: "At the hearing, the Board offered three amendments to the proposed rules which are reasonable, non-substantial changes (T. 263)."

8. Section 25 (p. 13) - Delete the sixth and seventh sentences and insert the following: "This suggestion has merit. Like the statement detailing allocation methods, it would assist in determining whether standards for offsets to costs and allocations of costs are being followed."

9. Section 25 (p. 13) - Amend the last sentence in the final paragraph on this page to read: "This is common usage and the change should be made."

10. Section 25 (p. 14) - Amend the last sentence from the final paragraph of this section to delete the phrase "stated that it."

11. Section 28 (p. 15) - Delete the last two sentences of this section.

12. Section 35 (pp. 17-18) - Delete the second paragraph of this section.

13. Section 36 (p. 18) - Delete the sixth sentence. In its place, insert the following: "A reasonable modification of the proposed rule would require the filing of the report 'up to sixty days prior' to the commencement of any accounting period of the hospital. The phrase 'up to sixty days prior' is used in lieu of the phrase 'on or before,' which was suggested by MHA, because it is not as open ended. Nevertheless, it still effectively deals with MHA's objections to the original proposal."

14. Section 38 (p. 19) - Delete the last three sentences. Insert instead: "The definition of aggregate rates in MHD 472 U limits the rule to charge modifications. (See Findings 12 and 15). The rule is reasonable as written.

15. Section 38 (p. 19) - Amend the first part of the fourth sentence to read as follows: "The Board finds it is reasonable to combine sections "c", "d", and "e" in one section renumbered as MHD 481 D.2, to read:"

16. Section 49 (p. 24) - Add a sentence to this finding after the reference in the second sentence of this page to the provision suggested by the Board at the hearing. The additional sentence should read: "This proposed provision should be modified to delete the first two words - 'All possible'."

17. Section 53 (p. 26) - Amend the last sentence to read: "The rule is reasonable, but in view of Blue Cross's argument, the Board will limit the allowance to the amount of the original grant or loan guarantee."

18. Section 55 (pp. 27-28) - Amend the last sentence on this page to read as follows: "Second, the provision provides an incentive to all payors (the words 'granted to certain patients, groups of patients, or third party payors at the time services are paid for' should be deleted from (bb) to avoid confusion and to remain consistent with the definition of 'charges' (see Finding #12)) to take steps that will reduce the cost to the hospital."

19. Section 55 (p. 28) - Amend the last sentence to read: "Third, the Board will conduct an on-going evaluation of the reasonableness of these discounts."

20. Section 57 (p. 29) - Add the following sentence at the end of this section: "The change takes the following form in the rules: 'In order to include plant capital needs in rates the hospital must fund the plant capital requirement and be in receipt of a Certificate of Need as required by Minn. Stat. § 145.71 et seq.'."

21. Section 59 (p. 30) - Amend the third sentence on this page to read: "It was noted by the Hearing Examiner that this rule as proposed could encourage what the Board intends not to encourage and that the temptation could be difficult to resist by the hospitals."

22. Section 59 (p. 30) - Amend the sixth sentence to read: "This defect has been cured by eliminating the provision entirely." Delete the last two sentences.

23. Section 60 (pp. 31-32) - Delete the third through seventh sentences of the paragraph beginning on the bottom of p. 31.

24. Section 62 (p. 33) - Delete the last sentence in this section. Insert the following: "The following language is added to rule MHD 487 A.1. b(4): 'In addition, the annual increment to the plant capital fund, when projected over the life of the depreciable assets of the hospital using the current year's experience, should be evaluated with regard to the individual hospital's capital needs in relationship to the appropriate health systems agency's areawide health plan and the State Health Planning and Development Agency's State Health Plan.' "

25. Section 63 (p. 33) - Amend the last sentence to read: "The Board finds that this change clarifies the rule."

26. Section 68 (p. 35) - Delete the last two sentences. Insert the following language: "The following addition to the rule will provide additional flexibility: 'Exceptions to the rule may be granted if the hospital can show that alternative uses of their funds are to the economic benefit of current patients and/or in the best interests of the community served'."

27. Section 70 (p. 37) - Delete the last three sentences. Insert: "The proposed method contained in the rule and explained by the Statement of Justification is reasonable."

28. Section 71 (p. 38) - Delete the last sentence in this section.

29. Section 74 (p. 39) - Delete the last two sentences and insert: "The Board believes that the rule can be clarified by adding a provision to the end of 487 C.1.b. stating, 'If a report is not found to be incomplete during such additional period, it shall be deemed to be complete and filed as of the initial day of receipt by the System.' "

30. Section 74 (p. 39) - Amend the last sentence of the second paragraph on this page to read: "The Board finds it appropriate to modify the phrase quoted above to read, '. . . with a statement describing the report's deficiencies'. "

31. Section 74 (pp. 40-41) - Amend the last sentence in this section to read: "These two sections have been re-worded to more accurately and appropriately meet the objectives stated by the Board and are now reasonable."

32. Section 76 (p. 42) - Amend the last sentence in this section to strike all words following the word "Act."

33. Section 83 (pp. 43-44) - Delete this entire section.

34. Conclusion No. 4 (p. 45) - Delete.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 20th day of April, 1977.

STATE OF MINNESOTA

BOARD OF HEALTH



WARREN R. LAWSON, M.D.
Secretary and Executive Officer

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System.

FINDINGS OF FACT

The above-entitled matter came on for hearing on January 5 and 6, 1977, in the Board Room, Minnesota Department of Health Building, 717 Delaware Street, S.E., Minneapolis, Minnesota, before Steve M. Mihalchick, Hearing Examiner appointed by the Chief Hearing Examiner.

This is a rules hearing pursuant to Minn. Stat. Ch. 15, to determine whether proposed new Minn. Rules MHD 471-511 should be adopted.

The following persons appeared for the Board of Health (Board): Fredric L. Sattler, Consulting Director, Minnesota Hospital Rate Review System, Department of Health (Department); John Breviu, Special Assistant Attorney General, representing the Department of Health; Kent Peterson, Chief of Planning & Resources Control, Department of Health; and Stephen M. Jackson, Legislative Analyst/Health, Minnesota House of Representatives, Former Consultant to the Board of Health.

Eighty persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard.

After the record in this hearing was closed and after receiving the report of the Hearing Examiner, the Minnesota Board of Health (hereinafter "Board") considered this matter at its March 10, 1977 meeting.

Based upon all the records and proceedings, herein, the Board makes and enters the following:

FINDINGS OF FACT

PROCEDURAL REQUIREMENTS

1. On November 11, 1976, the Board filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules;
(b) A proposed Order for Hearing and authorizing resolution;
(c) A proposed Notice of Hearing; and
(d) A Statement of the estimated length and number of people attending the hearing.

2. On November 30, 1976, a Notice of Hearing and a copy of the proposed rules were published at 1 State Register 832.

3. On November 23, 1976, the Board mailed the Notice of Hearing, with an attached summary of the proposed rules, to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice.

4. On December 10, 1976, the Board filed the following documents with the Office of Hearing Examiners:

(a) The Order for Hearing and authorizing resolution;
(b) The Notice of Hearing as mailed;
(c) The Affidavit of Receipt of the Secretary of State's list;
(d) The Affidavit of Mailing;
(e) The Secretary of State's Certificate and list;
(f) The Affidavit of Mailing of a notice pursuant to Minn. Stat. § 15.0412, subd. 6, a copy of the Notice and material received pursuant to the Notice;
(g) The names of Board personnel who will represent the agency; and
(h) A combined Statement of Need and Evidence (the Statement of Justification).

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing.

5. The record remained opened through January 26, 1977, for the receipt of written comments and statements. Nine public comments were received within the 20-day period. Two additional comments were received thereafter and are included in the record because the Board must consider all comments received before it takes final action.

6. Prior to the hearing, Mr. O'Hare of the Health Insurance Association of America (HIAA) telephoned the Examiner to ask some procedural questions. During that conversation, Mr. O'Hare asked whether it would be appropriate to point out some matters occurring during the drafting of the proposed rules that might appear to be unfair. The Examiner advised him that it would be quite appropriate. At the hearing, Mr. O'Hare raised

two such matters. First, that HIAA had had little opportunity to participate in the drafting of the rules. Second, that Mr. Sattler, the new head of the Hospital Rate Review System, had formerly been an employee of the Minnesota Hospital Association (MHA). The MHA had previously conducted the voluntary rate review system in Minnesota, and under the proposed rules represents the primary regulated groups (T.20-29). The Board responded by showing that HIAA had been invited to participate during the drafting stage and did so (Ex. 16), and by stating that the Board had made a nationwide search for a qualified director and had found that person to be Mr. Sattler (T. 22-29). The Board finds that HIAA had ample opportunity to participate in the drafting of these rules and that Mr. Sattler's former position has not biased him in favor of the MHA or hospitals. Nonetheless, Mr. O'Hare's concerns on these matters were properly raised at the hearing. The mere appearance of fairness is an important part of administrative proceedings, and Mr. O'Hare's comments have helped clear up concerns that a number of people may have had.

STATUTORY AUTHORITY

7. 1976 Minn. Laws, ch. 296, art. II, §§ 1-9, is the Minnesota Hospital Administration Act of 1976 (the Act). It amended Minn. Stat. ch. 144 by adding Minn. Stat. §§ 144.695-144.703. (In this Report, citations will be to the statutory codification.) Under the Act, hospitals are required to annually file financial reports with the Board or a voluntary rate review organization and to submit any proposed rate increases to the Board or voluntary rate review organization for review at least 60 days prior to such increases. The Board is empowered to compile and analyze the data submitted, investigate financial operations of the hospitals and publicly comment on financial reports and increases.

The Act also authorizes the Board to approve voluntary reporting and rate review procedures of voluntary, non-profit rate review organizations.

8. Minn. Stat. § 144.703, subd. 1(a) provides:

> "[The Board may] adopt, amend, and repeal rules in accordance with Minnesota Statutes, Chapter 15."

Minn. Stat. § 144.702, subd. 2, provides, in relevant part:

> "The Board may approve voluntary reporting and rate review procedures which are substantially equivalent to reporting requirements and rate review procedures adopted by the board for reporting and rate reviews conducted pursuant to sections [144.698 to 144.701]. The board shall, by rule, prescribe standards for approval of voluntary rate review procedures. . . ."

(As a practical matter, it is expected that the MHA will become the voluntary rate review organization for all but a handful of the hospitals in Minnesota. MHA's existing system was used as a model for these rules. No other review organization appears on the horizon.)

MINN. RULE MHD 471 - SCOPE

9. This rule is necessary to define the coverage of the rate review system. Consistent with the Act, it reasonably states that all acute care hospitals licensed under Minn. Stat. §§ 144.50 to 144.58 are subject to the requirements of the rate review system (the System). Going further, it states that beds located in hospitals which are not licensed as acute care beds under the statutes are not subject to the rate review system. This provision recognizes the fact that non-acute care beds may be found in a hospital. These are nursing home or boarding care beds. 1976 Minn. Laws, ch. 173, provides a new licensure process for nursing home or boarding care beds located in hospitals. Because the Legislature has made this separation of acute and

non-acute care beds, it is a reasonable interpretation that the Legislature intended the rate review system to apply only to the acute care beds. Because costs associated with the non-acute care beds are often mingled with costs associated with acute care beds, it is necessary that a method of allocating these costs be prescribed. Therefore, the rule reasonably provides that these costs shall be allocated in a manner consistent with Medicare allocation formulas. This is a method used currently by hospitals and would impose the least possible additional burden on them.

MINN. RULE MHD 472 - DEFINITIONS

10. This rule defines 28 separate terms and phrases which are used in the Act and these rules, but which were not previously defined by the Act. They are necessary for uniform interpretation of the Act and the rules. There were no questions or comments on most of the definitions. All definitions not noted below are reasonable because they are consistent with generally accepted accounting principles and consistent with the Act, as was demonstrated by testimony at the hearing and in the Board's Statement of Justification (Ex. 12).

11. At the hearing, the Board amended the language of proposed MHD 472 B., the definition of "beds". The new definition provides: "Beds means the number of acute care beds licensed by the Minnesota Department of Health pursuant to Minnesota Statutes, Sections 144.50 to 144.58." "Beds" had been originally defined as "staffed and operating beds" because that is the way it is used within the rules for rate review purposes. However, the new definition is the one that is generally accepted for other purposes. Consistent with this change, the use of the word "beds" in subsequent portions of the rule will be qualified by addition of the phrase, "staffed and set up," wherever this more restricted definition was intended.

12. MHD 472 G. defines "charges" as, "the regular amounts charged to both paying patients and insurers who receive services, irrespective of any discounts, deductions, or other reductions in

these charges which, by contract or other agreement, may be applicable." The HIAA correctly pointed out that the word "insurers" is misused in this section inasmuch as insurers do not receive services; patients are the recipients of services. Further, the word "insurer" is used in a broader context than under the definition given in Minn. Stat. § 144.696, subd. 5, which includes only persons selling policies of accident and health insurance or non-profit health service plan subscriber contracts. (This excludes HMOs and self-insured groups.) HIAA offers a definition that would clear up these inconsistencies (Ex. B). The definition is reasonable and is adopted. It reads:

> "'Charges' means the regular amounts charged to patients and/or insurers, prepayment plans and self-insured groups on the patient's behalf. . . ."

HIAA also suggests that the remainder of the definition be deleted because the Act does not allow any discounts. That will be discussed in more detail below.

The term "rates" is used in two ways within the Act. First, it may mean "charges" as defined here, or it may mean an aggregate or overall rate charged by the hospital. At this point, it would be appropriate to add a provision that "the term 'charges' and 'rates' are synonymous for the purposes of these rules." The definitions of aggregate rates and adjusted rates will be discussed below. See Finding No. 15.

13. The Metropolitan Health Board points out that the definitions of "admissions", "emergency visits", and "out-patient visits" are in conflict in the proposed rules (Ex. C). The Metro Health Board offers four modifications to cure these defects which are reasonable and are adopted for that reason:

(a) Amend MHD 472 I. to read: "Emergency services" are those inpatient or outpatient hospital services that are necessary to prevent immediate loss of life or function due to the sudden onset of a severe medical condition.

(b) Amend MHD 472 J. to read: "Emergency visit" means an acceptance of a patient by a hospital for the purpose of providing emergency services in a distinct emergency service center.

(c) Amend MHD 472 R. to read: "Outpatient visit" means an acceptance of a patient by a hospital for the purpose of providing outpatient

services in a distinct outpatient service center.

(d) Amend MHD 474 B.2.f. and g. by deleting the word "admissions" and substituting the word "visits".

The MHA also commented on the definition of "emergency services" in that it had originally not included outpatient treatment services (Ex. H at 2). The definition suggested by the Metropolitan Health Board encompasses this matter.

14. The MHA also commented on the definition of "loss". In the case of the disposal of an asset, the proposed rule defines it as the excess of the cost of the asset over related proceeds. MHA quite correctly points out that loss is determined by depreciated costs rather than the original costs. They suggest, and the Examiner recommended, that the word "cost" be replaced by the term "net book value" in MHD 472 O.

15. Minn. Stat. § 144.701, subd. 1, authorizes the System to assure that "total costs of a hospital are reasonably related to the total services offered; that the hospital's aggregate revenues, as expressed by rates, are reasonably related to the hospital's aggregate costs; and that rates are set equitably." Thus, it is not the purpose of the System to review individual charges for individual procedures. Rather, the rate that is to be reviewed is an aggregate or average rate. Therefore, the "rate" to which the System must address itself is a function of total revenue per admission. Further, the rate should be adjusted for outpatient activities to more accurately express the relationship of total revenue to patients treated. The proposed rule defines "rate" as the average revenue for each inpatient admission for a full accounting period, i.e., total revenue divided by the number of inpatient admissions. It also defines "adjusted rate" as total revenue divided by the number of "adjusted inpatient admissions". The adjustment factor is determined by a formula which factors in the ratio of outpatient revenues to inpatient revenues.

Throughout the rule, the word "rate" is used where the Board actually intended the definition of "adjusted rate" to apply. This is somewhat confusing in itself. In addition, as noted above,

the word "rate" commonly means what has formerly been defined as "charges". To resolve this confusion, the Board has proposed the following modifications to MHD 472 U. Change the definition of "rate" to: "'Rate' means 'charges' as defined in MHD 472 G." Substitute the term "aggregate rate" for "adjusted rate" within this section, and substitute the term "aggregate rate" for the word "rate" throughout the remaining portions of rules where the word "rate" was intended to mean "average revenue per adjusted admission."

The MHA also suggests that because a significant portion of a hospital's outpatient activity involves emergency services, such services should be expressly included in the calculation of adjusted admissions (Ex. H at 3). The point is well-taken, and the rule will be modified accordingly.

Recapping the above proposals, MHD 472 U. would be modified to read as follows:

"U. 'Rate' means 'charges' as defined in MHD 472 G.

'Aggregate rate' means the average revenue per adjusted admission for a full accounting period determined by dividing total revenue by the number of adjusted admissions.

$$\frac{\text{Total Revenue}}{\text{Number of Adjusted Inpatient Admissions}}$$

Adjusted admissions are determined by:

$$\text{Number of Outpatient \& Emergency Visits} \times \frac{\text{Total Outpatient \& Emergency Revenue}}{\text{Number of Outpatient \& Emergency Visits}}$$

$$\times \frac{1}{\text{Inpatient Revenue Per Admission}} \quad \text{PLUS} \quad \text{The Number of Inpatient Admissions}$$

"The aggregate rate for the budget year shall always be based upon annually projected admissions as stated in the rate revenue and expense report."

MHA also suggested that the word "adjusted" be inserted between the words "projected" and "admissions" in the last sentence of the rule stated above (Ex. H at 4). That change is not necessary because it is already implied by the definition.

16. HIAA points out that MHD 472 AA, the definition of "third party payors" could be improved (T. 37). The word "insurers" is used in a very broad sense there, and, for clarity, the types of payors implied thereby should be specified. The terms "nonprofit service plan corporations," and "self-insured

or self-funded plans," will be inserted into the definition to clarify it.

MINN. RULE MHD 473 - THE MINNESOTA HOSPITAL RATE REVIEW SYSTEM

17. The Minnesota Hospital Rate Review System is the mechanism by which rate review is conducted. This rule simply states that the System is established; that it shall be operated by the Board or any voluntary non-profit rate review organization which has been approved by the Board; and that the System shall consist of reports, administrative procedures and standards. MHA suggested that the word "or" should be changed to "and" so that the System shall be operated by the Board and any voluntary rate review organization. This change is appropriate because even if all of the reviews are actually done by a voluntary organization or organizations, the Board retains over-all control and it is required to report to the Legislature. So modified, the rule is necessary and reasonable.

MINN. RULE MHD 474 - REPORT REQUIREMENTS

18. As a general introduction, this rule states that the system shall require annual financial information reports, rate revenue and expense reports and interim increase reports. These reports are authorized respectively by Minn. Stat. §§ 144.698, subd. 1; 144.701, subd. 2; and 144.701, subd. 5.

19. MHD 474 A., like the statute, provides that the annual financial information report shall include a balance sheet, an income and expense statement, and the hospital's Medicare cost report for the corresponding accounting period. The rule prescribes specific accounting categories and classifications which the balance sheet and income and expense statements should contain. These categories and classifications are those required by generally accepted accounting principles in hospital financial reporting. The MHA suggested two modifications in the classification of expenses in the expense statement (Ex. H at 5): "Management services" are listed under purchased services and under other professional fees. That is a redundancy which should be corrected by eliminating the term from the category of purchased

services. "Collection services" are listed under purchased services, but such services are more properly classified as professional services. MHA suggests, and the Board agrees, that "collection services" should be deleted from purchased services and listed under other professional fees.

The classifications and categories listed for the balance sheets and income/expense statements are suggestions only and the rule allows hospitals to submit these statements using their own classifications. In such case, the rule requires the hospital to include a narrative description of the scope and type of differences between its statements and those recommended by the rule. HIAA argues that the lack of uniform accounting standards is a principal weakness of the proposed rate review system (Ex. B at 3 and 4). The Examiner agreed, as did the Metropolitan Health Board (Ex. C). Nonetheless, as stated by the Board, it is without authority under the Act to require uniform accounting standards. It must also be remembered that the Act and these rules establish a system which is intended to be the first step in developing a statewide method of assuring efficiency and economy in the financial operations of hospitals. Such intent is found in Minn. Stat. § 144.701, subd. 4, which states: "The Board shall begin to compile relevant financial and accounting data concerning hospitals in order to have statistical information available for legislative policy-making." Uniform accounting was rejected by the Legislature during enactment of the Act.

HIAA also suggests that current assets on the balance sheets should disclose donor-restricted and unrestricted funds. The Board agrees that it would be desirable to disclose these funds and that such disclosure may be accomplished by footnoting the balance sheet or by providing statements of changes in fund balances.

20. MHD 474A.3. clarifies the language of Minn. Stat. § 144.698, subd. 1(c), which requires a copy of the hospital's most recent cost report filed for Medicare. The rule states that the cost report shall be for the period corresponding to that used

in the compilation of data for the balance sheet and revenue and expense report. This is necessary to make comparisons meaningful. Subsequent provisions of the rule dealing with filing deadlines make all these statements "the most recent".

21. MHD 474 A.4. requires that the annual financial information report be attested by the governing authority of the hospital or its designee. This is reasonable and is authorized by Minn. Stat. § 144.698, subd. 3.

22. MHD 474 A.5. requires "attestation by a qualified independent public accountant that the contents of the balance sheet and statement of income and expense are true and conform to the bases for judging the reasonable use of finances by a hospital as established by MHD 487 A." As MHA points out (Ex. H at 6; T. 259-262), public accountants are not generally in a position to attest to the "reasonable use of finances in a hospital as established by MHD 487.A." That, in fact, is the function of the System. MHA suggests that the rule be modified to require the accountant to attest to the fact that the contents of the balance sheet and statement of income and expense "have been audited". The MHA suggestion has merit and the rule will be accordingly modified.

23. MHD 474 B. requires the annual submission of a rate revenue and expense report. This report is used as the basis of the regular assessment of reasonableness of rates and charges and any increases in rates or charges; two of the System's duties under Minn. Stat. § 144.701, subds. 1 and 2. The rate revenue and expense report includes certain statistical and financial information for three separate accounting periods styled as the "prior year", "current year", and "budget year". The current year information is a combination of actual data and estimated data. As originally proposed, the rule required that information for at least the first eight months be actual. At least one hospital and the MHA believe that requiring eight months of actual

data is unreasonable and unrealistic because, considering that increase reports are required 60 days prior to the increase day, there remains only 60 days for the hospital to compile the data necessary for the report (T. 269-272; Ex. H at 7). At the hearing the Board agreed that eight months might be unreasonable (T. 270). The hospital and MHA both suggest that the rule require at least six months actual data. This figure appears to be reasonable and the rule will be so modified.

24. MHD 474 B.2. specifies the statistical information which must be included in the rate revenue and expense report. This rule recognizes that financial data is not of much use by itself and that related statistical information must be available. For example, to determine the average charge per patient per admission, the number of admissions must be known. The statistical requirements of the rule are minimal and include items that hospitals normally collect. At the hearing, the Board offered three amendments to the proposed rules which are reasonable, non-substantial changes (T. 263). To the requirement for the number of inpatient days for the hospital, "and each appropriate service center," was added. This is necessary because the System analyzes data on both a total hospital and service center basis. To the requirement for number of beds available for the hospital and for each appropriate routine service center, the Board added three separate "bed" statistics. Namely, the number of licensed beds, the number of beds physically present, and number of beds actually staffed and set up. This reflects the redefinition of "beds" in MHD 472E (see Finding No. 11). It was agreed at the hearing (T. 268 to 269), that the word "routine" should be deleted from the phrase "each appropriate routine service center". The Board also deleted the requirement that the hospital supply the average annual occupancy rate because the System can as easily compute that statistic as can the hospital.

This rule also requires that the hospital submit the number of units of service provided by each of the hospital's other service centers, and it allows the hospital to select the statistic that best measures the level of activity for a particular function

or service center. This section again raises the arguments on uniform accounting, with HIAA arguing that the System must select the best measure in order to operate effectively (Ex. B at 7), and the Board arguing that it is without authority to require uniform accounting (T. 266-268). Again, the Board's position is not unreasonable.

25. MHD 474 B.3. lists the financial information which must be included on the rate revenue and expense report. Interim financial statements in the form previously specified are reasonably required. These are necessary to monitor the consistency of the hospital's estimate of the full current year with that of a portion of the current year that has actually been experienced. The rule also requires a statement detailing the accounting method used to allocate expenses from non-revenue centers to revenue centers, and a statement of total direct and indirect costs for the hospital and for each of its service centers after allocation of expenses. HIAA suggested that the rule should require disclosure of direct and indirect costs before allocation (Ex. B at 8). This suggestion has merit. Like the statement detailing allocation methods, it would assist in determining whether standards for offsets to costs and allocations of costs are being followed.

The proposed rule requires a statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of patient days outstanding at the end of each period. These are necessary to assess the adequacy of the hospital's collection effort and as a part of determining each hospital's working capital requirement. As was noted at the hearing (T. 277) and by MHA (Ex. H at 7), the proper terminology should be "days' charges" rather than "patient days". This is common usage and the change should be made.

The Metropolitan Health Board suggested that an additional section be added to the rule requiring "a statement of the capital budget of the hospital". This information is obviously necessary to assess the hospital's financial policy, and the suggested language or something similar to it should be included in the rule. The Board unintentionally omitted such a statement from the rule.

26. MHD 474 B.4. lists three additional items which the rate revenue and expense report must contain. First is the pricing policy of the hospital, which incorporates the over-all pricing policy and financial objectives of the institution. The Board realizes that not all hospitals have such policies, but by this requirement is encouraging them to be established. In a complex financial venture such as a hospital, it is simply prudent management to have financial objectives. The proposed rule lists no criteria for items which must be included in such a policy statement. At the hearing, MHA raised the question of whether the rule requires the hospital to disclose in advance its plan for adjusting charges in the budget year. Such information is needed in order to analyze and comment on the rate review and expense report (T. 273-274). The Board replied that it considered this to be implied in the rule and that specific details would be incorporated in the forms to be drawn by the Board. Nonetheless, MHA requests that it be made express within the rule and has offered an amendment which would eliminate any ambiguity, and confirm the intent of the Board (Ex. H at 8). The proposal is reasonable and is incorporated within the rule in the form proposed except that the word "rates" is replaced by the term "aggregate rates" where it appears in the proposal.

This section also requires attestation that rates are set equitably and submission of copies of reports used to obtain any Certificate of Need for expansion. These are reasonable requirements.

27. MHD 474 C. states that an interim increase report is required whenever a hospital desires to amend or modify its rates

for the budget year except where such increases do not exceed limits prescribed elsewhere in the rule. Minn. Stat. § 144.701, subd. 5, requires this report and the exception.

28. MHD 474 C.2. further excepts the Commissioner of Public Welfare from filing the interim increase report where changes in rates during the budget year are the result of legislative policy and appropriations. This provision is necessary because the Commissioner of Public Welfare has no control over increases in "rates" caused by legislative policy and appropriations. HIAA argues that such changes in rates should still be reviewed by the System to assure that rates properly reflect the legislative changes (Ex. B at 8). The Board proposal, however, is reasonable.

29. Because this report is essentially an amendment to the budget year portion of the rate revenue and expense report, the rule requires the report be in the same form and contain the same information as required for the rate revenue and expense report. The rule reasonably requires information indicating any change in the budget year from the projected information already on file with the System and a narrative statement describing the reasons for amendments or modifications to the hospital's rates.

MINN. RULE MHD 481 - ADMINISTRATIVE PROCEDURES

30. This rule generally governs the basic administrative handling and processing of the various reports required by the rules or by the Act, as well as the handling and issuance of comments and other reports by the System.

30. MHD 481 A.1. states that the System shall design and issue forms as necessary for meeting the requirements of reports established by these rules. This is reasonable because such a form set will make it easier for the hospitals to file the required reports in the manner prescribed by these rules. The rule does not say that the Board's forms must be used. At the hearing, the Board stated that it would solicit comments of all interested parties in developing the form set (T. 275). MHA

requested that this stated intention be made definite by adding a provision to the rule that reads: "The hospitals under the system will be allowed to comment on the forms prior to their adoption." The Board feels that this would require additional rulemaking to specify such matters as notice and manner of submitting comments. The rule is reasonable as written.

32. MHD 481 A.2. and 4. describe the requirements for filing of the required reports. They state that the documents may be filed personally or by mail, and that no report shall be deemed filed until the System has ascertained its completeness in accordance with provisions of the rules. Since filing constitutes the commencement of such time periods as the 60-day requirement of Minn. Stat. § 144.701, subd. 5, it is necessary that the term be clearly defined. It is further reasonable to require that the required report be sufficiently complete to allow the System to make its analysis and review before the time period begins to run. Standards for determining completeness are provided in MHD 487 C.

33. Minn. Stat. § 144.698, subd. 4, states that all reports (except privileged medical information) filed with the System shall be open to public inspection. MHD 481 A.3. implements this statute by requiring the System to establish a method of record-keeping that facilitates easy public access to these records. The Board notes that the word "filing" or a form of it is used three times throughout this section in the rule proposed at public hearing.

Each time it has a different meaning, none of which correspond to the meaning with which it is used in other portions of the rules (namely, legally served and accepted). Because this part of the rule deals primarily with the term "filing" in its legal sense, the Board amends MHD 481 A.3. to read as follows:

> "The system shall establish a method of record-keeping which shall insure that reports and other documents are ordered, stored, designated and dated in such a manner that facilitates easy public access to the contents of those reports, documents, and other information as required by these rules. These records shall be open to public inspection during normal business hours."

34. MHD 481 B. requires that the report of annual financial information be filed within 120 days after the close of the hospital's full accounting period. Only Hennepin County Medical Center objected to 120 days as being too short (Ex. D). None of the hospitals represented at the hearing nor the MHA objected to this provision. The Board stated that the standard practice of institutions such as hospitals and their auditing firms is to have this type of fiscal information audited and available within a 120-day period. The Board finds that it is reasonable. The rule provides an exception for the Medicare cost report which may not, in fact, be filed with the Medicare Fiscal Intermediary within 120 days.

35. MHD 481 B.2. is entitled "Failure to File". It provides generally that a hospital which fails to file the annual financial information report within the time required or within the time allowed pursuant to an extension granted under the rules shall be deemed in violation of the rules. It requires the system to notify the Board and appropriate health systems agency of the violation. The Foundation for Health Care Evaluation requested that this and subsequent similar rules be modified so that the notice of violation will also be given to the appropriate professional standards review organization (PSRO). (Ex. E). PSROs were established to fulfill the requirements of Public Law 92-603, which mandates review of health care provided to patients under Medicare and Medicaid and other federally supported health care services. While the primary duties of the PSROs are different from those of the rate review system, it is undeniable that the efforts of all agencies and quasi-agencies involved in the health care delivery system be coordinated. For this reason, the rule is amended as suggested by the Foundation.

36. MHD 481 C. deals with filing of the report of rate revenue and expense. The proposed rule requires that each hospital file the report 60 days prior to the commencement of its accounting period. The 60-day requirement was based on the presumption that most hospitals raise their rates on the first day of their fiscal year. Because the Act requires 60-day notice before raising rates, the arrangement allows the elimination of a duplicate

interim increase report. However, the MHA stated that most hospitals would prefer to accumulate the financial data necessary to compile these reports during the last 60 days of the fiscal year and would not object to postponing any rate increases until 60 days after the start of their fiscal year (T. 280-281). A reasonable modification of the proposed rule that would require the filing of the report up to sixty days prior to the commencement of any accounting period of the hospital. The phrase "up to sixty days prior" is used in lieu of the phrase "on or before," which was suggested by MHA, because it is not as open-ended. Nevertheless, it still effectively deals with MHA's objections to the original proposal. MHA would also add the provision that "No change in rates shall be made until 60 days have elapsed from the date of filing." These changes should be incorporated in the rule. HIAA suggested that the time period be extended to 90 days to provide the System more time to review proposals and to allow hospitals to resubmit reports on the basis of the System's decision (Ex. B at 8). While 90 days would be convenient for the System, it would place additional burdens upon the hospitals. The 60-day figure is not unreasonable because it corresponds to the 60-day requirement of the statute.

37. MHD 481 C.2. contains a failure to file provision similar to that relating to the annual financial information report. The comments of Finding No. 35 apply.

38. MHD 481 D. reasonably requires that the interim increase report be filed 60 days prior to the effective date of any amendment or modification to rates if (a) the proposed rate exceeds allowable increase limits; (b) the amendments or modifications were not included in the report of rate revenue and expense; (c) it is not filed within 90 days of any other interim increase or rate revenue and expense report; and (d) there are no reports, fees or other documents or information due to the System from that hospital. MHA had some concerns about this section because of the difficulty of projecting what the final rate will be (Ex. H at 10). They suggest that because a hospital only controls

"charges", the rule should only apply to charges. The definition of aggregate rates in MHD 472 U.,limits the rule to charge modifications. (See Findings 12 and 15). The rule is reasonable as written.

Sections "c." and "d." (not within 90 days or when other information is outstanding) are actually instances where interim increase reports may not be filed. They are presently worded as "negative requirements", which is awkward and possibly confusing. Further, section "e." allows a waiver of these two sections, which might be read to apply to sections "a" and "b" also. The Board finds it is reasonable to combine sections "c", "d", and "e" in one section renumbered as MHD 481 D.2., to read:

> "An interim increase report may not be filed within ninety (90) days of any other interim increase or rate revenue and expense report filed by that hospital or when there are any reports, fees or other documents due to the system from that hospital. This provision may be waived by the system if the hospital can show cause therefor."

MHD 481 D.2. and D.3. would have to be renumbered. These changes could improve the clarity of the provision.

MHA suggested that the waiver provision should apply to all of MHD 481 D. (Ex. H at 12). That would be unreasonably broad.

39. MHD 481 D.2. states that failure to file a required interim increase report is a violation of the rules. If the violation is discovered during the budget year, the System may require the hospital to adjust its rates consistent with allowable increased limits until 60 days after the hospital properly files the report. If the violation is discovered after the budget year in which the violation occurred, the System may investigate the violation in order to determine its effect upon the rates of the hospital. The System may recommend a reduction in the rates of the hospital and require that the hospital submit interim increase reports for every increase in rates, irrespective of the allowable increase limits, for the next two accounting periods. No comments were made on these sections and they are reasonable because the Act specifically requires filing of amendments or modifications to rates at least 60 days in advance of their effective date.

40. MHD 481 D.2.d. recognizes that differences may occur between projections and actual budget year history such that a hospital may exceed allowable increase limits when it had not intended to do so and therefore not filed an interim increase report. The rule states that such a variation should never exceed 1.1 times the allowable increase limit. HIAA suggested that any excesses should be taken into account in the next accounting period (Ex. B at 8). That suggestion seems to be encompassed within the preceding section. MHA requested that the ten percent allowable variance be deleted from the rule because of the unpredictability of the variance and due to the fact that the hospital itself controls only charges. Charges are but one small part of the aggregate rate. The section is not unreasonable as proposed.

The rule does not provide an absolute standard. The system still must assess the effect of the violation upon the aggregate rate, and if the excess is caused by unpredictable and uncontrollable factors such as patient mix, no remediable action would be appropriate.

41. MHD 481 D.3. provides the mechanics by which the hospital can determine its allowable rate increase; that is, the amount by which it may increase its rates without submitting an interim increase report. This provision is necessary to allow the hospitals to do their budgeting and planning.

42. The Board withdrew MHD 481 E. at the hearing.

43. MHD 481.F. provides that an entity operating more than one hospital may act as the reporting organization for each hospital but must submit separate reports for each hospital and provide a statement detailing the financial relationship between it and its hospitals. This is necessary because the System must assess whether the rates of each hospital are set equitably. do so, it must have separate information on each hospital.

44. MHD 481 G. allows the System to grant extensions to a hospital which so requests and shows cause why such extension is necessary. This is necessary and reasonable because conditions may exist from time to time which legitimately prevent a hospital from meeting the time requirements.

MINN. RULE MHD 487 - INVESTIGATIONS, ANALYSIS AND REVIEW STANDARDS

45. MHD 487 establishes the basic criteria concerning the procedure employed to assess reasonableness of rates and increases. The standards set are purposely broad and flexible because the concept of hospital rate review is relatively new and still in an experimental state. The standards were established by reviewing existing rate review programs in other states and related literature dealing with financial requirements of hospitals and public utility rate-making. The standards will be subject to review and amendment as data from the System is compiled. It must also be remembered that the Legislature intended to establish a system of hospital financial disclosure (rate review) as opposed to a system of financial control (rate setting).

Therefore, the standards in these rules were designed to reflect and gather information about current financial practices of hospitals; not to set "desirable" financial practices.

46. MHD 487 A.1. lists the standards for financial requirements of hospitals. It states generally that rates charged to

patients or their insurers must be adequate to maintain the solvency of the hospital; that they should provide adequate funds to meet certain expenses. This is a reasonable introductory statement to the categorization of expenses which follows.

47. The first major category of expenses is, "Current operating needs related to patient care." The first item in this category is direct patient care. The rule provides that rates should provide finances to meet expenses such as salaries, wages, employer fringe benefits, services, supplies, normal maintenance, minor building modification and applicable taxes. The rule also recognizes that an amount should be included representing the value of services of members of religious orders and other voluntary groups equivalent to the amount that would be paid to employees for similar work (with certain limits). There was no comment on direct patient care expenses and they are clearly reasonable.

48. MHD 487 A.1.a.(2) provides for the second category of current operating needs, "interest expense." This rule reasonably recognizes the generally accepted fact that the financial needs of hospitals include payment of interest charges at a reasonable rate arising from the use of necessary funds borrowed from external sources for operating and plant capital needs. The rule defines interest as "necessary" if it is incurred on a loan made to satisfy a financial need of the hospital or a loan reasonably related to patient care. Under the amendment offered at the hearing by the Board (Ex. 15), a specific statement is made that loans made to expand facilities that have been determined to have excess capacity under the rule are not considered reasonably related to patient care. The Metro Health Board has proposed a similar statement (Ex. C), that the Board might consider for adoption. No objection was made to the concept of

these sections, but MHA did suggest that the exception for facilities having excess capacity should be limited to loans made to expand bed capacity in such facilities rather than expansion in general (Ex. H at 13; T. 44-46). MHA stated that even where a facility had excess bed capacity, it might legitimately expand its "facility" by adding needed new services or equipment. The Board maintains that such a modification is not necessary because the entire facility is generally geared to bed size; where there is excess bed capacity, there is generally excess facility in the broader sense. The Board's position is not unreasonable.

The rule reasonably states that interest is "proper" if not in excess of the rate a prudent borrower would have to pay in the existing money market at the time.

49. MHD 487 A.1.a.(3) provides for educational program expenses. This rule states that rates should provide the finances necessary to recover the net cost to the hospital of providing educational activities which directly contribute to the care of patients currently in the hospital or which contribute to the preventive health education of the population in the area the hospital serves. The second provision ran into opposition from insurers (Blue Cross and HIAA). They argue that hospitalized patients should pay only for the net costs of educational activities which directly contribute to their care and that the costs of those educational programs conducted for the benefit of non-patients should be paid by those participating in the program or from funds the hospital may have available for such a purpose (Exs. A and B at 9; T. 50, 53 and 54). The Board generally agreed that available funds should be utilized first, but stated that the intent of the provision is to encourage long-range cost containment. Health systems agencies and the State Health Planning and Development Agency are currently encouraging hospitals to engage in such community health education. In the long run, this should reduce the need for hospitalization, and thus, overall hospitalization costs. The Board recognized that the approach is unique and that there may possibly be short-run minor increases in expenses, but maintained that the possible long-run

benefits would be substantial as a result of less hospital utilization. The Board suggested that, in order to insure that hospitals utilize what other funds might be available, it would be appropriate to amend the section on net costs by adding the following provision:

> "All possible non-inpatient revenue sources, including fees from those receiving educational benefits, should be investigated and utilized prior to the inclusion of the costs of community preventive health education in financial requirements."

This proposed provision should be modified to delete the first two words -- "All possible". With such a provision, the proposed rule is reasonable.

MHD 487 A.1.a.(3)(e), as proposed, contains the provision that the costs for provision of community health education should not include any payments in excess of the normal salary or remuneration to professional employees and consultants to the hospital. This provision was originally proposed to recognize the responsibility of health professionals to provide educational services as a part of their duties in the hospital and to encourage hospitals to, whenever possible, collect fees from the people taking the courses or use other funds. MHA pointed out that many small hospitals do not have the professional employees on staff to provide these educational activities and must employ their services for that particular purpose. Further, in hospitals that do use their own staff, it is typically an additional duty after normal hours for which the health professionals reasonably expect additional remuneration. For these reasons, MHA urges that the provision be deleted. The Board agrees because the provision could unreasonably prevent a hospital from recovering reasonable expenses.

50. MHD 487 A.1.a.(4) provides for research program expenses. These expenses are limited to those which directly relate to daily patient care and only to the extent that non-patient revenue is unavailable to offset the costs. Unlike community health education, there are generally no state or federal requirements to provide research that are not adequately funded.

51. MHD 487 A.1.a.(5) provides for bad debt, charity allowances and contractual allowances. The proposed section also included "courtesy discount allowances", but at the hearing, the Board deleted all reference to such allowances because they would either be "cost-justified" or "non-cost justified" discounts as defined elsewhere (T. 58-59). This section generally identifies and defines three major sources of losses experienced in the conduct of normal hospital operations and defines how the System will determine acceptability of financial practice with regard to each of these expenses.

52. MHD 487 A.1.a.(5)(a)(i) defines bad debts as they are defined in the Medicare regulations. It then prohibits reclassification of charity care expenses as bad debts and requires that hospitals maintain records reflecting expenses in each of the other categories which are not, by definition, bad debts. Blue Cross suggested that the rules should set a limit on the amount of loss due to bad debts a hospital may include in patient charges. They offered the following modification to this rule:

> "Bad debts may be included in patient charges in an amount up to the median of its peer group but this amount shall not exceed one and one-half percent of the gross billings to patients as recorded by the hospital."

It should first be noted that the rules generally provide for determining reasonableness by comparison to the mean of the peer group rather than the median. It is appropriate that the System eventually develop more specific standards and limits; once sufficient data has been collected. Applying a figure such as one and one-half percent of gross billings at this point would be arbitrary for no data exists to support that particular figure. The rule as written is reasonable at this point in time.

53. MHD 487 A.1.a.(5)(a)(ii) provides a very narrow definition of charity allowance and includes only the provision of care at no charge to patients where such free care is required in connection with a Hill-Burton grant. The comments of Hennepin County Medical Center (Ex. D) and Blue Cross (Ex. A) highlight both sides of this issue. Hennepin County states that it will provide approximately $4,500,000 worth of charity care this year; approximately $370,000 of that is required under the Hill-Burton Act. If the System does not allow Hennepin County to pass along some of this obligation to patients and third parties in

the form of rates, they will be obliged "to rely upon the regressive and repressive property tax to meet our statutory and moral obligations." Blue Cross argues that patients and their insurers should not have to pay even for the charity care provided under the Hill-Burton program. Blue Cross points out that because of depreciation expense, price level adjustments and a charity care requirement of twice the original grant amount, patients and their insurers may, in fact, have to pay four times the original Hill-Burton grant amount. The Board took a middle ground, stating that generally the costs of those who cannot pay for their hospital care should not be borne by the remaining hospital population in the amount that they pay for hospital care or health insurance, but allowing Hill-Burton obligations because of the requirements placed on the hospital by the program. The rule is reasonable, but in view of Blue Cross's argument. The Board will limit the allowance to the amount of the original grant or loan guarantee.

54. MHD 487 A.1.a.(5)(a)(iii) allows hospitals to claim two types of discounts; governmental contract adjustments and cost-justified discounts. "Governmental contract adjustments" are defined as those discounts from the established charges required due to governmental reimbursement practices. It is necessary to recognize these discounts because, by law and regulation, such programs as Medicare and Medicaid do not fully reimburse hospitals for their actual costs. Because it is improper to require hospitals to operate at a loss, these differentials must be passed along to other patients or those who pay those other patients' charges. Blue Cross argues that it is unfair to include the amount of governmental discounts in patients' charges (Ex. A). That may be so, but it is what the law requires. The rule will have the effect of making this "hidden tax" more visible.

55. The provision allowing "cost-justified discounts" was among the most controversial provisions of the rule. Minn. Stat. § 144.701, subd. 1, after requiring the Board to assure that total costs of a hospital are reasonably related to total services offered, and that aggregate revenues are reasonably related to

aggregate costs states:

> "The Board shall prohibit hospitals from discriminating among insurers in its rates."

It seems clear that the statute uses the word "rates" in this sense of the word "charges" in this particular provision. It must also be remembered that the statute defines "insurer" as a person selling policies of accident and health insurance or a non-profit health service plan. In other words, it does not include HMOs, self-insured or governmental payors. Thus, the statute does not require the Board to prohibit hospitals from discriminating among these types of payors. In the proposed rule, the Board has essentially interpreted the word "discriminating" to include only unfair discrimination. It thus provides that discounts may be provided to certain patients, groups of patients, or third-party payors where the hospital can demonstrate that the value of services or other benefits provided by these persons or groups is at least as great as the discount granted. The effect of the rule is to treat all payors, not just insurers, alike. MHA argues that the Legislature intended to prohibit discounts to all payers and urges that the section be amended to allow only discounts required by law; the governmental contractual allowances (Ex. H at 15). HIAA and North American Life and Casualty Company (NALAC) argue that the statute quite clearly and explicitly prohibits any discrimination among insurers as that term is defined and that the proposed allowance of cost-justified discounts is contrary to the statute (Exs. B at 9 and G). One hospital supported the rule (Ex. K), though that was because HMOs could reduce its cost. HMOs are not subject to the non-discrimination requirement of the Act. Similar arguments were advanced at the hearing (T. 61-65, 69-76 and 83-100). The Board believes that the term "discrimination" is open to interpretation and that the cost-justified discounts provision of the rule interprets it in a manner consistent with the purposes of the Act. In the first place, such discounts are includable only to the extent that there is an actual and demonstrable savings to the hospital in terms of real money. Second, the provision provides an

incentive to all payors (the words "granted to certain patients, groups of patients, or third party payors at the time services are paid for" should be deleted from (bb) to avoid confusion and to remain consistent with the definition of "charges" (See Finding #12)) to take steps that will reduce the cost to the hospital. The net savings are then passed along to members of the group represented by that payor. There is some argument that this "benefit" should be passed along to all payors. The practical effect of that would be to eliminate any incentive and there would be no "benefit" for anyone. Third, the Board will conduct an ongoing evaluation of the reasonableness of these discounts.

56. MHD 487 A.1.a.(5)(b) provides that losses in revenues due to bad debts, charity losses and contractual allowance must be offset against available non-patient income before they are included in rates. HIAA, logically proceeding from its argument that no discounts should be allowed, argued that this provision should be deleted (Ex. D at 9). Because the preceding sections are not unreasonable and should be included in the rule, this provision is necessary to insure the minimum impact of allowing those costs.

Blue Cross also suggested that the rule provide that under no conditions may courtesy discounts be included in patient charges (Ex. A). That provision does not appear to be necessary because courtesy discounts would not, by definition, be cost-justified and thus would not be allowable.

57. MHD 487 A.1.b. provides the next major category of expenses - plant capital needs. These provisions recognize the need for hospitals to generate funds to purchase and replace capital items, prescribe a method of accounting for such funds, describe permissible uses of the funds, and describe a method of determining the magnitude of the hospital's plant capital needs.

58. The introductory portion of this rule states that plant capital needs must be funded to be included in the rates and that funding of depreciation shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund. Blue Cross suggested that an additional provision be added stating:

"In order to include depreciation expense and inflation factors in patient charges, the hospital must have received certificate of need approval when required (Ex. A)"

The Board agreed that that was its intent and that Blue Cross's suggestion would make it more explicit (T. 107). This change should be adopted so that the rules do not encourage conflicts with Certificate of Need requirements. The change takes the following form in the rule: "In order to include plant capital needs in rates, the hospital must fund the plant capital requirement and be in receipt of a certificate of need as required by Minnesota Statutes §145.71 et. seq."

59. MHD 487 A.1.b.1. requires that finances related to building, building equipment and movable equipment be placed in an identifiable fund and that the annual increment to this fund should be the amount of the annual debt principal payment (adjusted as level payments over the life of the debt instrument), or the annual straight-line depreciation, whichever is greater, plus inflation factors.

MHA and Blue Cross both suggested that restrictions on the use of the fund should be incorporated in the rule (Ex. H at 17 and A). The MHA proposal contains references to the requirement for Certificates of Need in appropriate situations, and for that reason is somewhat better than Blue Cross's proposal. MHA further suggested that plant capital needs include funding for land and land improvements because these items are often financed with debt, and, in the case of land improvements, are subject to depreciation. Further, there is no practical way to separate these items from building and equipment for reporting purposes. MHA lists a number of places within the rule in which the words "land" and "land improvements" should be inserted.

Blue Cross suggested that the provision allowing for annual increment to the fund in the amount of the adjusted annual debt payment should be deleted (Ex. A). Blue Cross feels that straight-line depreciation plus inflation factors provides a reasonable allowance for annual debt principal payment requirements. Blue

Cross visualizes a situation where a loan includes a large balloon as the final payment. Under the rule, the hospital would be able to include the entire balloon payment in its rate for that year. The Board justified its provision allowing either the greater of depreciation or adjusted principal payment in recognition of the fact that the debt instrument may have a shorter life than the asset and may produce a demand for cash which cannot be met by depreciation allowances. While the concern about a balloon payment urged by Blue Cross could not occur because payments are required to be computed as level over the life of the instrument, it seems clear that the rule will tend to encourage financing on short-term instruments. The Board stated that it was not intending to encourage such borrowing and that the reasonableness of the debt instrument itself is always open to review (T. 102-103). It was noted by the Hearing Examiner that this rule, as proposed, could encourage what the Board intends not to encourage and that the temptation could be difficult to resist by the hospitals. Further, there are no standards anywhere in the rule for determining the reasonableness of the debt instrument. For these reasons, the Examiner believed that the provision was unreasonable as written. This defect has been cured by eliminating the provision entirely.

HIAA also points out that the alternate wording of the provision would allow recapture in excess of the cost of the asset. In other words, the accelerated principal repayment amount could be taken until the debt was repaid, and then the remaining straight-line depreciation expense could be taken for the life of the asset. This was not intended and the provision has been deleted which will exclude the possibility.

60. MHD 487 A.1.b.(1)(b) describes the inflation factors that will be allowed as an annual increment to plant capital funds. These factors are provided to recognize the impact of inflation upon capital assets and the desirability of allowing hospitals to purchase new assets or replace existing assets without incurring overly large amounts of debt. The factors allow hospitals to accumulate cash to be used to purchase building and building equipment and movable equipment. HIAA considered these inflation factors to be the single most questionable financial

requirement in the proposed rules. They regard this approach to the problem of providing sufficient capital for replacement and expansion as completely arbitrary. Funds will be provided to hospitals regardless of the need of a particular hospital and will result in underfunding some hospitals and grossly overfunding the needs of other hospitals. They further argue that such funding will in itself create pressure for expansion by the mere availability of such resources. HIAA points out that because Medicare and Medicaid do not recognize price level depreciation, the entire burden of this allowance would be borne by non-government financed patients. HIAA urges consideration of an alternative method of meeting the needs of hospitals to generate sufficient revenues to meet future community health care needs and points to the method used by the State of Washington.

> "The Washington Hospital Cost Commission gives separate consideration to the hospital capital requirements, which include:
>
> 1. The principal payment on debt;
> 2. Needed additional capital expenditures; and
> 3. Working capital needs.
>
> These requirements are delineated annually in the hospital budget submission. The Commission, in reviewing these financial needs, looks then to the sources of funds available to cover these requirements. Such sources include funded historical cost-depreciation as well as other nonpatient revenue sources. If the sources of funds available are not sufficient to meet the capital requirements of the institution, then the Commission will allow a growth and development factor to be included in the rates. We believe such an approach is entirely reasonable in that it ties the growth and development factor to specific purpose of projects and, therefore, eliminates the danger created by arbitrarily assigning price level depreciation, which will allow some institutions to obtain greater payments than necessary, and others not enough. In addition, the danger of perpetuating an institution or part of an institution, which is not needed, is also eliminated. Therefore, we would suggest this as a more reasonable alternative than price level depreciation." (Ex. I)

The Board did comment at the hearing that it had considered alternatives similar to that suggested by HIAA. One of the reasons for not adopting any of the other alternative methods was a fear of being unable to draft the rule in a form that would withstand the requirements of rule-making; apparently because it would be difficult to prescribe standards to be applied to a case by case review of capital needs and funding methods.

Inflation factors were fully discussed and argued at the hearing (T. 112-158). The evidence and arguments presented demonstrate that the Board's proposal is not unreasonable. It contains sufficient controls to prevent over-funding and encourages use of alternate funds where available.

61. MHA suggested that the words "inflation factors" be replaced with the term "price level depreciation" because that is a more commonly understood term. However, the term "inflation factors" is somewhat broader and would provide more flexibility in the rule.

62. The proposed rule has a provision requiring that annual interest earned from an investment of this fund should be used to reduce the inflation factor requirements. HIAA argued that interest income should be used to reduce or offset plant capital needs. This logically follows from its argument that inflation factors should not be included (Ex. B at 14). MHA argued that earned interest should be allowed to accumulate in the fund to a specified point and then be applied to reduce the inflation factor requirements (Ex. H at 20). In a similar vein, Blue Cross suggested that consideration be given to placing a limitation upon the amount of funds that may be accumulated (Ex. A). All these suggestions deal to some degree with controlling excess funding. It would be reasonable to include some form of control in the rule, but it would seem appropriate that the control be placed on the accruals to the fund rather than the accumulated total. Otherwise, it would be possible for a hospital to pass a great deal of money through the fund without ever accumulating an unreasonable amount. The following language is added to rule MHD 487 A.1.b.(4): "In addition, the annual increment to the plant capital fund, when projected over the life of the depreciable assets of the hospital using the current year's experience, should be evaluated with regard to the individual hospital's capital needs in relationship to the appropriate health systems agency's areawide health plan and the State Health Planning and Development Agency's State Health Plan.

63. MHD 487 A.1.b(5) provides for a hierarchy of sources of funds to which the hospitals should turn if it has a plant capital need and insufficient funds in the identified fund. First, the hospital should rely on sources other than charge-paying patients (e.g., grants, gifts, funded capital). Second, to the extent such sources are inadequate, borrowed funds or leases. Third, to the extent these two sources are inadequate, then approved inclusion in rates when it can be demonstrated that such inclusion in rates will result in a lower cost to current patients than would result from the borrowing of funds or leasing of plant capital assets. The stated intention is reasonable, but, the language used may not clearly carry out that intent. The Board has, therefore, amended paragraphs MHD 487 A.1.b.(5)(b) and (c) to read as follows:

> "(b) Borrowed funds or leases to the extent income from sources other than patients can be demonstrated to be inadequate; or
>
> "(c) Approved inclusion in rates to the extent it can be demonstrated that insufficient resources exist from (a) and (b) above, and that inclusion in rates will result in a lower cost to current patients than would result from the borrowing of funds or leasing of plant capital assets. Approval of inclusion in rates shall be by the system upon demonstration by the hospital of both of the conditions herein stated. Once approved, the inclusion in rates of these additional financial requirements may be considered reasonable. Any portion of the annual equal amortized historical costs of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated."

The Board finds that this change clarifies the rule.

64. MHD 487 A.1.c. provides for the third major category of financial requirements, incremental operating cash needs (otherwise known as working capital). There is no doubt of the necessity for working capital, and this section reasonably outlines the method for calculating working capital requirements.

HIAA's general comment on this section was that it contains no norms for calculating acceptable parameters for working capital.

The Board again stated that at this point in the development of the System, reasonableness will generally be determined by peer group comparisons. Again, as data is compiled and analyzed, more specific standards can be set (T. 165-168). MHA and Blue Cross both addressed the issue of considering the amount of finances held in specific funds in assessing the reasonableness of working capital. MHD 487 A.1.c.(3)(b) provides that the reasonableness of the working capital allowances depends, inter alia, upon "The amount of finances that a hospital may hold in reserve funds." MHA was concerned that the term "reserve funds" was ambiguous and that such funds as the depreciation fund and other restricted funds should not be considered in determining the reasonableness of working capital (T. 164). Blue Cross felt that it should be made certain that unrestricted cash and investments should be included in determining working capital needs (Ex. A and T. 170-171). The proposed rule is reasonable for it allows the System the degree of flexibility necessary to make overall assessments of the reasonableness of the working capital requirements of a hospital.

65. MHA suggested that a clarification of MHD 487 A.1.c. (2) was necessary to insure that accounts receivable were broken down by a third party payor category (Ex. H at 22-21). That suggestion is helpful and could be included within the rule. Breakdown by category of payor will be useful in assessing the effect of each category of payor on the hospital's financial condition.

66. MHD 487 A.2. deals with income from sources other than patients. Generally, such income should be used to offset the hospital's expenses, but there are exceptions, and this section specifies the treatment of such income.

67. MHD 487 A.2.a. generally states that restricted funds must be used for the purpose for which they are restricted. The rule also recognizes that it may be more prudent to borrow or finance a building or equipment purchase than to expend monies restricted for that purpose. The rule reasonbly treats such a transaction as unreasonable unless the hospital can demonstrate that the financing method used is to the economic benefit of current patients.

68. MHD 487[illegible]2.b. provides that unres[illegible]icted funds from non-patient sources should be used to reduce the total financial requirements of a hospital. This is the one provision of the rule to which the MHA has serious objections (Ex. H at 21; T.181-184). MHA opposes it primarily because it would pre-empt the authority of local hospital boards who, they allege, can best determine what the intent of a donor may be and what the needs of a hospital's community may be. They argue that such a rule would have a serious and adverse effect on philanthropic giving in the future. They also note that, eventually, patients in general will benefit from such funds regardless of whether they are applied to current operations or future needs. The Board stated that it felt it was appropriate to offset unrestricted funds to financial requirements because: (1) it is in the current patient's best interests to do so; (2) if a donor intends to restrict the funds for future use, he can well do so; (3) the system of price level depreciation and funded depreciation provide adequate funds for future expansion; (4) under generally accepted accounting principles, unrestricted donations are classified as current income, and therefore, should offset current expenses; and (5) that any savings on future interest is small when compared to the dollar for dollar offset if applied to current expenses. The Board stated that the provision should be applied in a reasonable manner; that is, they would not intend to immediately include the corpus of substantial existing unrestricted funds and that they would deem it reasonable to treat very large donations in a manner that would spread out the benefit over a number of years. Even HIAA, which generally felt that the entire section was too liberal, agreed that some reasonable approach should be taken in evaluating the use of these funds (T. 184-193). It appears to the Board that the proposed provision was unreasonably restrictive. There may be situations in which not applying unrestricted funds to current operations could result in overall cost savings to the community. If a hospital can demonstrate that such a situation exists, it should be allowed to so restrict the funds. The following addition to the rule will provide additional flexibility: "Exceptions to this rule may be granted if the

hospital can show that alternative uses of these funds are to the economic benefit of current patients and/or in the best interests of the community served."

69. MHD 487 A.2.c. deals with auxiliary enterprises and states essentially that profits from such enterprises should primarily be used to offset financial requirements and that such enterprises should be self-sufficient and profitable. It would allow losses incurred from such enterprises only to the extent it can be demonstrated that such enterprise is a fringe benefit to employees or of direct economic benefit to current patients. MHA argues that this is a one-way street; that it is unfair to require the hospital to include profits from such enterprises, but not to include losses. They offer an amendment that would require that gains or losses from such enterprises not be considered in the financial requirements of the hospital (Ex. H at 22) (It might be noted that MHA would leave in the provision that any losses related to fringe benefits or direct economic benefit can be included; effectively reversing the direction of the one-way street.) The Board finds that the proposal is reasonable. If a hospital chooses to operate an auxiliary enterprise, the benefits of that should accrue to the hospital and through the hospital, to the current patients. On the other hand, since these enterprises are not directly necessary to patient care, the patient should not be charged for losses which are incurred because of imprudent management.

70. MHD 487 A.3. recognizes that changes in rates may be necessary due to variations from projected volumes of activity and services and states that the financial requirements of a hospital for a budget year should reflect adjustments for volumes of activity and service realized during the prior and current years. There are some difficulties with the precise wording of the section which should be corrected, but the rule provides that if a hospital over or under-projects its volume in a service center, its next year's financial requirements should be respectively increased or reduced by the percentage of fixed to total costs of that service center multiplied by the difference between the

actual and budgeted income of that service center. The general concept in prospective rate setting is that the rate is set at the beginning of the budget year, and no retrospective adjustments are made at the end of the year for variations from projections. This provision provides a limited exception to that general rule. MHA argued that this approach needs more study before it is implemented (Ex. H at 22-25). They point to the fact that there are variables other than volume that are difficult to predict and to the difficulty of defining and determining fixed to variable cost ratios for service centers. At the hearing, the Board admitted to the lack of evidence and difficulty of computing this ratio, but stated the hospitals would be able to use any of three methods in determining it. The alternatives are described in the Statement of Justification. The proposed method contained in the rule and explained by the Statement of Justification is reasonable.

71. MHD 487 A.4. treats excess capacity. This section relates to the plant capital needs section where price level factors are applied to depreciation. It states that in hospitals where excess capacity exists, the annual inflation factor will be reduced by the proportion of excess beds to total beds available. Excess capacity is determined by comparing that hospital's occupancy rate based on staffed and set-up beds to the average occupancy rate of other hospitals with common characteristics; in other words, the average of the peer group. When the System makes a preliminary determination that there is excess capacity, the determination will be submitted to the appropriate Health Systems Agency and to the State Planning and Development Agency. These agencies may then comment to the System regarding the consistency of the preliminary determination with health planning standards regarding occupancy rates.

HIAA argued that these requirements were too liberal. NALAC stated that peer group comparisons were not valid when the entire peer group has excess capacity and urged that some minimum standards be set. MHA stated that the whole problem of excess capacity is so enormous that it is beyond the scope of the rate review system to resolve (T. 215-233). MHA suggested that the preliminary determination of excess capacity be based on hospitals having an occupancy rate more than 20% below the average of the peer group. The Board's position is a reasonable middle ground between these arguments. The Foundation for Health Care Evaluation also suggested that the appropriate PSRO be included among the agencies notified of a preliminary determination of excess capacity. The Foundation also suggested the rule state the scope of review by the PSROs. Their suggestion is rather lengthy and the purpose will better be served by modifying the last sentence of MHD 487 A.4.a. to read:

> "These agencies may comment to the system regarding the consistency of this preliminary determination with health care standards regarding occupancy rates in their areas of expertise."

The Foundation suggests a parallel modification to the MHD 487 A.4.b. which should be adopted (Ex. E).

72. MHD 487 B. implements the provisions of Minn. Stat. §§ 144.698, subd. 5; 144.699 and 144.701 authorizing the Board to investigate hospital rates. The Board reasonably interprets the statutes to require that such investigations be supplemental to the regular review of reports submitted as otherwise required by the Act and rules. It may be necessary on certain occasions to undertake a longer and more detailed investigation of existing rates than is allowed by the normal 60-day review. The rule reasonably requires notice to the hospital of the investigation, application of the standards established by the rules, and a subsequent investigative report detailing the findings. No comments were offered on this section.

73. MHD 487 C. is necessary to describe the administrative standards for the review of reports required by the Act.

74. MHD 487 C.1. deals with completeness. Its provisions are necessary because the System cannot make a lengthy review unless the required reports are substantially complete. The provisions reasonably place the burden upon the hospital to submit adequate data for the System to be able to commence its review. As mentioned previously, a report is not deemed to be "filed" until the System has ascertained that it is complete. "Complete" means that the report contains adequate data for the System to commence its review. The rule reasonably allows the System ten days to determine whether the report is complete. The System may also, within ten days, notify the hospital that it will require up to 30 additional days to determine completeness. The rule provides that if the System has not responded to the hospital within ten working days, the report is deemed to be complete and filed as of the initial day of receipt by the System. The Board stated at the hearing that the same rule would apply to reports deemed complete during a 30-day extension period (T. 236). The Board believes that the rule can be clarified by adding a provision to the end of 487 C.1.b. stating, "If a report is not found to be incomplete during such additional period, it shall be deemed to be complete and filed as of the initial day of receipt by the System." Such a provision clarifies the Board's intent.

MHD 487 C.1.c. provides that a report determined to be incomplete shall be returned immediately to the hospital "stating the need for more data." As stated in the Statement of Justification, the Board requires that the report be returned to the hospital with a specific statement of how the report is incomplete. The rule, as written, does not make that clear. The Board finds it appropriate to modify the phrase quoted above to read, " . . . with a statement describing the report's deficiencies."

MHD C.1.e. provides for the situation where a hospital discovers errors in any of its submitted reports which have been deemed to be complete. It requires the hospital to inform the System of the error and submit an amendment to the report. Because it is necessary to determine whether such an amendment

should affect the 60-day period, the rule provides that in the case of an interim increase report or a rate revenue and expense report, the submittal of an amendment shall not affect the filing date if the hospital informs the System of any errors within 30 days of the initial filing and the amendment is submitted to the System by a date determined by the hospital and System to be acceptable. If either of these conditions are not fulfilled, the report will be deemed to be filed as of the date the amendment is submitted (thereby re-starting the 60-day period before which the hospital can increase its rates).

MHD 487 C.l.f. addresses the same problem from the view of the System discovering the error. It states that if the System discovers an error which will have a noticeable impact upon its ability to render fair comment, it may require the hospital to amend and re-submit the report. If the error is discovered within 30 days of filing, the filing date will not be affected if the amended report is submitted by a date which is acceptable to the System and the hospital. If the discovery of the error occurs more than 30 days after the filing date of the original report, the filing date will be set back to the date the amendment is submitted.

These provisions recognize some basic concepts. First, the hospital is required to submit complete and accurate reports, and if it discovers an error, it must inform the System. Second, if the errors are promptly discovered and corrected, or if they are not of such great magnitude so as to affect the System's ability to make a fair comment, the hospital should not be penalized by having its rate increase delayed. Third, the hospital should not be penalized if the System unreasonably delays in discovering a significant error. Fourth, the hospital should not unreasonably benefit from a delay by it in submitting an amended report. That is, if the hospital unreasonably delays in submitting an amended report, its rate increase should be delayed until the System has had reasonable opportunity to make comment. The Board believes that the two sections as written were unreasonable because they were not sufficiently flexible; section "e" did not allow for correc-

tion of insignificant errors after 30 days and section "f" did not protect hospitals from unresonable delay by the System in detecting significant errors. MHA offered some amendments to increase the flexibility of the rule (Ex. H at 26-27). These amendments would result in a rule that would allow rate increases to go into effect even though amendments were not filed by a date acceptable to the System. These two have been re-worded to more accurately and appropriately meet the objectives stated by the Board and are now reasonable.

75. MHD 487 C.2. states the general rules for reviewing rate revenue and expense reports and interim increase reports. They shall be reviewed on a basis of the rate and cost history of each hospital on an institutional and a service center basis. Comparisons between hospitals may be made on an institutional and service center basis when it can be shown that those hospitals and service centers share common characteristics. This has been noted before. HIAA argued that the System should establish norms (Ex. B at 15) NALAC's comment that comparison by peer group is of little value when the entire peer group is unreasonable applies here as well. Again, these rules are but a first step and it is impossible at this time to establish meaningful norms and standards. The rule is not unreasonable.

76. Minn. Stat. § 144.701, subd. 5, authorizes the Board, and thus the System, to review and publicly comment on any rate increases. MHD 487 C.2.b. implements this authority by stating that the System shall comment on interim increase reports and rate revenue and expense reports to the hospital, the Board and the public, and that the comment shall state that a hospital's existing or proposed rates are reasonable or are in question. A comment that a hospital's rates are in question may be based upon a determination that the rates deviate from the average of other hospitals in the peer group; the rates provide revenue which is in excess of expenses which deviate from past practices of the hospital, of peer hospitals or from the reasonableness standards stated in MHD 487 A.; or if the hospital has not demonstrated that its rates are necessary and consistent with the

standards established in MHD 487 A. The only question on this section of the rules was on the timing of the comment (T. 243-244). It is the intent of the Board that the comments would be issued prior to the implementation of proposed budgets or proposed rate increases. That seems to be the primary intent of the Act.

77. MHD 487 D. states that all official meetings of the System, including executive sessions, which occur for any purpose related to completion of an investigation, release of the results of an analysis, or issuance of a comment shall be open to the public and that public notice shall be given one week in advance of any such official meetings. The Minnesota Open Meeting Law applies to the Board, and since any voluntary review agency which may operate the System is acting in the Board's stead, the law should apply to it, too.

78. MHD 487 E. provides that the burden of proof shall be on the hospital to establish reasonableness, equity and lack of discrimination in its system of proposed rates. It is reasonable to require a hospital to justify its rates and that appears to be a primary purpose of the Act.

79. MHD 487 F. states that the System may, when two or more investigations, analyses or reviews involve common questions of fact, address the common questions of fact and make comments applicable to all hospitals under consideration. This is reasonable because it provides for uniform application of the standards and is administratively convenient. It imposes no burden upon the hospitals.

80. MHA suggested that an additional section be added describing an appeal mechanism (Ex. H at 27). This is a subject that should be addressed in future amendments. To include it now would be a substantial change from the proposed rules as noticed.

MINN. RULE MHD 494 - APPROVAL FOR OPERATION OF THE SYSTEM.

81. Minn. Stat. § 144.702, subd. 2, states that the Board may approve voluntary reporting and rate review procedures which

are substantially equivalent to the reporting requirements and rate review procedures adapted by the Board and shall, by rule prescribe standards for giving such approval. This rule is necessary to implement that statutory directive. The rule reasonably provides for application procedures by describing the application period, the required contents of the application, and a time limit upon the Board for approving or disapproving the application. As required by the statute, the rule requires that the applicant demonstrate that reports and procedures are substantially equivalent to those established by the Board. The rule also provides that the Board may fail to renew or revoke its approval if the reporting and review procedures of the applicant are no longer substantially equivalent to those established by the Board. The only comment on this rule was that MHA felt comfortable with it (T. 253).

MINN. RULE MHD 504 - BOARD DETERMINATION OF ALLOWABLE INCREASE LIMIT.

82. Minn. Stat. § 144.701, subd. 5, allows the Board to exempt rate increases which have a minimal impact on hospital costs from the 60-day advance notice requirement. The rule provides that the Board shall establish the quarterly increase limits for the next six quarters. Such projections are necessary to allow the hospitals adequate time for financial planning. The allowable increase is reasonably expressed as a percentage based upon the consumer price index. The allowable increase limits are threshhold values to be used by hospitals in determining whether they must file interim increase reports. It is not a standard to measure the reasonableness of rate increases. The rule as written is sufficiently flexible to allow the Board to establish the limit on a general basis or on a peer group basis. These provisions are reasonable.

MINN. RULE MHD 509 - FEES

83. Minn. Stat. § 144.701, subd. 6, authorizes the Board to set filing fees for the rate revenue and expense reports and interim increase reports that are filed with the Board. This rule establishes those fees and is graduated according to the number of licensed acute care beds in the hospital. The statute requires the Board to consider the length and complexity of the report being filed in setting the fee. Bed size may generally be related to the expected length and complexity of the report. The rates set in the rule are based on those charged by the MHA in its current voluntary program. No objection was made to this rule. MHA did request that a provision be added to make it clear that the rates set by the rule applied only to reports submitted to the Board and not to the rates of any voluntary review organization approved by the Board (Ex. H at 28; T. 250-253). The Board agreed that the suggestion was reasonable and should be included within the rule.

MINN. RULE MHD 510 - OFFICIAL OFFICES.

84. This rule states that, for the purposes of the rate review system, the official offices of the Board are those located at the Department of Health Building in Minneapolis. It is necessary and reasonable to designate this office because the several district offices of the Board of Health are not involved in the review system and it would be inappropriate and confusing if reports were filed in any other office.

MINN. RULE MHD 511 - SEVERABILITY.

85. This rule is a standard severability provision which insures that the entire set of rules is not rendered void if any particular section is declared unconstitutional or invalid.

OTHER

86. The Board offered a number of minor changes and modifications to the proposed rules at the hearing. Except as expressly found otherwise above, these changes are reasonable, necessary. and non-substantial.

CONCLUSIONS

1. Due, timely and adequate legal notice of the hearing was properly served and published by the Board. All other substantive and procedural requirements of statute and rule have been fulfilled.

2. The Board has demonstrated its statutory authority to adopt the rules.

3. The Board has demonstrated the need for and reasonableness of the adopted rules.

Dated this 30 day of March, 1977.

MINNESOTA STATE BOARD OF HEALTH

Valentine O'Malley

VALENTINE O'MALLEY, M.D.
President

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS
ROOM 300 – 1745 UNIVERSITY AVENUE
ST. PAUL, MINNESOTA 55104
(612) 296-6910

March 10, 1977

Mrs. Vera J. Likins
Commission of Public Welfare
Fourth Floor
Centennial Office Building
St. Paul, Minnesota - 55155

RE: In the Matter of the Proposed Adoption of Amendments to Rule 52 of the Department of Public Welfare Governing Regulations for Determining Welfare per diem Rates for Providers of Services for Mentally Retarded Residents
Our File No. DPW-77-028-SM

Dear Mrs. Likins:

I enclose herewith the official file in the above-entitled matter together with my Report.

Yours very truly,

STEVE M. MIHALCHICK
Hearing Examiner

SMM/eag
Encs.

STATE OF MINNESOTA)
(ss.
COUNTY OF RAMSEY)

AFFIDAVIT OF SERVICE

Eileen A. Gaiovnik, being first duly sworn, deposes and says that on the 10th day of March 1977, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice to Interested Persons, DPW-77-028-SM

unstamped, by placing in the designated tray to be collected by messenger for delivery to the central mailing station as required by Minn. Stat., § 16.54 (1974), a true and correct copy thereof on all persons at the addresses shown on the ~~attached mailing list~~ Hearing Register who indicated thereon that they wished to be notified when the Examiner's Report was submitted to the Agency.

Eileen A. Gaiovnik

Subscribed and sworn to before me
this 10th day of March, 1977.

Sandra A. Haven

SANDRA A. HAVEN
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires July 29, 1983

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS
ROOM 300 – 1745 UNIVERSITY AVENUE
ST. PAUL, MINNESOTA 55104
(612) 296-6910

March 10, 1977

TO ALL INTERESTED PARTIES:

RE: In the Matter of the Proposed Adoption of Amendments to Rule 52 of the Department of Public Welfare Governing Regulations for Determining Welfare per diem rates for Providers of Services for Mentally Retarded Residents
Our File No. DPW-77-028-SM

The Report of the Hearing Examiner in the above-entitled matter has been submitted to the Department of Public Welfare Please note that the Report is a recommendation only and that the Department may accept, modify or reject any part of it. However, the Department may not take any final action on the proposed rule until at least ten days have expired. During that time, the Department and the Office of Hearing Examiners will make a copy of the Report available for review by any interested individual. Copies will be furnished by the Office of Hearing Examiners for $1.60 each. Please use the enclosed order form.

A copy of the Report has also been filed with the Legislative Reference Library.

Yours very truly,

Susan K. Derus

SUSAN K. DERUS
Administrative Assistant

SKD/eag
Enc.1

AN EQUAL OPPORTUNITY EMPLOYER

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

Re: In the Matter of the Proposed Adoption of Amendments to Rule 52 of the Department of Public Welfare Governing Regulations for Determining Welfare per diem Rates for Providers of Services for Mentally Retarded Residents

CERTIFICATION OF OFFICIAL RECORD

Docket No.

I, Steve M. Mihalchick, Hearing Examiner in the above-entitled matter, do hereby certify that the items identified on the attached list(~~s~~) constitute the entire official record in the above-entitled matter to date.

All the listed items are enclosed herewith unless specifically excepted below.

Exceptions:

(X) None.

( ) The original transcript of the proceedings herein was previously delivered.

( ) The proceedings have not been transcribed. The reporter's notes or recording tapes will be maintained until the time for appeal has run.

( ) Other exceptions:

Dated: 3/10/77

S. Mihalchick

RECORD DOCUMENTS

DOCKET DPW-77-028-SM

DATE 2/11/77 (closed 3/3/77)

TITLE Amendments to Minn. Rule DPW 52

EXHIBIT / ITEM	PARTY: DEPT'S	PARTY: PUBLIC'S	MARKED	REC'D	OBJECTION
Copy of Proposed Rules	A		✓	1-12-77	
Order	B		✓	"	
Proposed Notice	C		✓	"	
Order	D		✓	1-17-77	
Notice as mailed	E		✓	"	
Aff't Receipt of SOS (1-6-77) list	F		✓	"	
SoS Cert & list	G		✓	"	
Affit of Mailing (1-7-77)	H		✓	"	
Statement of Need	I		✓	"	
Statement of Evidence	J		✓	"	
cc - Rep. Carter Inc.	K		✓	2-11-77	
cc - Portland Rs	L		✓	"	hearing
ARRM		1	✓	"	
Hearing Register	M		✓	"	
Johnson's, Riverside B.H.		2	✓	2-17-77	post-hearing
Original Transcript	-	-	-	2-22-77	
MAPRFMR		3	✓	3-3-77	
Dept of Administration		4	✓	"	record closed
Examiner's Report	-	-	-	3-10-77	
Notice to Interested Persons	-	-	-	3-10-77	

3/10/77

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of Amendments to Rule 52 of the Department of Public Welfare Governing Regulations for Determining Welfare per diem Rates for Providers of Services for Mentally Retarded Residents.

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing on February 11, 1977, in St. Paul, before Steve M. Mihalchick, Hearing Examiner appointed by the Chief Hearing Examiner.

This is a rules hearing pursuant to Minn. Stat. Ch. 15, to determine whether proposed amendments to Minn. Rule DPW 52 should be adopted.

The following persons appeared for the Department of Public Welfare (DPW): James J. Hiniker, Deputy Commissioner; Paul Zerby, Deputy Attorney General; Robert Rau, Audit Director, and Thomas Neumann, Auditor. Twenty-nine persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard.

Pursuant to Minn. Stat. § 15.0412, subd. 4 (1976), this Report shall be available for review to all affected individuals upon request for at least ten days.

The Department shall, if it proposes to adopt the rules as originally proposed or amended, submit the complete hearing record, including its Findings and Order, to the Chief Hearing Examiner no earlier than ten days subsequent to the receipt of this Report. This submission shall also clearly indicate any changes made to the rules as originally proposed, preferably in the format that will be submitted to the State Register for publication. The Chief Hearing Examiner shall complete his review and submit his report to the Department on the issues of substantial changes in the rule and compliance with Minn. Stat. § 15.0412 within ten calendar days. Thereafter, the Department shall be responsible for filing the rules with the Attorney General.

Based upon all the records and proceedings herein, the Examiner makes the following:

FINDINGS OF FACT

PROCEDURAL REQUIREMENTS

1. On January 5, 1977, a Notice of Hearing and a copy of the proposed rules were published at 1 State Register 1002.

2. On January 7, 1977, DPW mailed the Notice of Hearing to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice.

3. On January 12, 1977, DPW filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules;
(b) A proposed Order for Hearing; and
(c) A proposed Notice of Hearing.

4. On January 17, 1977, DPW filed the following documents:

(a) The Order for Hearing;
(b) The Notice of Hearing as mailed;
(c) The Affidavit of Receipt of the Secretary of State's list;
(d) The Affidavit of Mailing;
(e) The Secretary of State's Certificate and list;
(f) The Statement of Need; and
(g) The Statement of Evidence including the names of witnesses to be called.

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing.

5. The record remained open through March 3, 1977, for the receipt of written comments and statements. Four public comments were received during the 20-day period. Included among the public comments are the comments of the Minnesota Department of Administration (Ex. 4).

STATUTORY AUTHORITY

6. Minn. Rule DPW 52 (Rule 52) is an existing rule adopted pursuant to authority in Minn. Stat. §§ 256B.04, subd. 2 and 256B.27. Those sections authorize the Commissioner of Public Welfare to adopt rules and require reports relating to Medical Assistance for Needy Persons. Further, Minn. Stat. § 252.27, subd. 1 (1976), provides that the cost of caring for any child who is mentally retarded, epileptic or emotionally handicapped

shall be paid by the appropriate county. The county paying the costs of such care and treatment shall, subject to uniform regulations established by the Commissioner of Public Welfare, receive reimbursement not exceeding 70% of such costs from funds made available for this purpose by the Legislature. These statutes authorizing the original adoption of Rule 52 authorize its amendment in this proceeding.

PROPOSED AMENDMENT TO MINN. RULE DPW 52 A.2 OBJECTIVES

7. In this section, and throughout the rule, it is necessary to delete the references to Intermediate Care Facilities/ Mentally Retarded (ICF/MR) and replace it with the broader term "residential facilities for the mentally retarded". This is because the ICF/MR designation applies only to the Medical Assistance Program, and, as noted above, Rule 52 deals with funding from sources other than the Medical Assistance Program. The proposed change in wording reasonably clarifies that fact. As was noted at the hearing, there are a number of places within Rule 52 where the change was not made. For consistency, the words should be changed wherever they appear throughout the rule. This would not be a substantial change.

PROPOSED AMENDMENTS TO MINN. RULE DPW 52 B. - RATE DETERMINATION

8. DPW 52 B.1.a. generally provides that the historical rate will be determined by dividing reasonable costs for the most current fiscal year by actual resident days. DPW proposes to add a provision to this section that states: "Such rate shall be based on occupancy of no less than 80%. The 80% occupancy factor shall apply only to facilities of more than 10 beds." The effect of the provision is to reduce the per diem rate for facilities whose occupancy drops below 80% of licensed capacity. Operating at less than capacity is inefficient and at some point becomes a waste of public funds. It is therefore necessary to set a limit to discourage low occupancy rates. DPW statistically analyzed various bed size and occupancy rate combinations. Applying the ten-bed and 80% parameters, DPW found that four of 27 facilities would be affected. This proposal, as with the majority of DPW's proposed changes, had the support, or at least the acceptance of

all the interested persons and associations who addressed the issue at the hearing (Ex. 1, and T. 47-50). The Management Services Division, Department of Administration, supported the 80% lower limit, and also suggested that an incentive factor be included in the rule similar to that found in Minn. Rule DPW 49 (Ex. 4). They suggest dividing cost by a maximum of 93% of capacity. The effect of this would be to provide an increased per diem rate to facilities whose occupancy rate exceeded 93%. DPW may wish to consider this suggestion for inclusion in the rule. However, the Examiner would note that facilities for the mentally retarded are not designed to be long-term care facilities. Hopefully, the residents will improve and move out of the facility. Encouraging a very high occupancy rate may encourage the facilities to retain the residents for longer than ideal periods in order to inflate their occupancy rate. The rule is reasonable as written.

9. Rule 52 requires the facility to add or deduct cost changes that it knows will occur during the rate year to or from the historical costs. These changes are restricted to certain listed expense categories. Thus, if a facility knows that it will incur an expense during its rate year that was not included in the current year, it may add in that expense. Likewise, if a certain expense was incurred during the current year that will not be incurred during the rate year, that expense must be deducted. DPW 52 B.1.c.(2) currently provides: "If the provider cannot substantiate the fact that such facts and commitments did exist as of the filing date, [the cost change will not be allowed]." It has generally been the policy of DPW that these facts must be substantiated by some form of written commitment existing as of the filing date. However, exceptions have been made where it can otherwise be shown that the commitment did, in fact, exist, but where it was impossible or extremely difficult to have that commitment in written form as of the date of filing. The fact that many of the facilities subject to Rule 52 are small and had previously been unaware of DPW's policy had caused a number of them to lose known cost change allowances because they had not

substantiated them with a written commitment. To make that policy clearer to these providers, DPW proposes to modify the above quoted section to read: "If the provider cannot substantiate the fact that such facts and written commitments did exist as of the filing date, ..." This was the one proposal that received some opposition (T. 12-21, and 47; Ex. 3). In a prospective rate setting system such as Rule 52, it is the general rule that the rate is determined at or near the beginning of the budget year and that no adjustments are made to the rate thereafter. Essentially, the facility must plan and justify its budget for the rate year and then live with the resulting per diem rate. There was no disagreement as to this general concept nor to the general policy of DPW in requiring written demonstration of known cost changes. However, the proposed change would effectively eliminate any possibility of allowing a known cost change in those rare situations where a cost change commitment in fact existed, but where written documentation was impossible or extremely difficult to provide. Mr. Rau stated that in such a unique situation, DPW would have to examine the case to determine whether the facts were similar to previous appeals in this area where non-documented cost changes were allowed. He also stated that the appeal mechanism was available (T. 21). DPW was unable to draft language that would provide for the unique exception (T. 21). The proposed change is unreasonable because it does not provide the minimal flexibility that even DPW says should exist. The prior decisions could not have been made under the proposed language.

The Examiner would note that the rule in its current form appears to have worked rather well and has been interpreted in a manner consistent with the policy expressed by DPW at the hearing. However, if DPW continues to desire to express its policy more clearly within the rule, the Examiner would suggest that DPW consider inserting the following sentence after the second sentence in DPW 52 B.1.c.(2): "The existence of such facts and commitments must be demonstrated by written documentation in existence as of the filing date except where the provider can otherwise clearly demonstrate that such facts and commitments did exist

and that written documentation was impossible or very difficult to obtain."

10. DPW 52 B.2.c. contains provisions indicating that payments are made by the county welfare boards. Since the rule was originally adopted, the mechanism has been changed so that payment under the Medical Assistance Program is made directly by DPW, rather than by the counties. Therefore, DPW reasonably proposes to delete the reference to the counties from this section. At the hearing, DPW noted that similar changes should be made to sections B.5.e. and C.1.f.(2)(a). These modifications are similar to that proposed in the notice and would be non-substantial changes.

11. DPW proposes to delete Section B.3.b. which currently allows small providers to elect to be paid at a flat rate rather than using the cost reporting system to determine per diem rates. During calendar year 1976, only three facilities requested the flat rate. The fact that so few facilities utilize this option makes it continued availability unjustified. The Association of Residences for the Retarded in Minnesota (ARRM) agreed, stating that improved cost awareness should result (Ex. 1). The deletion of this provision is reasonable.

12. Existing DPW 52 B.4.b. provides that welfare rates will be limited to a 15% increase over the previous welfare rate. It then provides that this limitation does not apply to minimum, immediate requirements imposed by federal, state and local laws and regulations in the expense categories listed for known cost changes under Section B.1.c.(1). It has been DPW's experience that the wording of this exception is too general and has made administrative determinations difficult. It also encouraged several disagreements with providers. It has also been DPW's experience over the three years of Rule 52's existence that governmentally-required changes typically occur in the cost items of additional employment of personnel, physical plant improvements and licensed capacity changes. Therefore DPW proposes to delete the existing general statement and replace it with the following exception to the 15% increase limit:

"(1) Salaries for additional personnel, depreciation and interest expense for physical plant improvements or other fixed assets, and changes in licensed capacity insofar as these cost changes are incurred to meet minimum and immediate requirements imposed by federal, state or local laws and regulations."

The Minnesota Association of Private Residential Facilities for the Mentally Retarded pointed out that the change had the effect of eliminating some of the cost categories referred to in the old rule. For example: taxes, utilities and insurance. The Association argues that DPW failed in its Statement of Need or Notice of Hearing to point out the impact of this change. The Examiner finds the Statement of Need adequately pointed out that DPW felt that only the three broad cost areas were justified under this exception to the maximum rate limitation. It is a rather easy step to say that DPW felt that anything other than these three listed areas was not justified. As to the reasonableness of the changes, DPW stated that it has been and will continue to be the policy under this provision to pass through expenses which are related to additional personnel. This would include increased payroll taxes, workers' compensation insurance, etc. That is a reasonable interpretation of the rule, but DPW should consider clarifying that intention by adding the phrase, "and related expenses" after the word "Salaries" in this subsection. The Association and ARRM suggested that property taxes should be included within this exception to the maximum rate limitation. DPW stated that it did not and would not normally allow increased property taxes to be passed through under this exception. It stated that normal property tax increases should be included within the 15% increase limit. DPW seemed to be addressing the situation where property taxes normally increase on a given piece of property, but there was no discussion of increased property taxes due to expanded or improved facilities where that expansion or improvement was done to comply with governmental requirements. It would seem logical that if depreciation and interest expenses for such physical plant improvements are allowed, then increases in property taxes (and utilities, for that matter) associated with that improvement should also be included. The rule is not unreasonable as written because the 15%

increase limit should be sufficient to absorb any reasonable increases in expenses in these two areas due to a required expansion, but DPW should examine the rule to determine whether it would be appropriate to make specific provision for these items.

13. There was also discussion at the hearing of cases where DPW had allowed increases in property taxes to be passed through when that increase was due to new owners having a different tax status. In such situations, it is simply unreasonable to apply the limit. However, DPW reasonably declined to specify the exception in the rule. These are truly unique situations that must be dealt with on a case-by-case basis.

14. DPW also proposed a second exception to the maximum increase limit. This proposal would allow salary increases in excess of 6% to be passed through the 15% increase limit if such salary increases are reasonable and required to bring the facility's salaries within the salary range of comparable facilities. In administering Rule 52, DPW has noticed that established facilities have difficulty competing for qualified employees because their salaries have been limited by the increase limit. A similar limit is not imposed on new facilities who are able to begin paying higher salaries when they are established. It is the intention of DPW to leave this provision in the rule for no more than two years, which should be sufficient time to allow equalization of salaries throughout the industry. There was discussion at the hearing on what reasonable salaries should be. That will have to be determined on a case-by-case basis under the parameters established in the rule. The changes proposed by DPW to this section are reasonable.

15. The Department of Administration offered a number of comments on the overall rate limitation provision. They suggested first of all that the 15% figure should be reduced to 10% because all price relevant indices had increased less than 10% during the last year. To so modify the rule at this point would be a substantial change and an additional hearing would be required. The Examiner would note that this particular rule previously provided for a 10% increase limit and was amended to 15% effective

January 1, 1976. The Department of Administration also suggested deleting the pass-throughs for governmentally-required changes altogether or limiting them even more strictly. This would, again, be a substantial change. It appears to the Examiner that a number of the limits suggested by the Department of Administration are already provided in the rule in the known cost change section. They suggest that capital expenditure pass-throughs should not be included in the historical costs of subsequent cost reports. If such costs are expensed during the year, they would have to be deducted from historical costs in the subsequent year because they would not be a cost that would be incurred in the subsequent budget year. However, if the capital expenditure is capitalized over the life of the asset, it is entirely appropriate to continue to carry it within the historical cost portion of the subsequent year's reports, because the pro-rated cost, from an accounting standpoint, continues to be incurred in each of those subsequent years. DPW should consider the suggestions of the Department of Administration for future amendments.

16. The remaining portion of DPW 52 B.4.b. provides a general exception to the increase limitation if the requested welfare rate does not exceed certain dollar figures. In making its revisions to this section, DPW did not change this provision, but did re-number it as subsection c. By so re-numbering the provision, it becomes possible to read it as an exception not only to the increase limitation, but also to the private pay limitation provided in section B.4.a. That was not intended and the Examiner would suggest that the provision not be separately numbered.

PROPOSED AMENDMENTS TO MINN. RULE DPW 52 D.1.i. - TOP MANAGEMENT COMPENSATION LIMITATION

17. The current rule on top management compensation, in addition to a salary based on bed size, limits compensation to "no more than 60 cumulative employment hours per week." This provision was difficult to administer because of the difficulty of monitoring the hours. DPW therefore proposes to delete the section and replace it with a provision that the compensation must be justified under the reasonable compensation standards provided

in Section D.1.c. The existing rule also provides that the total top management compensation for an individual or a group of individuals is $35,000, regardless of the number of facilities managed. DPW proposes to delete that requirement and allow a maximum compensation of $35,000 per facility. This change is necessary to recognize that each facility is an individual entity and because DPW's experience has shown that the $35,000 limitation on multiple facilities has, in some cases, been too restrictive. These changes are reasonable because all such salaries must now be subjected to the reasonable compensation standards provided in the rule. The Department of Administration suggested some additional limitations and specifications within this section of the rule (Ex. 4). They suggested that $20,000 be the maximum limit for the top administrator; that the maximum salary should only be paid for full-time, on-site administrative work; that the duties of an administrator should be defined; and that limits should be set for both the top administrator and for the top level of management in a facility. Once again, it would seem that the proposed rule reasonably provides for all those contingencies by its reference to Section D.1.c. which contains reasonable compensation standards.

PROPOSED AMENDMENT TO MINN. RULE DPW 52 E. - EFFECTIVE DATE

18. The proposed changes here are necessary to specify the effective date of the proposed revisions and reasonably make them effective as of January 1, 1977.

OTHER

19. There are some numbering errors in the rule as it was printed in the State Register. Some of these were pointed out by ARRM (Ex. 1). They apparently occurred when the rule was renumbered to conform with State Register requirements and they should be corrected. Section C.3.a.(3) is incorrectly numbered as Section C.3.a.(d). Cross-references to other sections contained in C.3.a.(2); C.3.a.(4); D.1.i. and D.5.a.(1)(a) appear to be in error.

20. One facility made comments regarding provisions of the rule that were not proposed for amendment in this proceeding (Ex.

2). The Examiner would suggest that DPW contact that facility to answer their questions.

CONCLUSIONS

1. Due, timely and adequate legal notice of the hearing was properly served and published by the Department. All other substantive and procedural requirements of statute and rule have been fulfilled.

2. The Department has demonstrated its statutory authority to adopt the proposed amendments.

3. With the exception noted in Finding No. 9, the Department has demonstrated the need for and reasonableness of the proposed amendments.

4. The Examiner has offered a number of suggestions which he believes would improve the proposed amendments. These suggestions are not intended to preclude the Department from making its own non-substantial changes and improvements.

RECOMMENDATION

The Hearing Examiner recommends that the proposed amendments be modified as suggested in the Findings and, so modified, that they be adopted.

Dated this 10th day of March, 1977.

STEVE M. MIHALCHICK
Hearing Examiner

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS, COMMISSIONER

OF PUBLIC WELFARE

In the Matter of the Proposed Amendment to Rule 52 of the Minnesota Department of Public Welfare

ORDER ADOPTING RULES

The above mentioned matter came on for hearing before Mr. Steve M. Mihalchick, Hearing Examiner, appointed by the Chief Hearing Examiner, on February 11, 1977, after proper notice as required by Minnesota Statutes § 15.0412 was served on all persons, associations and other interested groups registered with Secretary of State for that purpose.

At said hearing proposed amendments to Minn. Rule DPW 52 were considered as originally proposed as shown in the attached Exhibit A hereto. The following persons appeared for the Department of Public Welfare (DPW); James J. Hiniker, Deputy Commissioner; Paul G. Zerby, Deputy Attorney General; Robert J. Rau, Audit Director, DPW. Twenty-nine persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard. Based upon the proceedings as indicated in the Report of Hearing Examiner, dated March 10, 1977, a copy of which is attached as Exhibit B hereto, the Hearing Examiner made Findings of Fact, Conclusions and Recommendations.

Pursuant to Minnesota Statutes § 15.0412 subd. 4 (1976), said Report has been available to all affected persons for over ten days subsequent to the date of the Report.

After affording interested persons an opportunity to present written and/or oral statements, having reviewed all of the testimony, having considered all of the evidence adduced, having considered the report of the Hearing Examiner, and upon all the proceedings and testimony herein and applicable statutory standards or criteria, and having determined the need for the above-captioned rules and the reasonableness thereof.

NOW, THEREFORE, IT IS ORDERED THAT the Commissioner hereby adopts and incorporates herein the Report of the Hearing Examiner, dated March 10, 1977, to the following extent:

1. All Findings of Fact of the Hearing Examiner, except Finding of Fact No. 9, are adopted and incorporated in full. Finding of Fact No. 9 of the Hearing Examiner is rejected and the following Finding is adopted in lieu thereof:

> 9. Rule 52 requires the facility to add or deduct cost changes that it knows will occur during the rate year to or from the historical costs. These changes are restricted to certain listed expense categories. Thus if a facility knows

that it will incur an expense during its rate year that was not included in the current year, it may add in that expense. Likewise, if a certain expense incurred during the current year will not be incurred during the rate year, that expense must be deducted. DPW 52 B.1.C.(2) currently provides:

> "If the provider cannot substantiate the fact that such facts and commitments did exist as of the filing date, (the cost change will not be allowed)"

It has generally been the policy of DPW that these facts must be substantiated by some form of written commitment existing as of the filing date. To incorporate that policy into the rules and to make the policy clear to all providers, DPW proposes to modify the just quoted section to read:

> "If the provider cannot substantiate the fact that such facts and written commitments did exist as of the filing date, . . ."

DPW identified the need for adding the word "written" to commitments by presenting two appeal case decisions which were related to this documentation issue (T. 12). The decisions did demonstrate the need for clarification of the rule pertaining to commitments clearly identifiable to DPW in the process of welfare rate determination. In rebuttal to opposition to the word "written" DPW did testify to the same requirement being used for nursing homes (Minn. Reg. DPW 49) without inclusion of the specific appeal before the Office of Hearing Examiners on that issue. However, the documentation provision is similarly administered in both rules (49 and 52) by the Department. DPW continued its testimony by asserting the fact that the commitments must not only be written, but they must be communicated in order to be allowable (T. 19 - 20). DPW also argued that written commitments must be communicated to DPW in the rate request. Testimony continued on this provision of the rule (T. 24) and DPW did argue for the need and reasonableness of the additional word. Therefore, the Commissioner does hereby find such provision reasonable.

2. Conclusions 1, 2 and 4 of the Hearing Examiner are adopted and incorporated in full.

3. Conclusion No. 3 of the Hearing Examiner is rejected and the following Conclusion is made in lieu thereof:

> 3. The Department has demonstrated the need for and reasonableness of the proposed amendments.

IT IS FURTHER ORDERED THAT the Commissioner hereby adopts the proposed amendments to Rule 52 of the Minnesota Department of Public Welfare so that from and after this day of May 17, 1977, said Rule 52 shall read in its entirety as set forth in the attached Exhibit C, hereto, pursuant to the authority vested in me, pursuant to Minnesota Statutes, Chapters 15 and 256B.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins

VERA J. LIKINS
Commissioner

that it will incur an expense during its rate year that was not included in the current year, it may adjust that expense. Likewise, if a certain expense incurred during the current year will not be incurred during the rate year, that expense must be deducted. DPW 52 B.1.C.(2) currently provides:

> "If the provider cannot substantiate the fact that such facts and commitments did exist as of the filing date, (the cost change will not be allowed)"

It has generally been the policy of DPW that these facts must be substantiated by some form of written commitment existing as of the filing date. To incorporate that policy into the rules and to make the policy clear to all providers, DPW proposes to modify the just quoted section to read:

> "If the provider cannot substantiate the fact that such facts and written commitments did exist as of the filing date, . . ."

DPW identified the need for adding the word "written" to commitments by presenting two appeal case decisions which were related to this documentation issue (T. 12). The decisions did demonstrate the need for clarification of the rule pertaining to commitments clearly identifiable to DPW in the process of welfare rate determination. In rebuttal to opposition to the word "written" DPW did testify to the same requirement being used for nursing homes (Minn. Reg. DPW 49) without inclusion of the specific appeal before the Office of Hearing Examiners on that issue. However, the documentation provision is similarly administered in both rules (49 and 52) by the Department. DPW continued its testimony by asserting the fact that the commitments must not only be written, but they must be communicated in order to be allowable (T. 19 - 20). DPW also argued that written commitments must be communicated to DPW in the rate request. Testimony continued on this provision of the rule (T. 24) and DPW did argue for the need and reasonableness of the additional word. Therefore, the Commissioner does hereby find such provision reasonable.

2. Conclusions 1, 2 and 4 of the Hearing Examiner are adopted and incorporated in full.

3. Conclusion No. 3 of the Hearing Examiner is rejected and the following Conclusion is made in lieu thereof:

> 3. The Department has demonstrated the need for and reasonableness of the proposed amendments.

IT IS FURTHER ORDERED THAT the Commissioner hereby adopts the proposed amendments to Rule 52 of the Minnesota Department of Public Welfare so that from and after this day of May 17, 1977, said Rule 52 shall read in its entirety as set forth in the attached Exhibit C, hereto, pursuant to the authority vested in me, pursuant to Minnesota Statutes, Chapters 15 and 256B.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

VERA J. LIKINS
Commissioner

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS, COMMISSIONER

OF PUBLIC WELFARE

In the Matter of the Proposed Amendment to Rule 52 of the Minnesota Department of Public Welfare

ORDER ADOPTING RULES

The above mentioned matter came on for hearing before Mr. Steve M. Mihalchick, Hearing Examiner, appointed by the Chief Hearing Examiner, on February 11, 1977, after proper notice as required by Minnesota Statutes § 15.0412 was served on all persons, associations and other interested groups registered with Secretary of State for that purpose.

At said hearing proposed amendments to Minn. Rule DPW 52 were considered as originally proposed as shown in the attached Exhibit A hereto. The following persons appeared for the Department of Public Welfare (DPW); James J. Hiniker, Deputy Commissioner; Paul G. Zerby, Deputy Attorney General; Robert J. Rau, Audit Director, DPW. Twenty-nine persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard. Based upon the proceedings as indicated in the Report of Hearing Examiner, dated March 10, 1977, a copy of which is attached as Exhibit B hereto, the Hearing Examiner made Findings of Fact, Conclusions and Recommendations.

Pursuant to Minnesota Statutes § 15.0412 subd. 4 (1976), said Report has been available to all affected persons for over ten days subsequent to the date of the Report.

After affording interested persons an opportunity to present written and/or oral statements, having reviewed all of the testimony, having considered all of the evidence adduced, having considered the report of the Hearing Examiner, and upon all the proceedings and testimony herein and applicable statutory standards or criteria, and having determined the need for the above-captioned rules and the reasonableness thereof.

NOW, THEREFORE, IT IS ORDERED THAT the Commissioner hereby adopts and incorporates herein the Report of the Hearing Examiner, dated March 10, 1977, to the following extent:

1. All Findings of Fact of the Hearing Examiner, except Finding of Fact No. 9, are adopted and incorporated in full. Finding of Fact No. 9 of the Hearing Examiner is rejected and the following Finding is adopted in lieu thereof:

> 9. Rule 52 requires the facility to add or deduct cost changes that it knows will occur during the rate year to or from the historical costs. These changes are restricted to certain listed expense categories. Thus if a facility knows

MINNESOTA DEPARTMENT OF HEALTH RULES

CHAPTER TWENTY-EIGHT

Proposed Rules for the

Minnesota Hospital Rate Review System

MHD 471 Scope.

A. All acute care hospitals licensed pursuant to Minnesota Statutes, Sections 144.50 to 144.58 are subject to the requirements of the Minnesota Hospital Rate Review System established by these rules.

B. Beds located in these hospitals, which are not licensed as acute care beds pursuant to Minnesota Statutes, Sections 144.50 to 144.58, are not subject to the requirements of the Minnesota Hospital Rate Review System. Where costs incurred through the operation of these beds are co-mingled with the costs of operation of acute care beds in a hospital subject to the system, associated revenue and expenses and other related data shall be separated in a manner consistent with the normal step-down requirements for allocation of costs as stated by 20 CFR 405.453 (Medicare).

C. Citations of Federal law or Federal regulations incorporated in these rules are for those laws and regulations then in effect on April 1, 1976.

MHD 472 Definitions. For the purposes of these rules, the following terms have the meanings given them:

A. "Accounting period" means the fiscal year of a hospital which is a period of twelve consecutive months established by the governing authority of a hospital for purposes of accounting.

B. "Admissions" means the number of patients accepted for inpatient services in beds licensed for inpatient hospital care.

C. "Applicant" means a voluntary nonprofit rate review organization which has applied to the board for approval or renewed approval of its reporting and review procedures.

D. "Auxiliary enterprises" means significant continuing revenue-producing activities which, while not related directly to the care of patients, are businesslike activities commonly found in health care institutions for the convenience of employees, physicians, patients and/or visitors:

1. An activity is significant if either its revenues or direct costs exceed $.20 per inpatient day;
2. An activity is businesslike if it has related direct costs equal to at least 25% of its revenues;
3. Irrespective of the above criteria, all parking lots, private physicians' offices, and retail operations are considered to be auxiliary enterprises.

E. "Beds" means the average number of beds in a hospital which are in place and operating with staff regularly assigned to them during an accounting period. This number need not be equivalent to the licensed or constructed bed capacity but it shall be equivalent to the average number of those beds commonly considered to be set up and staffed during an accounting period.

F. "Burden of proof" means the burden of persuasion by the preponderance of the evidence.

G. "Charges" means the regular amounts charged to both paying patients and insurers who receive services, irrespective of any discounts, deductions, or other reductions in these charges which, by contract or other agreement, may be applicable.

H. "Cost" means the amount, measured in money, of cash expended or other property transferred, services performed or liability incurred, in consideration of goods or services received or to be received.

I. "Emergency services" are those inpatient hospital services and outpatient hospital diagnostic services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to life or health of the individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.

J. "Emergency visit" means an admission of a patient to a hospital which maintains a distinct emergency service center for purposes of receiving emergency services.

K. "Expanded facility" means any expansion or alteration in the scope of service of an institution subject to the provisions of the Minnesota Certificate of Need Law, Minnesota Statutes §145.71 to 145.84, or Section 1122 of the Social Security Amendments of 1972, Public Law 92-603, according to the definitions contained in these laws and the current regulations sanctioned by them.

L. "Expense(s)" means costs that have been incurred in carrying on some activity and from which no benefit will extend beyond the period for which the expense is recorded.

M. "Fiscal year" means that period of twelve consecutive months established by the State for the conduct of its business.

N. "Inpatient hospital services" means the following items and services furnished by a hospital to an inpatient of such a hospital:

1. Bed and board;
2. Nursing services and other related services;
3. Use of hospital facilities;

4. Medical social services;

5. Drugs, biologicals, supplies, appliances and equipment;

6. Certain other diagnostic or therapeutic items or services; and

7. Medical or surgical services provided by certain residents-in-training.

O. "Loss" means the excess of all expenses over revenues for an accounting period or the excess of all or the appropriate portion of the cost or assets over related proceeds, if any, when items are sold, abandoned, or either wholly or partially destroyed by casualty or otherwise written off.

P. "Non-revenue center" means a service center which incurs direct operating expenses but which does not generate revenue directly from charges to patients for services. These centers, which rely on revenue from revenue centers to meet their expenses, may include such service centers of a hospital as:

1. General services, including:

   a. Dietary services;

   b. Plant operation and maintenance services;

   c. Housekeeping services;

   d. Laundry services; and

   e. Other services.

2. Fiscal services;

3. Administrative services; and

4. Medical care evaluation services.

Q. "Outpatient services" mean those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and which are not inpatient services.

R. "Outpatient visit" means an admission of a patient to a hospital which maintains a distinct outpatient diagnostic service center for purposes of providing outpatient services.

S. "Program" means the reporting and review procedures proposed by an applicant.

T. "Quarter" means that period of the fiscal year corresponding to a three-month period of time for which the State regularly gathers information for the conduct of its business. For purposes of these rules, a fiscal year is composed of four quarters corresponding to the following groupings of months: a quarter is defined by the time period represented by the months of July, August and September; a quarter is defined by the time period represented by the months of October, November and December; a quarter is defined by the time period represented by the months of January, February and March; and, a quarter is defined by the time period represented by the months of April, May and June.

U. "Rate" means the average revenue for each inpatient admission

$$\frac{\text{Total Revenue}}{\text{Number of Inpatient Admissions}}$$

for a full accounting period. "Adjusted rate" means the average revenue for each adjusted admission

$$\frac{\text{Total Revenue}}{\text{Number of Adjusted Inpatient Admissions}}$$

Adjusted admissions are determined by:

$$\text{Number of Outpatient Visits} \times \frac{\text{Total Outpatient Revenue}}{\text{Number of Outpatient Visits}} \times \frac{1}{\text{Inpatient Revenue Per Admission}} \text{ PLUS } \text{The Number of Inpatient Admissions}$$

The rate for the budget year shall always be based upon annually

projected admissions as stated in the rate revenue and expense report.

V. "Restricted funds" mean funds donated to the hospital which are restricted for a specific purpose by the donor.

W. "Revenue(s)" or "income(s)" means the value at the hospital's full established charges of all hospital services rendered to patients, regardless of the amounts actually paid to the hospital by or on behalf of patients.

X. "Revenue center" means a service center which incurs direct operating expenses and which generates revenue from patients on the basis of charges customarily made for services that center offers directly to patients. Revenue centers may include such service centers of a hospital as:

1. Daily patient services (routine services) including:
    a. Medical services;
    b. Surgical services;
    c. Pediatric services;
    d. Intensive care services;
    e. Psychiatric services;
    f. Obstetric-gynecological services;
    g. Newborn nursery services;
    h. Premature nursery services;
    i. Other routine services.
2. Other nursing services (special services), including:
    a. Operating room services;
    b. Recovery room services;
    c. Delivery and labor room services;
    d. Central services and supply services;

e. Intravenous therapy services;

f. Emergency services;

g. Other special services.

3. Other professional services (ancillary services), including:

a. Laboratories;

b. Blood bank;

c. Electrocardiology;

d. Radiology;

e. Pharmacy;

f. Anesthesia;

g. Physical therapy;

h. Other special services.

Y. "Service center" means an organizational unit of a hospital for which historical and projected statistical and financial information relating to revenues and expenses are accounted. A service center may be a routine, special, or ancillary service center. A service center may also be a revenue center or a non-revenue center.

Z. "System" means the Minnesota Hospital Rate Review System and any applicant approved to operate it or the board.

AA. "Third party payors" mean insurers, health maintenance organizations licensed pursuant to Minnesota Statutes, Chapter 62D, and governmental insurance programs, including the health insurance programs authorized by Title V, Title XVIII and Title XIX of the United States Social Security Act (Medicare and Medicaid).

BB. "Unrestricted funds mean funds not restricted by the donor and funds designated by the governing authority of the hospital, not including revenues in excess of expenses.

MHD 473 The Minnesota Hospital Rate Review System. The Minnesota Hospital Rate Review System is established. This system shall be operated by the board or any voluntary nonprofit rate review organization whose reporting and review procedures have been approved by the board, pursuant to MHD 496. The system shall consist of reports, administrative procedures, and standards.

MHD 474 Report Requirements. The system shall require annual financial information and rate revenue and expense, and interim increase reports.

A. Annual Financial Information Report. Each hospital shall submit an annual financial information report to the system. This report shall include:

1. a. A balance sheet detailing the assets, liabilities, and net worth of the hospital. This balance sheet should include information on:

(1) Current assets, including:

(a) Cash;

(b) Marketable securities;

(c) Accounts and notes receivable;

(d) Allowances for uncollectable receivables and third party contractuals;

(e) Receivables from third party payors;

(f) Pledges and other receivables;

(g) Due from other funds;

(h) Inventory; and

(i) Prepaid expenses.

(2) Plant capital allowances, including historical cost of, price level increments related to and accumulated

depreciation related to:

(a) Land;

(b) Land improvements;

(c) Buildings;

(d) Leasehold improvements;

(e) Building equipment;

(f) Movable equipment; and

(g) Construction in progress.

(3) Deferred charges and other assets, including:

(a) Other assets;

(b) Investments in non-operating property, plant and equipment;

(c) Accumulated depreciation on investments in non-operating plant and equipment; and

(d) Other intangible assets (e.g., good will, unamortized borrowing costs).

(4) Current liabilities, including:

(a) Notes and loans payable;

(b) Accounts payable;

(c) Accrued compensation and related liabilities;

(d) Other accrued expenses;

(e) Advances from third party payors;

(f) Payable to third party payors;

(g) Due to other funds;

(h) Income taxes payable; and

(i) Other current liabilities.

(5) Deferred credits and other liabilities, including:

(a) Deferred income taxes;

(b) Deferred third party revenue;

(c) Long-term debt; and

(d) Fund balances.

(6) In the case of hospitals owned by, operated by, affiliated with, or associated with an organization, corporation, or other hospital(s), a statement of the flow of funds between the hospital and that organization, corporation or other hospital(s). This statement shall detail all transactions between the hospital and the organization, corporation or other hospital(s).

b. In the event that a hospital maintains a balance sheet which includes information which differs from the information required by the balance sheet recommended by MHD 474 A.1.a., above, the hospital may substitute its balance sheet. This balance sheet shall include a narrative description of the scope and type of differences between its balance sheet and that balance sheet recommended by MHD 474 A.1.a., above.

2. a. A detailed statement of income and expenses, including:

(1) Gross revenues from and expenses directly attributable to revenue centers;

(2) All operating revenues and expenses other than those directly associated with patient care;

(3) Reductions in gross revenues that result from charity care, courtesy discounts, contractual adjustments, administrative and policy adjustments, provision for bad debts, and other factors;

(4) Direct expenses incurred by the research and educational, general, fiscal, and administrative service centers;

(5) Direct revenue and expense received or incurred from non-hospital operations; and

(6) A statement of expenses by a natural classification of expenses for the hospital as a whole. The natural classification of expenses may include such factors as:

(a) Salaries and wages, including:

(i) Management and supervision;

(ii) Technicians and specialists;

(iii) Registered nurses;

(iv) Licensed practical nurses;

(v) Aides and orderlies;

(vi) Clerical and other administrative employees;

(vii) Environment and food service employees;

(viii) Physicians;

(ix) Non-physician medical practitioners;

(x) Vacation, holiday, sick pay, and other non-worked compensation.

(b) Employee benefits, including:

(i) F.I.C.A.;

(ii) State unemployment insurance and federal unemployment insurance;

(iii) Group health insurance;

(iv) Pension and retirement;

(v) Workmen's compensation insurance; and

(vi) Group life insurance.

(c) Professional fees - medical, including:

(i) Physicians' remuneration; and

(ii) Therapists and other non-physician.

(d) Other professional fees, including:

(i) Consulting and management services;

(ii) Legal services; and

(iii) Auditing services.

(e) Special departmental supplies and materials.

(f) General supplies, including:

(i) Office and administrative supplies;

(ii) Employee wearing apparel;

(iii) Instruments and minor medical equipment which are non-depreciable;

(iv) Minor equipment which is non-depreciable; and

(v) Other supplies and materials.

(g) Purchased services, including:

(i) Medical - purchased services;

(ii) Repairs and maintenance - purchased services;

(iii) Medical school contracts - purchased services;

(iv) Management services;

(v) Collection services; and

(vi) Other purchased services.

(h) Other direct expenses, including:

(i) Depreciation, amortization, and rental or

lease expenses necessary to maintain an adequate plant capital fund, pursuant to MHD 487 A.1.b.;

(ii) Utilities - electricity;

(iii) Utilities - gas;

(iv) Utilities - water;

(v) Utilities - oil;

(vi) Other utilities;

(vii) Insurance - professional liability;

(viii) Insurance - other;

(ix) Licenses and taxes other than income taxes;

(x) Telephone and telegraph;

(xi) Dues and subscriptions;

(xii) Outside training sessions;

(xiii) Travel; and

(xiv) Other direct expenses.

b. In the event that a hospital maintains accounts which include information resulting in detailed statements of income and expense which differ from the information required by the statement of income and expense recommended by MHD 474 A.2.a., the hospital may substitute its statement of income and expenses. This statement shall include a narrative description of the scope and type of differences between its statement of income and expenses and that statement recommended by MHD 474 A.2.a.

3. An unaudited copy of the hospital's cost report filed pursuant to requirements of Title XVIII of the United States Social Security Act stated in 20 CFR 405.406 (b). This cost

report shall correspond to the same accounting period as that used in the compilation of data for other requirements for the report of annual financial information.

4. Attestation by the governing authority of the hospital or its designee that the contents of the report are true.

5. Attestation by a qualified, independent public accountant that the contents of the balance sheet and statement of income and expense are true and conform to the bases for judging the reasonable use of finances in a hospital, as established by MHD 487 A.

B. Rate Revenue and Expense Report.

1. Each hospital shall submit a report of rate revenue and expense to the system on an annual basis. This report shall include statistical and financial information for:

   a. The hospital's last full and audited accounting period prior to the accounting period during which a hospital files this report with the system. This period shall be known as the prior year. Information for the prior year shall be actual.

   b. The hospital's full accounting period during which a hospital files this report with the system. This period shall be known as the current year. Information for the current year shall be actual and estimated according to the following:

      (1) Information for at least the first eight months shall be actual;

      (2) Information for the last four months may be estimated.

c. The hospital's next subsequent full accounting period following the accounting period during which the report is filed with the system. This period shall be known as the budget year. Information for the budget year shall be projected.

2. Statistical information for the rate revenue and expense report shall include:

a. The number of inpatient days for the hospital.

b. The number of admissions for the hospital and for each appropriate service center.

c. The average number of full-time-equivalent employees during each accounting period for the hospital and for each of its service centers. An employee or any combination of employees which are reimbursed by the hospital for 2080 hours of employment per year is a full-time-equivalent employee.

d. The number of beds available for the hospital and for each appropriate routine service center.

e. The average annual occupancy rate for the hospital and for each appropriate routine service center.

f. The number of outpatient clinic admissions (visits) for the hospital.

g. The number of emergency admissions (visits) for the hospital.

h. The number of units of service provided by each of the hospital's other service centers. The hospital shall select the statistic that best measures the level of activity for a particular function or service center

and that, in addition, is compiled on a routine basis by the hospital to serve as the appropriate unit of service for each of its service centers.*

3. Financial information for the rate revenue and expense report shall include:

   a. An interim financial statement of the hospital which shall include an interim balance sheet and an interim income and expense statement for the current year only. The balance sheet and income and expense statement shall conform to the requirements of MHD 474 A.1. and MHD 474 A.2. This financial statement shall contain a minimum of six months of actual information for the current year.

   b. A statement of expenses for the hospital and for each of its service centers and a statement according to natural classifications of expenses as provided by MHD 474 A.2.a.(6).

   c. A statement detailing the accounting method used to allocate expenses from among the non-revenue centers to revenue centers, which shall detail compliance with the offsets to costs and allocation of costs specified by the bases for judging stated by MHD 487 A.

---

* For example, although patient days might be used as the unit of service for daily patient services, treatments, procedures, visits, hours or other statistics would be the applicable measure of activity in other service centers.

d. A statement of total direct and indirect costs for the hospital and for each of its service centers after the step-down allocation of expenses.

e. A statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of patient days outstanding at the end of each period.

f. A statement of changes in financial position showing the source and application of all funds for each period.

4. The report of rate revenue and expense shall also contain the following information:

a. The pricing policy of the hospital which incorporates the overall pricing policy and financial objectives of the institution.

b. Attestation by the hospital's governing authority or its designee that the rates are set equitably and without discrimination among insurers.

c. In the case of a hospital with expanded facilities, a copy of the hospital's report used to obtain a certificate of need for the expanded facility which projects the patient and service activity levels of the expanded facility for its first five years of operation.

C. Interim Increase Reports.

1. Each hospital desiring to amend or modify rates for the budget year stated in the rate revenue and expense report then on file with the system to an extent exceeding the allowable increase limit prescribed according to MHD 504, shall submit an interim increase report.

2. In instances where changes in rates during the budget year are the result of legislative policy and appropriations to hospitals subject to these rules which are operated by the commissioner of public welfare, this report is not required.

3. The interim increase report shall include statistical and financial information for:

   a. The period of the budget year immediately preceding the effective date of amendments or modifications to the rates for the budget year which are stated in the rate revenue and expense report then on file with the system. Data for this period shall be actual for all expired months of the budget year, excepting the sixty-day period immediately preceding the filing of this report for which data may be projected.

   b. The period immediately subsequent to and including the effective date of these amendments or modifications which terminates at the end of the last day of the budget year. Information for this period shall be projected on the basis of these rate amendments or modifications.

4. Statistical information for each period established by MHD 474 C.3. for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to MHD 474 B.2., which shall be recorded for each period stated by MHD 474 C.3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

5. Financial information for each period established by MHD 474 C.3. for the interim increase report shall include that

required of a hospital for the rate revenue and expense report, pursuant to MHD 474 B.3., which shall be recorded for each period stated by MHD 474 C.3., above. This information shall indicate any change in the budget year from the projected information then on file with the system.

6. This report shall also include a narrative statement describing the reason for amendments or modifications to the hospital's rates.

MHD 475--MHD 480 RESERVED FOR FUTURE USE

MHD 481 Administrative Procedures.

A. General Provisions for Filing of Reports.

1. Forms to be Specified. The system shall design and issue forms as necessary for meeting the requirements of reports established by these rules. These forms shall contain clear instructions for their completion.
2. All documents may be filed personally or by the United States Postal Service with the system at the system's official offices during normal business hours.
3. The system shall establish a method of filing which shall insure that reports and other documents are ordered, filed, designated and dated in such a manner that facilitates easy public access to the contents of those reports, documents, and other information as required by these rules. These files shall be open to the public inspection during normal business hours.
4. No report required by these rules shall be deemed to be filed until the system has ascertained the completeness of

the report in accordance with the provisions of MHD 487 C.1.

B. Filing of Report of Annual Financial Information.

1. Each year, each hospital shall file a report of annual financial information as required by MHD 474 A. with the system within 120 days after the close of that hospital's full accounting period. The cost report of the hospital filed pursuant to the requirements of Title XVIII of the United States Social Security Act (20 CFR 405.406(b)) may be filed separately from the other requirements for the report of annual financial information, provided:

   a. It is filed no later than the time it is required to be filed with the Medicare Fiscal Intermediary as identified according to 20 CFR 405.651, et. seq. (Medicare). The hospital shall inform the system of this date when filing other information required by this report.

   b. The report of annual financial information is considered incomplete until the receipt of the unaudited cost report, but the hospital is not considered in violation of rules until the date required by the Medicare Fiscal Intermediary for the submission of the unaudited Medicare cost report.

   c. The audited Medicare cost report is submitted as soon as is practicable to substitute for the unaudited Medicare cost report. The submission of an audited Medicare cost report shall not affect the official filing date of a report of annual financial information.

2. Failure to File. Any hospital which fails to file the annual financial information report, and which has not requested an extension of time pursuant to MHD 481 G., to file that report shall be considered to be in violation of rules. The system shall notify the board and the appropriate health systems agency to this effect. Pursuant to Minnesota Statutes, §144.55, the board may consider this violation as cause to revoke, suspend or deny reissuance of that hospital's license to operate.

C. Filing of Report of Rate Revenue and Expense.

1. Each year, each hospital shall file a report of rate revenue and expense sixty days prior to the commencement of any accounting period of the hospital.

2. a. Failure to File. Any hospital which fails to file a report of rate revenue and expense, and which has not requested an extension of time, pursuant to MHD 481 G., to file that report shall be considered to be in violation of rules. The system shall notify the board and the appropriate health systems agency to this effect. Pursuant to Minnesota Statutes, §144.55, the board may consider this violation as cause to revoke, suspend or deny reissuance of that hospital's license to operate.

b. A hospital which fails to file a report of rate revenue and expense, and which has requested an extension of time, pursuant to MHD 481 G., to file that report may be charged an additional late fee as authorized by MHD 509 C.

c. A hospital which fails to file a report of rate revenue

and expens● and which has not reques●d an extension of time, pursuant to MHD 481 G., to file that report shall not amend or modify its rates until sixty days after that hospital files that report with the system.

D. Filing of Interim Increase Reports.

1. A hospital shall file an interim increase report sixty days prior to the effective date of any amendments or modifications to rates then on file with the system for the budget year if:

a. The proposed rate change exceeds the allowable increase limit established according to MHD 504.

b. Amendments or modifications to rates which are to become effective after the first day of the budget year and prior to the end of the last day of the budget year were not included in the report of rate revenue and expense then on file with the system.

c. It is not filed within ninety (90) days of any other interim increase or rate revenue and expense report filed by that hospital.

d. There are no reports, fees, or other documents or information due to the system from that hospital.

e. These provisions may be waived by the system if the hospital can show cause why they should be waived.

2. Failure to File.

a. A hospital which fails to file an interim increase report with the system when it is required to file such a report pursuant to MHD 474 C., shall be considered in violation of these rules.

b. If this violation is discovered by the system during the budget year, the system may require a hospital so violating these rules to adjust its rates to be consistent with the allowable increase limits until sixty days after the hospital properly files an interim increase report.

c. If this violation is discovered by the system subsequent to the expiration of the budget year during which the violation occurred, the system may investigate this violation, pursuant to MHD 487 B., in order to determine the effect of this violation upon the rates of the hospital. The system may recommend a reduction in the rates of the hospital and require that the hospital submit interim increase reports for every increase in rates, irrespective of the allowable increase limits, for the next two subsequent full accounting periods following the discovery of the violation.

d. In making any retrospective assessment of a hospital's compliance with requirements to file interim increase reports, the system shall recognize that actual rates for the budget year may exceed projected rates for that budget year by a reasonable amount due to slight variations from projected information contained in the rate revenue and expense report then on file with the system. A reasonable amount may vary with the financial and statistical composition of each hospital but, it should never exceed one and one-tenth times the allowable increase limit for the accounting period in question.

3. Allowable Increase Limits: Hospital Calculation.

In order for a hospital to determine the extent to which it may increase its rates during the budget year before it is required to submit an interim increase report, the hospital shall:

a. Add the four quarterly allowable increase limits established by the board, pursuant to MHD 504, which are appropriate for the budget year of the rate revenue and expense report then on file with the system. This calculation provides the hospital with an allowable increase limit for the budget year stated in percentage terms; then,

b. Subtract from the allowable increase limit for the budget year the percentage of rate increase for the hospital, if any, from the current year to the budget year, as stated in the rate revenue and expense report then on file with the system. To the extent that the remainder from this calculation is positive, the hospital may increase its rates for the hospital by this amount at any time during the budget year. Cumulative increases in the rates of the hospital over the budget year up to this amount do not require the submission of an interim increase report. The system should be advised by the hospital at the time that rates are being so increased, stating the reason for and general scope of such an increase. The next subsequent rate revenue and expense report of the hospital should detail these increases.

c. Amendments or modifications which do not exceed the allowable increase limit or provide for rate decreases may take effect immediately upon determination by the hospital's governing authority or its designee. These amendments or modifications shall be noted in the hospital's next subsequent rate revenue and expense report.

E. Application for Variance in Rate Determination.

If a hospital desires to adopt an alternative method of accounting, cost control, rate determination or payment which may affect the way in which the system proceeds in its assessment of that hospital's rates, it shall notify the system sixty days in advance of the effective date of this new method. Such notification shall detail the new method, including expected impacts upon hospital revenues, expenses and rates as well as the impact of the new method on the equity with which rates are set.

F. Filing of Reports: Multi-Hospital Corporations and Other Organizations Operating More Than One Hospital.

The system requires the filing of all reports for each individually licensed acute care hospital, as provided by MHD 474. A multi-hospital corporation or organization operating more than one hospital may act as the reporting organization for the hospital to the system. This reporting organization shall provide all information separately for each hospital it operates. The reporting organization shall also provide with this information, a statement detailing the financial relationship between each hospital it operates and the reporting organization, as required by MHD 474 A.1.a.(6), for the annual financial information report.

G. Filing of Reports: Extensions. Upon reasonable cause being shown by a hospital, the system may extend any period of time established for the submittal of any report or other information, or any period of time established for the performance of any other act permitted or prescribed by these rules, for an additional and specified period of time.

MHD 482-MHD 486 RESERVED FOR FUTURE USE

MHD 487 Investigations, Analysis and Review Standards. The system shall investigate, analyze and review all reports and other information it receives relating to hospital rates according to the following standards:

A. Bases for Judging the Reasonable Use of Finances in a Hospital. In all investigations, analyses, and reviews conducted pursuant to Minnesota Laws 1976, Chapter 296, Article II, Sections 1 through 9, and these rules, the system shall recognize that rates must supply the financial resources necessary to meet the financial requirements of a hospital. In meeting the reporting requirements of these rules, hospitals shall address the contents of their reports to and indicate their compliance with these financial requirements and to the other stated bases for judging the reasonable use of finances in a hospital. The system shall then conduct investigations, analyses and reviews following these established bases.

1. Financial Requirements of Hospitals. The rates charged to patients or their insurers by a hospital must be adequate to maintain the solvency of the hospital. Rates should provide adequate money to meet expenses incurred in the following specific categories:

a. Current Operating Needs Related to Patient Care.

In meeting the needs of a hospital to provide health care services, rates should provide finances necessary to meet expenses incurred by:

(1) Direct Patient Care.

(a) Rates should provide finances to meet expenses in this category which may include salaries, wages, employee fringe benefits, services, supplies, normal maintenance, minor building modification and any applicable taxes.

(b) The monetary value of services provided by members of religious orders, other organized religious or social service groups or organizations or by a unit of government, such as a county, may be included in rates, provided:

(i) That value does not exceed the amount that would have been paid to regular salaried hospital employees for the provision of the same services;

(ii) The maximum value for non-governmental services is the cash payment to the order, group or organization from the hospital;

(iii) That value is reduced by the expense incurred by the hospital for the provision of any room and/or board without charge to members of those orders, groups, or organizations.

(2) Interest Expense.

(a) Rates should provide the finances necessary to recover costs incurred by the hospital due to necessary and proper interest on funds borrowed for operating and plant capital needs.

(b) Interest on funds borrowed for operating needs is the cost incurred for funds borrowed for a relatively short term. This interest is usually attributable to funds borrowed for such purposes as working capital for normal operating expenses.

(c) Interest on funds borrowed for plant capital needs is the cost incurred for funds borrowed for plant capital purposes, such as the acquisition of facilities and equipment, and capital improvements. These borrowed funds are usually long-term loans.

(d) Interest is necessary if it is:

(i) Incurred on a loan made to satisfy a financial need of the hospital. Loans which result in excess funds or investments should not be considered necessary;

(ii) Incurred on a loan made for a purpose reasonably related to patient care. Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost and which has been determined to have excess capacity, pursuant

to MHD 487 A.4., or whose services have been determined to be inappropriate, pursuant to Public Law 93-641, §1523 (a)(6) (National Health Planning and Resources Development Act of 1974), are not considered to be for a purpose reasonably related to patient care.

(e) Interest is proper if it is incurred at a rate not in excess of what a prudent borrower would have to pay in the money market existing at the time the loan was made.

(3) Educational Program Expenses.

(a) Rates should provide the finances necessary to recover the net cost to the hospital of providing educational activities which:

(i) Are approved educational activities and can be demonstrated to directly contribute to the care of patients who are in hospitals during the time the cost is incurred; and

(ii) Can be demonstrated to contribute to the preventive health education of the population of areas of patient origin which the hospital serves.

(b) "Approved educational activities" means formally organized or planned programs of study usually engaged in by hospitals in order to enhance the

quality of patient care in a hospital. These activities shall be licensed where required by State law. Where licensing is not required, the hospital shall be able to demonstrate that it has received approval for its activity from a recognized national professional organization for the particular activity. Approved educational activities include those programs defined as approved by 20 CFR 405.116(f) (Medicare) and 20 CFR 405.421(e) (Medicare).

(c) "Net cost" means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursement from grants, tuition and specific donations.

(d) "Orientation" and "on-the-job training" costs are recognized as normal operating costs of hospitals for employees of the hospital.

(e) The extent of costs incurred for the provision of educational activities contributing to the preventive health education of the population of the hospital's areas of patient origin should not exceed that amount necessary to provide activities recommended appropriate for hospitals by the State Health Planning and Development Agency, pursuant to Public Law 93-641, §1523 (a)(6). In any instance, these costs should not include any payments in excess of

the normal salary or remuneration to professional employees of the hospital or health professionals who maintain consultative, contractual, or patient relationships with that hospital.

(4) Research Program Expenses. Rates should provide finances necessary to meet costs incurred by a hospital due to research programs which directly relate to daily patient care to the extent that non-patient revenue of the hospital is unavailable to offset these research costs. Rates should not provide finances necessary to meet costs incurred by a hospital due to research purposes, over and above usual patient care.

(5) Bad Debt, Charity Allowances, Courtesy Discount Allowances, and Contractual Allowance Expenses.

(a) Rates should provide finances necessary to recover losses in revenue due to bad debts, charity allowances, courtesy discount allowances, and contractual allowances.

(i) "Bad debts" mean amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. Accounts receivable and notes receivable are designations for claims arising from the rendering of services, and are collectible in money in the

near future. These amounts should not include any amount attributable to a reclassification of any expenses incurred due to the provision of charity care. Income reductions due to charity allowances, courtesy discount allowances and contractual allowances should be recorded as such in the records of a hospital and not as bad debts.

(ii) "Charity allowances" mean the provision of care at no charge to patients determined to be qualified for care according to 42 CFR 53.111(f) and (g), in hospitals required to provide free care, pursuant to 49 U.S.C. §291, et. seq. (The Hill-Burton Act).

(iii) "Contractual allowances" and "courtesy discounts" are those governmental contract adjustments to or other cost justified discounts or differentials from the established charges of a hospital.

(aa) "Governmental contract adjustments" are those discounts from the established charges required due to governmental reimbursement practices established pursuant to regulations authorized by such governmental programs as those created by Title V,

Title XVIII and Title XIX of the United States Social Security Act.

(bb) "Cost justified discounts" or "differentials" mean those cash, trade, or quantity discounts or differentials from the established charges granted to certain patients, groups of patients, or third party payors at the time services are paid for. In order to include the amount of these discounts or differentials in rates, hospitals shall demonstrate that the value, as measured in money, of services or other benefits for an accounting period provided by certain patients, groups of patients, or third party payors to the hospital is equal to or greater than the aggregated amount, as measured in money, of the differential or discount granted to certain patients, groups of patients or third party payors for that same accounting period.

(cc) Discounts or differentials which are not cost justified in a manner consistent with MHD 487 A.1.a.(5)(a)(iii)(bb), above, shall not be included

in rates but shall be treated as reductions in revenue and recorded by the hospital as such.

(b) These losses in revenues due to bad debts, charity allowances, courtesy discount allowances, and contractual allowances should be offset by available and applicable income from sources other than patients, as identified by MHD 487 A.2., before these losses are included in rates. Such offsets should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs.

b. Plant Capital Needs. Rates should provide the finances necessary for various plant capital needs. Plant capital needs must be funded to be included in the rates. Funding of depreciation shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund.

(1) Finances which relate to building and building equipment and movable equipment shall be placed in an identifiable fund. The annual increment to this fund should be:

(a) The greater of:

(i) The annual debt principal repayment on buildings, building equipment and movable

equipment. This principal repayment should be computed as though it were a level payment over the life of the debt instrument; or

(ii) The annual straight-line depreciation expense on buildings, building equipment and movable equipment.

(b) Plus inflation factors, annually determined and consistent with the established useful lives of buildings, building equipment, and movable equipment. These inflation factors shall be determined by the system on the basis of a price level adjustment index recognized by independent public appraisers as expressing the annual price level adjustment from historical cost of hospital buildings, hospital building equipment and movable equipment. The system shall derive these factors from any of the most current indices then available to the system which give specific recognition to the following factors:

(i) The effect of inflation upon the replacement cost of existing buildings, building equipment, and movable equipment, based upon their historical cost; and

(ii) The effect of inflation upon funds necessary for the modification of or addition to hospital buildings, building equipment, and movable equipment.

(2) 100 percent of the inflation factors should be included by the hospital as the annual inflation factor unless the hospital has been determined to have excess capacity, as provided by MHD 487 A.4., or by the appropriate health systems agency and State Health Planning and Development Agency. In instances where excess capacity exists, the annual inflation factor and the level of debt principal payment in excess of the depreciation allowance permitted by MHD 487 A.1.b.(1) should be reduced by the proportion of facilities determined to be in excess.

(3) The fund may not be sufficient to retire existing debt.

(4) The annual interest income earned from an investment of this fund annually should be used to reduce the inflation factor requirements for plant capital needs which are included in rates.

(5) In the event that sufficient financial resources are not available in this fund to meet plant capital needs (including the need for the replacement of existing facilities and the need for expansion of the scope of services to accommodate advances in medical technology, where either or both of these needs have received certificate of need approval when required), the additional financial resources should be acquired from:

(a) Income from appropriate sources other than patients;

(b) Borrowed funds or leases when income from sources other than patients can be demonstrated to be inadequate; or

(c) Approved inclusion in rates, when the hospital can demonstrate that insufficient resources exist in (i) or (ii) above, or when a hospital can demonstrate that inclusion in rates will result in a lower cost to patients than would result from the borrowing of funds or leasing of plant capital assets. Approval of inclusion in rates shall be by the system upon demonstration by the hospital of either or both of the conditions herein stated. Once approved, the inclusion in rates of these additional financial requirements may be considered reasonable. Any portion of the annual equal amortized historical cost of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated.

(6) If a hospital can demonstrate that an emergency exists, then the hospital may, with certificate of need approval, include the cost of the emergency plant capital needs directly in its rates in a manner consistent with the previous financial practices of that hospital.

(7) If a hospital can demonstrate that the inclusion in

the fund of any specific capital debt will result in a greater cost to patients than depreciation or retirement of that debt under consistent financial practices of that hospital which differ from the funding of plant capital needs as stated by these rules, then a hospital may choose not to fund the specific capital debt. In this instance, the hospital should provide complete information to the system regarding the precise method which will be used to meet such a plant capital need. Direct inclusion of plant capital needs in rates requires approval by the system as provided by MHD 487 A.1.b., above.

c. Incremental Operating Cash Needs. Rates should provide finances to maintain a reasonable working capital allowance.

(1) The working capital allowance which may be included in rates is determined by the annual incremental difference between (net accounts receivable and inventories and prepaid expenses) and (salaries payable and other net payables) at the end of an accounting period. Any increases in working capital over the prior year, as stated in the first report of annual financial information submitted to the system by a hospital shall form the initial basis for the system's assessment of the reasonableness of the working capital allowance.

(2) The amount of working capital is dependent upon the number of days charges in accounts receivable for the hospital. These days charges should be stated in aggregate for an accounting period and a statement of accounts receivable by payor.

(a) Payors may include:

(i) Third party payors, including:

(aa) Medicare;

(bb) Medicaid;

(cc) Blue Cross;

(dd) Health maintenance organizations;

(ee) Other insurers; and

(ii) Paying patients.

(b) The number of days charges in accounts receivable for the hospital is determined by:

$$\frac{\text{Total Net Accounts Receivable At The End Of An Accounting Period}}{\frac{\text{Total Patient Charges For The Same Accounting Period}}{\text{Actual Number Of Calendar Days In That Same Accounting Period}}}$$

(3) "Net accounts receivable" means the dollar amount accounts receivable at the end of an accounting period less estimated discounts and differentials and reserve for uncollectibles.

(a) To the extent that the number of days charges in accounts receivable for a hospital increases from one accounting period to another subsequent accounting period, the hospital may increase rates to maintain its working capital allowance.

(b) To the extent that the number of days charges in accounts receivable for a hospital which is attributable to a particular payor or category of payors decreases, the working capital allowance should be reduced by that amount.

(4) "Inventories" means the dollar amount in inventories at the end of an accounting period. The dollar amount in inventories should not increase from one accounting period to another subsequent accounting period unless the hospital can justify such an increase as due to inflation, alterations in scope or volume of services offered.

(5) "Other net payables" means total payables at the end of an accounting period less all liabilities owed to third party payors and less the current portion of plant capital expenditure from the plant capital fund.

(6) The reasonableness of the working capital allowance depends upon factors including:

(a) The number of days charges in accounts receivable for a hospital compared with the number of days charges in accounts receivable for other hospitals determined by the system to share common characteristics. This number may be compared for hospitals in total;

(b) The amount of bad debts accrued by a hospital during an accounting period; and

(c) The amount of finances a hospital may hold in reserve funds.

2. Income From Sources Other Than Patients. In all investigations, analyses, and reviews conducted pursuant to these rules, the system shall recognize that hospitals have sources of income other than patients which are intended to be or may be used for the reduction of its rates. In meeting the reporting requirements of these rules, hospitals shall disclose the extent to which this income is used to offset costs and to provide service in such a manner as to reduce rates charged patients. This income includes:

a. Restricted Endowment Funds, Specific Purpose Funds, and Gifts.

(1) Income from endowment funds or gifts restricted by donors to provide for services for designated patients should be used to reduce the payment for those services.

(2) Income from endowment funds or gifts restricted by donors to provide for buildings and movable equipment should be used to reduce the designated building and movable equipment capital needs, as appropriate.

(3) If a hospital has restricted funds which could be used for a building or equipment purchase but chooses instead to use borrowed money, all costs

associated with paying off the incurred debt should not be considered reasonable unless the hospital demonstrates that the financing method used was to the economic benefit of patients then utilizing that building or equipment.

(4) If funds are restricted to a particular type of plant capital project, which is not a replacement of a previous or existing project, these funds should not be used until the hospital has obtained a certificate of need, if required, for that type of plant capital project.

(5) If funds or the income therefrom are restricted to the provision of charity care, these funds or their income should be annually budgeted to offset charity care requirements prior to the budgeting of the use of any patient-generated revenue for charity care for any accounting period.

(6) Funds restricted to research should be used if needed and available to offset any research costs. Patient revenues from revenue cost centers should not be used to provide matching monies for non-patient-care related research.

b. Unrestricted Funds from Non-Patient Sources. Unrestricted funds from non-patient sources should be used to reduce the total financial requirements of a hospital.

c. Auxiliary Enterprises. Profits from such enterprises operated by hospitals should be used primarily to offset the financial requirements of a hospital. Such enterprises should be self-sufficient and profitable. Any

losses incurred by the hospital due to such an enterprise which can be demonstrated to be a fringe benefit to hospital employees or of direct economic benefit to patients receiving care during the period of incurred loss may be included in rates.

d. Special Projects Income. Income received to finance special projects or salaries paid to special project employees should be deducted from financial requirements before determining the amount of payment to be made for patient services. Income to the hospital from the special projects in excess of the projects' financial requirements should be used to offset the hospital's financial requirements.

e. Income from sources other than patients used as offsets to rates should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payors or by governmental programs. If such a condition should result, the offsets should be adjusted to that portion which would not cause this condition.

3. Variations From Budgeted Volumes of Activity and Service. Changes in rates may be necessary due to variations from budgeted volumes of activity and service. The financial requirements of a hospital for a budget year should reflect adjustments in volumes of activity and service realized during the prior and current years.

a. If a hospital over-projects its volume in a service center, in the next year its financial requirements

should be increased by an amount equal to the percentage of (fixed) costs for that service center and multiplied by the income loss due to unrealized activity.

b. If a hospital under-projects its volume in a service center, in the next year its financial requirements should be reduced by the percentage of (fixed) costs of that service center and multiplied by the budgeted income of that service center.

4. Excess Capacity. For hospitals with occupancy rates below the average occupancy rate of other hospitals determined by the system to share common characteristics, rates set on the basis of costs may produce unreasonable charges to patients. The system may assess the rates of such hospitals where the criteria of need for beds shall be consistent with the demand for beds as indicated on a hospital or a service center level by occupancy rates. In cases where low occupancy appears to affect hospital rates, the hospital shall be considered to have excess capacity.

a. Prior to any determination by the system that excess capacity exists in a hospital, the system shall submit its preliminary determination to the appropriate health systems agency and to the State Health Planning and Development Agency, both of which are identified according to Public Law 93-641, §1515 and §1521. These agencies may comment to the system regarding the consistency of this preliminary determination with health planning standards regarding occupancy rates.

b. If these agencies comment that this preliminary determination is consistent with health planning standards and, if applicable, the declarations of an appropriateness review, then the system may determine a hospital to have excess capacity. This determination shall state in quantitative terms the extent of any determination of excess capacity and the basis for the determination.

c. In hospitals where excess capacity exists, the annual inflation factor and any debt principal payment to the plant capital fund which relates to beds, in excess of the depreciation allowance permitted by MHD 487 A.1.b.(1), should be reduced by the proportion of excess beds to total beds available.

B. Investigations.

1. The system may investigate any or all hospital rates, rate components or rate structures established by a hospital or common to more than one hospital. Such investigations shall be supplemental to and not in place of review of reports of rate revenue and expense or interim increase reports as authorized by MHD 487 C.2.

2. The system shall investigate the basis of existing rates as contained in the rate revenue and expense reports of hospitals in an effort to assess whether or not current rates are reasonable, equitable, and non-discriminatory among insurers.

3. The system shall notify any hospital or hospitals whose rates, rate components or rate structures are to be investigated, as provided by (1) or (2) above, and shall state the objective of such an investigation.

4. Investigations and subsequent reports shall analyze rates, rate components and rate structures in accordance with the bases for judging established by MHD 487 A.

5. Investigative Report. Subsequent to an investigation, the system shall issue an investigative report which shall detail its findings. The findings of an investigative report shall be considered in the review of any interim increase or rate revenue and expense report subsequently submitted by an investigated hospital.

C. Review of Reports.

1. General Provisions: Completeness.

a. Each report required by these rules shall be reviewed by the system in order to ascertain that the report is complete. A report shall be deemed to be filed when the system has ascertained that the report is complete. Complete means that the report contains adequate data for the system to commence its review in a form determined to be acceptable by the system pursuant to MHD 474 A., MHD 474 B., and MHD 474 C., as appropriate.

b. If the system has not responded to the hospital within ten working days after the receipt of a report by the system, the report is deemed to be complete and filed as of the initial day of receipt by the system. The system may stipulate any additional time it may need to ascertain a report's completeness in which case, the ten working day period does not apply. Such stipulated additional time shall not exceed thirty days after the day of the initial receipt of a report by the system.

c. A report determined by the system to be incomplete shall be returned immediately by the system to the hospital stating the need for more data. The hospital shall resubmit an amended report to the system. Such a return and resubmittal shall be recorded in that hospital's file as maintained by the system. If the resubmitted report is determined to be complete by the system, then it shall be deemed to be filed on the date the resubmitted report is received by the system.

d. Reports filed with the system by hospitals prior to the effective date of this rule shall be deemed to be temporarily complete. Subsequent to the effective date of these rules, the system may require hospitals to amend these reports to conform with the requirements of these rules.

e. If a hospital discovers any error in its statements or calculations in any of its submitted reports ascertained by the system to be complete, it shall inform the system of the error and submit an amendment to a report.

(1) In the case of an interim increase report or a rate revenue and expense report, the submittal of an amended report by a hospital to the system shall not affect the date of filing or the sixty-day period required, providing:

(a) The hospital informs the system of any errors within thirty calendar days of the initial filing of a report; and

(b) The amendment to the report is submitted to

the system by a date determined by the hospital and the system to be acceptable.

(2) An amended rate revenue and expense report or interim increase report not meeting the conditions established by MHD 487 C.1.e.(1), above, shall be refiled as if it were a new report.

f. If the system discovers an error in the statements or calculations in a report filed with it which the system determines will have a noticeable impact upon its ability to render a fair comment on the report, it may:

(1) If the discovery occurs within thirty calendar days after the date of filing of the report, require the hospital to amend and resubmit the report by a date determined by the system and the hospital to be acceptable. The initial filing date is not affected in this instance.

(2) If the discovery occurs thirty calendar days or more after the date of filing of the report, require that the hospital resubmit a new report. The date of filing shall then be the date when the new report is submitted to the system, pending the determination by the system that the new report is complete.

2. Review of Rate Revenue and Expense Reports and Interim Increase Reports.

a. These reports shall be reviewed on a basis of the rate and cost history of each hospital on an institutional and a service center basis. Statistical and financial information available for a hospital as a whole institution may be compared with the same type of information

for other peer hospitals which share common characteristics. In instances where service centers among hospitals sharing common characteristics themselves share common characteristics, hospitals may be compared on a service center basis. Common characteristics may include:

(1) Similarity in available number of beds and related occupancy rates;

(2) Similarity in composition of areas of patient origin;

(3) Similarity in composition of patient services;

(4) The status of a hospital as a teaching or non-teaching institution;

(5) Similarity in size and composition of full-time-equivalent staff of the hospital and ratios of that staff to patient admissions; and

(6) Other data determined by the system to be appropriate which may be available pursuant to annual licensing report requirements as established pursuant to MHD 78(d)(1).

b. Comment. The system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the board and the public. The comment shall state that a hospital's existing and proposed rates are reasonable or are in question.

(1) Bases which may be used to comment that a hospital's existing and prospective rates are reasonable, include:

(a) Rates are similar to the average of the rates then in effect for other hospitals in a peer group;

(b) Prospective rates represent a minimal increase which is consistent with the principles of the bases for judging established by MHD 487 A.;

(c) Rates have been demonstrated by the hospital to be necessary and consistent with the principles of the bases for judging established by MHD 487 A.

(2) Bases which may be used to comment that a hospital's existing and prospective rates are in question include:

(a) Rates deviate from the average of the rates then in effect for other hospitals in a peer group;

(b) Rates provide revenue which is in excess of expenses which deviate from the past financial practices of that hospital, of hospitals sharing common characteristics, or which deviate from the principles of the bases for judging established by MHD 487 A.;

(c) Rates have not been demonstrated by the hospital to be necessary and consistent with the bases for judging established by MHD 487 A.

D. Public Meetings. All official meetings of the system, including executive sessions, which occur for any purpose related to completion of an investigation, release of results of an analysis, or issuance of comment upon review of reports pursuant to these rules shall be open to the public. Public notice shall be given

one week in advance of any official meetings of the system where the results of investigations, analyses or reviews are to be discussed or acted upon.

E. Burden of Proof. In all matters relating to the review of interim increase reports or rate revenue and expense reports or other analyses or investigations, the burden of proof of the reasonableness, equity and lack of discrimination of established or proposed rates under review shall rest with the hospital.

F. Consolidation. When two or more investigations, analyses or reviews involve common questions of fact, the system may address the common questions of fact and make comments applicable to all hospitals under consideration.

MHD 488-MHD 495 RESERVED FOR FUTURE USE

MHD 496 Approval for Operation of the System. The board may approve the operation of the system by any voluntary, nonprofit rate review organization.

A. Application. Such an organization desiring this approval may apply for approval by the following procedure:

1. Open Application Period. A voluntary, nonprofit rate review organization may apply for approval of its reporting and review procedures after January 1 and before March 31 of a fiscal year, or within ninety days after the effective date of these rules, for operation of the Minnesota Hospital Rate Review System during the next subsequent fiscal year.

2. Contents of Application. An application for approval shall include:

a. A detailed statement of the type of reports and administrative procedures proposed by the applicant which shall

demonstrate that, in all instances, the reports and procedures are substantially equivalent to those established by the system, pursuant to MHD 474, MHD 481, and MHD 487.

b. A statement that all reports determined to be complete and information filed with the applicant from its participating hospitals shall be available for inspection by the board and the public within five working days after completeness of reports is proposed to be determined and at least prior to the proposed date of issuance of any findings and comments.

c. Provisions establishing a proposed enrollment period for hospitals which shall not extend beyond March 31 of any fiscal year, or beyond ninety days after the effective date of these rules in the first instance, for any eligible hospital that wishes to participate in the proposed program of the applicant for the next three subsequent fiscal years.

d. Provisions establishing any proposed criteria whereby a hospital may be judged by the applicant to be eligible for participation in its proposed program.

e. Any additional statements or information which is necessary to insure that the proposed reporting and review procedures of the applicant are substantially equivalent to all the rules established for the system, pursuant to MHD 474, MHD 481, and MHD 487.

B. Review of Application.

1. Within forty-five calendar days of the receipt of an application for approval by a voluntary, nonprofit rate review organization, the board shall issue its decision that the

procedures for reporting and review proposed by the applicant are approved or disapproved. Approval by the board shall take effect immediately.

2. Disapproval. The board may disapprove any application on demonstration that the reporting and review procedures of any voluntary, nonprofit rate review organization are not substantially equivalent to those established by the board.

3. Reapplication. An organization whose application has been disapproved by the board may submit a new or amended application to the board within fifteen calendar days after disapproval of the initial application. An organization may only reapply for approval on one occasion during any fiscal year.

C. Annual Review of Applicant.

1. By March 31 of each year, any voluntary, nonprofit rate review organization whose reporting and review procedures have been approved by the board for the fiscal year then in progress which desires to continue operation of the system shall submit an annual review statement of its reporting and review procedures.

2. The annual review statement shall include:

   a. Attestation by the applicant that no amendments or modifications of practice contrary to the initially approved application have occurred; or,

   b. Details of any amendments or modifications to the initially approved application, which shall include justifications for those amendments or modifications.

3. The board may require additional information from the applicant supporting that the applicant's reports and procedures

are substantially equivalent to those established for the system.

4. Forty-five days from the receipt of the annual review statement, the board shall issue its decision that the applicant has renewed approval or that the applicant has been denied renewed approval. Renewed approval shall be immediately effective.

5. Denial of Renewed Approval. The board may deny renewed approval on the demonstration that the reporting and review procedures of any applicant are no longer substantially equivalent to those established for the system.

6. Reapplication. An applicant whose renewed approval has been denied by the board may submit a new or an amended annual review statement to the board within fifteen calendar days after denial of the initial statement. An applicant may only reapply on one occasion during the fiscal year.

7. A hospital enrolled with an applicant whose renewed approval has been denied and which has not enrolled with any other applicant whose reporting and review procedures have been approved by the board shall become subject to the system as operated by the board for the next three subsequent fiscal years.

D. Revocation of Approval. The board may revoke its approval of any applicant's reporting and review procedures at any time upon demonstration that the reporting and review procedures of that organization are no longer substantially equivalent to those required by the system.

MHD 497-MHD 503 RESERVED FOR FUTURE USE

MHD 504 Board Determination of Allowable Increase Limit.

A. The board maintains the authority to establish allowable increase limits. Increases in rates which have minimal impact upon the average charges per patient admission for the hospital are allowed to meet expenses incurred by a hospital due to inflation. Increases are determined to have minimal impact if they do not exceed, for any projected accounting period or portion thereof, a cumulative total of the appropriate quarterly allowable increase limits established by the board.

B. During the quarter of the first fiscal year that these rules are effective, the board shall establish a quarterly allowable increase limit:

1. For each of the full quarter(s) of its current fiscal year which remain unexpired at the time rules are promulgated; and

2. For each quarter of its next subsequent fiscal years necessary to result in a total of six quarterly allowable increase limits corresponding to the next six quarters of the current and next subsequent fiscal years occurring immediately after the implementation of these rules.

C. At the beginning of each quarter subsequent to the effective date of these rules, the board shall establish a quarterly allowable increase limit for the sixth subsequent quarter.

D. The board shall provide each hospital and each approved applicant with information concerning the quarterly allowable increase limits on each occasion that the board does establish such a limit.

E. Form. The quarterly allowable increase limit is a single percentage figure which is applicable to the average charges per

inpatient admission for the hospital.

F. Basis. This single percentage figure is based upon the averaged monthly Consumer Price Index, as published by the Division of Labor Statistics, U.S. Department of Commerce, stated as percent changes, for relevant previous quarters preceding the establishment of a quarterly allowable increase limit.

G. Compensation. Should quarterly allowable increase limits prospectively established by the board according to these rules allow increases in rates in excess or less than any actual increases in the Consumer Price Index, the board may compensate for this excess by:

1. Measuring the difference between the prospective quarterly allowable increase limits and the actual changes in the Consumer Price Index for expired quarters; and,
2. Adding or reducing by a reasonable proportion of that difference the next quarterly allowable increase limit to be established by the board.

H. Exceptions. Increases directly attributable to any of the following causes are allowable, providing the hospital notifies the system by letter at the time of such increases and the exception category under which the increase qualifies and the hospital documents any of these as the causes for increase in rates in its next subsequent report of rate revenue and expense:

1. The base cost and dollar amount of increased costs of malpractice insurance. The hospital shall provide information indicating the effective date of any related premium increases.
2. The increased cost of any government mandated pension funding requirements. The hospital shall indicate the effective date

of the related cost increase.

3. The increased cost of salaries, wages, or fringe benefits to employees resulting from labor negotiations. The hospital shall indicate the extent of increased costs.
4. Changes in Federal or State law or regulation which cause uncontrollable increases in cost. The hospital shall indicate the law or regulation causing change and the nature of the effect of the change upon rates.
5. Changes in rates in acute care beds in hospitals operated by the commissioner of public welfare due to legislative action.

MHD 505-MHD 508 RESERVED FOR FUTURE USE

MHD 509 Fees. Hospitals whose rates are reviewed by the system as operated by the board shall submit filing fees with rate revenue and expense reports and interim increase reports which are submitted to the board. These fees are based on the cost of reviews and the number of beds licensed as acute care beds in a hospital, pursuant to Minnesota Statutes, §§ 144.50 to 144.58.

A. Rate Revenue and Expense Report Fee. On each occasion which a hospital submits a rate revenue and expense report to the system as operated by the board, it shall accompany this report with a filing fee based upon the following schedules which shall be annually adjusted to reflect the impact of inflation upon these fees, providing the report is timely:

If the Number of Licensed Acute Care Beds of the Hospital Is:	Then the Filing Fee Is:
6 to 24	$ 385.00
25 to 49	$ 495.00
50 to 99	$ 710.00
100 to 149	$ 930.00
150 to 199	$1,150.00
200 to 249	$1,370.00
250 to 299	$1,590.00
300 to 349	$1,810.00
350 to 399	$2,025.00
400 to 449	$2,250.00
450 to 499	$2,470.00
500 or over	$2,685.00

B. Interim Increase Report Fee. On each occasion which a hospital submits an interim increase report to the system as operated by the board, it shall accompany this report with a filing fee. This fee shall be one-half of the rate revenue and expense report fee, as established by MHD 509 A., providing the report is timely.

C. "Timely" means that each report has been submitted within the time prescribed by MHD 481 C.1. or MHD 481 D.1., as appropriate, that an extension of these reporting times, as permitted by MHD 481 G., has not been necessary, and that the report has been determined to be complete, pursuant to MHD 487 C.1. If a report does not meet these standards, the board may require the submission of an additional late fee according to the following late fee schedule:

1. A report submitted after the reporting times established by MHD 481 C.1. or MHD 481 D.1., as appropriate, for which an extension in time has been permitted, pursuant to MHD 481 G., shall be liable for a late fee in addition to the filing fee established by MHD 509 A. or MHD 509 B.,above, as appropriate. This late fee shall be ten percent of the filing fee established by MHD 509 A. or MHD 509 B., above and as appropriate for that hospital.

2. A report submitted by a hospital which is determined not to be complete, pursuant to MHD 487 C.1., shall be liable for a late fee for each occasion on which a resubmission as provided by MHD 487 C.1. occurs. This late fee shall be, for each such occasion of resubmission, five percent of the filing fee paid on submission of the initial report to the board by the hospital as established by MHD 509 A. or MHD 509 B., above.

3. Reports not submitted or submitted after the reporting times established by MHD 481 C.1. or MHD 481 D.1., as appropriate, for which an extension has not been requested or permitted, pursuant to MHD 481 G., shall be liable for the cost of a full audit by an independent public accountant, as necessary for the completion of the report in addition to the filing fee established by MHD 509 A. or MHD 509 B., above, as appropriate.

D. The board may suspend all or any portion of the filing fees and late fees herein established upon cause being shown by a hospital. Such cause may consider such factors as:

1. The inability of a hospital to pay the fees without directly affecting the rates.
2. The occurrence of any emergency financial condition of a hospital, including natural disasters or difficulties associated with completion of reports related to sicknesses or other absences of related hospital employees or other administrative complications resulting in delay in the completion of reports.
3. Other factors which relate to the economic condition or administrative condition of a hospital.

MHD 510 Official Offices. For purposes of these rules, the official offices of the board are:

Minnesota State Board of Health
717 Delaware Street, Southeast
Minneapolis, Minnesota 55440

MHD 511 Severability. If any section or provision of these rules is declared unconstitutional or void by any court of competent jurisdiction, or its applicability to any person or circumstances is held invalid, the constitutionality or validity of the remainder of the rules and the applicability to other persons and circumstances are not affected, and to this end, the sections and provisions of these rules are declared to be severable.

MHD 512-MHD 520 RESERVED FOR FUTURE USE.

RECEIVED
DEC 10 1976
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

ORDER FOR HEARING

IT IS HEREBY ORDERED that a public hearing on the above-captioned rules be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota 55413, on January 5, 1977 commencing at 9:00 a.m. and continuing until all persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that a Notice of Hearing be mailed to all persons or representatives of associations or other interested groups who have registered their names with the Secretary of State for that purpose.

IT IS FURTHER ORDERED that the Notice of Hearing be published in the State Register.

Dated: November 9, 1976

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Bd's Exhibit No. 5
File No.
Date

RESOLVED, that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and he hereby is granted the authority and directed to call a hearing for the purpose of promulgating rules of the Board of Health relating to The Minnesota Hospital Rate Review System as well as perform any and all acts incidental thereto, including but without being limited thereto, signing an order for hearing and notice of hearing as well as requesting the appointment of a hearing examiner for all hearings.

The above resolution was adopted by the Board of Health on October 14, 1976.

RECEIVED
NOV 9 1976
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

ORDER FOR HEARING

IT IS HEREBY ORDERED that a public hearing on the above-captioned rules be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota 55413, on January 5, 1977 commencing at 9:00 a.m. and continuing until all persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that a Notice of Hearing be mailed to all persons or representatives of associations or other interested groups who have registered their names with the Secretary of State for that purpose.

IT IS FURTHER ORDERED that the Notice of Hearing be published in the State Register.

Dated: November 9, 1976

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Bd's Exhibit No. 3
File No.
Date

RESOLVED, that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and he hereby is granted the authority and directed to call a hearing for the purpose of promulgating rules of the Board of Health relating to The Minnesota Hospital Rate Review System as well as perform any and all acts incidental thereto, including but without being limited thereto, signing an order for hearing and notice of hearing as well as requesting the appointment of a hearing examiner for all hearings.

The above resolution was adopted by the Board of Health on October 14, 1976.

CERTIFICATE OF BOARD OF HEALTH'S

AUTHORIZING RESOLUTION

I, Warren R. Lawson, M.D., do hereby certify that I am the Secretary and Executive Officer of the Minnesota Board of Health, a board duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of a resolution adopted at a meeting of the said Board duly and properly called and held on the 14th day of October, 1976, that a quorum was present at said meeting; that a majority of those present voted for the resolution; that said resolution is set forth in the minutes of said meeting and has not been rescinded or modified.

> RESOLVED, that Warren R. Lawson, M.D., Secretary and Executive Officer of the Minnesota State Board of Health, be and he hereby is granted the authority and directed to call a hearing for the purpose of promulgating rules of the Board of Health relating to the Minnesota Hospital Rate Review System as well as perform any and all acts incidental thereto, including but without being limited thereto, signing an order for hearing and notice of hearing as well as requesting the appointment of a hearing examiner for all hearings.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 20th day of April, 1977.

STATE OF MINNESOTA

BOARD OF HEALTH



WARREN R. LAWSON, M.D.
Secretary and Executive Officer

EX III

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System.

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing on January 5 and 6, 1977, in Minneapolis before Steve M. Mihalchick, Hearing Examiner appointed by the Chief Hearing Examiner.

This is a rules hearing pursuant to Minn. Stat. Ch. 15, to determine whether proposed new Minn. Rules MHD 471-511 should be adopted.

The following persons appeared for the Board of Health (Board): Frederic L. Sattler, Consulting Director, Minnesota Hospital Rate Review System, Department of Health (Department); John Breviu, Special Assistant Attorney General, representing the Department of Health; Kent Peterson, Chief of Planning & Resources Control, Department of Health; and Stephen M. Jackson, Legislative Analyst/Health, Minnesota House of Representatives, Former Consultant to the Board of Health.

Eighty persons attending the hearing signed the register. The hearing continued until all interested groups and persons had an opportunity to be heard.

Pursuant to Minn. Stat. § 15.0412, subd. 4 (1976), this Report shall be available for review to all affected individuals upon request for at least ten days.

The Board shall, if it proposes to adopt the rules as originally proposed or amended, submit the complete hearing record to the Chief Hearing Examiner no earlier than ten days subsequent to the receipt of this Report. This submission shall also clearly set out any changes made from the rules as originally proposed, if any, which may be in the same format which will be submitted to the State Register for publication. The Chief Hearing Examiner shall complete his review and submit his report to the Board on the issues of substantial changes in the rule and compliance with Minn. Stat. § 15.0412 within ten calendar days. Thereafter,

the Board shall be responsible for filing the rules with the Attorney General.

Based upon all the records and proceedings herein, the Examiner makes the following:

FINDINGS OF FACT

PROCEDURAL REQUIREMENTS

1. On November 11, 1976, the Board filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules;
(b) A proposed Order for Hearing and authorizing resolution;
(c) A proposed Notice of Hearing; and
(d) A Statement of the estimated length and number of people attending the hearing.

2. On November 30, 1976, a Notice of Hearing and a copy of the proposed rules were published at 1 State Register 832.

3. On November 23, 1976, the Board mailed the Notice of Hearing, with an attached summary of the proposed rules, to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice.

4. On December 10, 1976, the Board filed the following documents with the Office of Hearing Examiners:

(a) The Order for Hearing and authorizing resolution;
(b) The Notice of Hearing as mailed;
(c) The Affidavit of Receipt of the Secretary of State's list;
(d) The Affidavit of Mailing;
(e) The Secretary of State's Certificate and list;
(f) The Affidavit of Mailing of a notice pursuant to Minn. Stat. § 15.0412, subd. 6, a copy of the Notice and material received pursuant to the Notice;
(g) The names of Board personnel who will represent the agency; and
(h) A combined Statement of Need and Evidence (the Statement of Justification).

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing.

5. The record remained opened through January 26, 1977, for the receipt of written comments and statements. Nine public comments were received within the 20-day period. Two additional comments were received thereafter and are included in the record because the Board must consider all comments received before it takes final action.

6. Prior to the hearing, Mr. O'Hare of the Health Insurance Association of America (HIAA) telephoned the Examiner to ask some procedural questions. During that conversation, Mr. O'Hare asked whether it would be appropriate to point out some matters occurring during the drafting of the proposed rules that might appear to be unfair. The Examiner advised him that it would be quite appropriate. At the hearing, Mr. O'Hare raised two such matters. First, that HIAA had had little opportunity to participate in the drafting of the rules. Second, that Mr. Sattler, the new head of the Hospital Rate Review System, had formerly been an employee of the Minnesota Hospital Association (MHA). The MHA had previously conducted the voluntary rate review system in Minnesota, and under the proposed rules represents the primary regulated groups (T.20-29). The Board responded by showing that HIAA had been invited to participate during the drafting stage and did so (Ex. 16), and by stating that the Board had made a nationwide search for a qualified director and had found that person to be Mr. Sattler (T. 22-29). The Examiner finds that HIAA had ample opportunity to participate in the drafting of these rules and that Mr. Sattler's former position has not biased him in favor of the MHA or hospitals. Nonetheless, Mr. O'Hare's concerns on these matters were properly raised at the hearing. The mere appearance of fairness is an important part of administrative proceedings, and Mr. O'Hare's comments have helped clear up concerns that a number of people may have had. The Examiner was among those persons, for this hearing has the outward appearance of having the regulators and the regulated in almost complete agreement about the content of the rules. Where such agreement exists, suspicions are aroused.

STATUTORY AUTHORITY

7. 1976 Minn. Laws, ch. 296, art. II, §§ 1-9, is the Minnesota Hospital Administration Act of 1976 (the Act). It amended Minn. Stat. ch. 144 by adding Minn. Stat. §§ 144.695-144.703. (In this Report, citations will be to the statutory codification.) Under the Act, hospitals are required to annually file financial

reports with the Board or a voluntary rate review organization and to submit any proposed rate increases to the Board or voluntary rate review organization for review at least 60 days prior to such increases. The Board is empowered to compile and analyze the data submitted, investigate financial operations of the hospitals and publicly comment on financial reports and increases. The Act also authorizes the Board to approve voluntary reporting and rate review procedures of voluntary, non-profit rate review organizations.

8. Minn. Stat. § 144.703, subd. 1(a) provides:

> "[The Board may] adopt, amend, and repeal rules in accordance with Minnesota Statutes, Chapter 15."

Minn. Stat. § 144.702, subd. 2, provides, in relevant part:

> "The Board may approve voluntary reporting and rate review procedures which are substantially equivalent to reporting requirements and rate review procedures adopted by the board for reporting and rate reviews conducted pursuant to sections [144.698 to 144.701]. The board shall, by rule, prescribe standards for approval of voluntary rate review procedures. . . ."

(As a practical matter, it is expected that the MHA will become the voluntary rate review organization for all but a handful of the hospitals in Minnesota. MHA's existing system was used as a model for these rules. No other review organization appears on the horizon.)

MINN. RULE MHD 471 - SCOPE

9. This rule is necessary to define the coverage of the rate review system. Consistent with the Act, it reasonably states that all acute care hospitals licensed under Minn. Stat. §§ 144.50 to 144.58 are subject to the requirements of the rate review system (the System). Going further, it states that beds located in hospitals which are not licensed as acute care beds under the statutes are not subject to the rate review system. This provision recognizes the fact that non-acute care beds may be found in a hospital. These are nursing home or boarding care beds. 1976 Minn. Laws, ch. 173, provides a new licensure process for nursing home or boarding care beds located in hospitals. Because the Legislature has made this separation of acute and

non-acute care beds, it is a reasonable interpretation that the Legislature intended the rate review system to apply only to the acute care beds. Because costs associated with the non-acute care beds are often mingled with costs associated with acute care beds, it is necessary that a method of allocating these costs be prescribed. Therefore, the rule reasonably provides that these costs shall be allocated in a manner consistent with Medicare allocation formulas. This is a method used currently by hospitals and would impose the least possible additional burden on them.

MINN. RULE MHD 472 - DEFINITIONS

10. This rule defines 28 separate terms and phrases which are used in the Act and these rules, but which were not previously defined by the Act. They are necessary for uniform interpretation of the Act and the rules. There were no questions or comments on most of the definitions. All definitions not noted below are reasonable because they are consistent with generally accepted accounting principles and consistent with the Act, as was demonstrated by testimony at the hearing and in the Board's Statement of Justification (Ex. 12).

11. At the hearing, the Board amended the language of proposed MHD 472 B., the definition of "beds". The new definition provides: "Beds means the number of acute care beds licensed by the Minnesota Department of Health pursuant to Minnesota Statutes, Sections 144.50 to 144.58." "Beds" had been originally defined as "staffed and operating beds" because that is the way it is used within the rules for rate review purposes. However, the new definition is the one that is generally accepted for other purposes. Consistent with this change, the use of the word "beds" in subsequent portions of the rule will be qualified by addition of the phrase, "staffed and set up," wherever this more restricted definition was intended.

12. MHD 472 G. defines "charges" as, "the regular amounts charged to both paying patients and insurers who receive services, irrespective of any discounts, deductions, or other reductions in

these charges which, by contract or other agreement, may be applicable." The HIAA correctly pointed out that the word "insurers" is misused in this section inasmuch as insurers do not receive services; patients are the recipients of services. Further, the word "insurer" is used in a broader context than under the definition given in Minn. Stat. § 144.696, subd. 5, which includes only persons selling policies of accident and health insurance or non-profit health service plan subscriber contracts. (This excludes HMOs and self-insured groups.) HIAA offers a definition that would clear up these inconsistencies (Ex. B). The definition is reasonable and should be adopted. It reads:

> "'Charges' means the regular amounts charged to patients and/or insurers, prepayment plans and self-insured groups on the patient's behalf. . . ."

HIAA also suggests that the remainder of the definition be deleted because the Act does not allow any discounts. That will be discussed in more detail below.

The term "rates" is used in two ways within the Act. First, it may mean "charges" as defined here, or it may mean an aggregate or overall rate charged by the hospital. At this point, it would be appropriate to add a provision that "the term 'charges' and 'rates' are synonymous for the purposes of these rules." The definitions of aggregate rates and adjusted rates will be discussed below. See Finding No. 15.

13. The Metropolitan Health Board points out that the definitions of "admissions", "emergency visits", and "out-patient visits" are in conflict in the proposed rules (Ex. C). The Metro Health Board offers four modifications to cure these defects which are reasonable and should be adopted for that reason:

(a) Amend MHD 472 I. to read: "Emergency services" are those inpatient or outpatient hospital services that are necessary to prevent immediate loss of life or function due to the sudden onset of a severe medical condition.

(b) Amend MHD 472 J. to read: "Emergency visit" means an acceptance of a patient by a hospital for the purpose of providing emergency services in a distinct emergency service center.

(c) Amend MHD 472 R. to read: "Outpatient visit" means an acceptance of a patient by a hospital for the purpose of providing outpatient

services in a distinct outpatient service center.

(d) Amend MHD 474 B.2.f. and g. by deleting the word "admissions" and substituting the word "visits".

The MHA also commented on the definition of "emergency services" in that it had originally not included outpatient treatment services (Ex. H at 2). The definition suggested by the Metropolitan Health Board encompasses this matter.

14. The MHA also commented on the definition of "loss". In the case of the disposal of an asset, the proposed rule defines it as the excess of the cost of the asset over related proceeds. MHA quite correctly points out that loss is determined by depreciated costs rather than the original costs. They suggest, and the Examiner recommends, that the word "cost" be replaced by the term "net book value" in MHD 472 O.

15. Minn. Stat. § 144.701, subd. 1, authorizes the System to assure that "total costs of a hospital are reasonably related to the total services offered; that the hospital's aggregate revenues, as expressed by rates, are reasonably related to the hospital's aggregate costs; and that rates are set equitably." Thus, it is not the purpose of the System to review individual charges for individual procedures. Rather, the rate that is to be reviewed is an aggregate or average rate. Therefore, the "rate" to which the System must address itself is a function of total revenue per admission. Further, the rate should be adjusted for outpatient activities to more accurately express the relationship of total revenue to patients treated. The proposed rule defines "rate" as the average revenue for each inpatient admission for a full accounting period, i.e., total revenue divided by the number of inpatient admissions. It also defines "adjusted rate" as total revenue divided by the number of "adjusted inpatient admissions". The adjustment factor is determined by a formula which factors in the ratio of outpatient revenues to inpatient revenues.

Throughout the rule, the word "rate" is used where the Board actually intended the definition of "adjusted rate" to apply. This is somewhat confusing in itself. In addition, as noted above,

the word "rate" commonly means what has formerly been defined as "charges". To resolve this confusion, the Board has proposed the following modifications to MHD 472 U. Change the definition of "rate" to: "'Rate' means 'charges' as defined in MHD 472 G." Substitute the term "aggregate rate" for "adjusted rate" within this section, and substitute the term "aggregate rate" for the word "rate" throughout the remaining portions of rules where the word "rate" was intended to mean "average revenue per adjusted admission."

The MHA also suggests that because a significant portion of a hospital's outpatient activity involves emergency services, such services should be expressly included in the calculation of adjusted admissions (Ex. H at 3). The point is well-taken, and the rule might be modified accordingly.

Recapping the above proposals, MHD 472 U. would be modified to read as follows:

"U. 'Rate' means 'charges' as defined in MHD 472 G.

'Aggregate rate' means the average revenue per adjusted admisson for a full accounting period determined by dividing total revenue by the number of adjusted admissions. The number of adjusted admissions is determined by the following formula:

$$\text{Number of Outpatient and Emergency Visits} \times \frac{\text{Total Outpatient and Emergency Revenue}}{\text{Number of Outpatient and Emergency Visits}} \times \frac{1}{\text{Inpatient Revenue Per Admission}} \text{ Plus } \text{The Number of Inpatient Admissions}$$

"The aggregate rate for the budget year shall always be based upon annually projected admissions as stated in the rate revenue and expense report."

MHA also suggested that the word "adjusted" be inserted between the words "projected" and "admissions" in the last sentence of the rule stated above (Ex. H at 4). That change is not necessary because it is already implied by the definition.

16. HIAA points out that MHD 472 AA, the definition of "third party payors" could be improved (T. 37). The word "insurers" is used in a very broad sense there, and, for clarity, the types of payors implied thereby should be specified. The terms "nonprofit service plan corporations," and "self-insured

or self-funded plans," could be inserted into the definition to clarify it.

MINN. RULE MHD 473 - THE MINNESOTA HOSPITAL RATE REVIEW SYSTEM

17. The Minnesota Hospital Rate Review System is the mechanism by which rate review is conducted. This rule simply states that the System is established; that it shall be operated by the Board or any voluntary non-profit rate review organization which has been approved by the Board; and that the System shall consist of reports, administrative procedures and standards. MHA suggested that the word "or" should be changed to "and" so that the System shall be operated by the Board and any voluntary rate review organization. This change would be appropriate because even if all of the reviews are actually done by a voluntary organization or organizations, the Board retains over-all control and it is required to report to the Legislature. So modified, the rule is necessary and reasonable.

MINN. RULE MHD 474 - REPORT REQUIREMENTS

18. As a general introduction, this rule states that the system shall require annual financial information reports, rate revenue and expense reports and interim increase reports. These reports are authorized respectively by Minn. Stat. §§ 144.698, subd. 1; 144.701, subd. 2; and 144.701, subd. 5.

19. MHD 474 A., like the statute, provides that the annual financial information report shall include a balance sheet, an income and expense statement, and the hospital's Medicare cost report for the corresponding accounting period. The rule prescribes specific accounting categories and classifications which the balance sheet and income and expense statements should contain. These categories and classifications are those required by generally accepted accounting principles in hospital financial reporting. The MHA suggested two modifications in the classification of expenses in the expense statement (Ex. H at 5): "Management services" are listed under purchased services and under other professional fees. That is a redundancy which should be corrected by eliminating the term from the category of purchased

services. "Collection services" are listed under purchased services, but such services are more properly classified as professional services. MHA suggests, and the Examiner agrees, that "collection services" should be deleted from purchased services and listed under other professional fees.

The classifications and categories listed for the balance sheets and income/expense statements are suggestions only and the rule allows hospitals to submit these statements using their own classifications. In such case, the rule requires the hospital to include a narrative description of the scope and type of differences between its statements and those recommended by the rule. HIAA argues that the lack of uniform accounting standards is a principal weakness of the proposed rate review system (Ex. B at 3 and 4). The Examiner agrees, as does the Metropolitan Health Board (Ex. C). Nonetheless, as stated by the Board, it is without authority under the Act to require uniform accounting standards. It must also be remembered that the Act and these rules establish a system which is intended to be the first step in developing a statewide method of assuring efficiency and economy in the financial operations of hospitals. Such intent is found in Minn. Stat. § 144.701, subd. 4, which states: "The Board shall begin to compile relevant financial and accounting data concerning hospitals in order to have statistical information available for legislative policy-making." Uniform accounting was rejected by the Legislature during enactment of the Act.

HIAA also suggests that current assets on the balance sheets should disclose donor-restricted and unrestricted funds. The Examiner agrees that it would be desirable to disclose these funds and that such disclosure may be accomplished by footnoting the balance sheet or by providing statements of changes in fund balances. The Board should consider inserting the appropriate language.

20. MHD 474A.3. clarifies the language of Minn. Stat. § 144.698, subd. 1(c), which requires a copy of the hospital's most recent cost report filed for Medicare. The rule states that the cost report shall be for the period corresponding to that used

in the compilation of data for the balance sheet and revenue and expense report. This is necessary to make comparisons meaningful. Subsequent provisions of the rule dealing with filing deadlines make all these statements "the most recent".

21. MHD 474 A.4. requires that the annual financial information report be attested by the governing authority of the hospital or its designee. This is reasonable and is authorized by Minn. Stat. § 144.698, subd. 3.

22. MHD 474 A.5. requires "attestation by a qualified independent public accountant that the contents of the balance sheet and statement of income and expense are true and conform to the bases for judging the reasonable use of finances by a hospital as established by MHD 487 A." As MHA points out (Ex. H at 6; T. 259-262), public accountants are not generally in a position to attest to the "reasonable use of finances in a hospital as established by MHD 487.A." That, in fact, is the function of the System. MHA suggests that the rule be modified to require the accountant to attest to the fact that the contents of the balance sheet and statement of income and expense "have been audited". The rule is unreasonable as proposed because it requires the accountant to perform functions he would not normally perform. If he did perform such services, it would involve considerable unnecessary expense to the hospital. The rule must be modified, and the suggestion of MHA is a reasonable modification.

23. MHD 474 B. requires the annual submission of a rate revenue and expense report. This report is used as the basis of the regular assessment of reasonableness of rates and charges and any increases in rates or charges; two of the System's duties under Minn. Stat. § 144.701, subds. 1 and 2. The rate revenue and expense report includes certain statistical and financial information for three separate accounting periods styled as the "prior year", "current year", and "budget year". The current year information is a combination of actual data and estimated data. As originally proposed, the rule required that information for at least the first eight months be actual. At least one hospital and the MHA believe that requiring eight months of actual

data is unreasonable and unrealistic because, considering that increase reports are required 60 days prior to the increase day, there remains only 60 days for the hospital to compile the data necessary for the report (T. 269-272; Ex. H at 7). At the hearing the Board agreed that eight months might be unreasonable (T. 270). The hospital and MHA both suggest that the rule require at least six months actual data. This figure appears to be within the realm of reasonableness and the rule should be so modified.

24. MHD 474 B.2. specifies the statistical information which must be included in the rate revenue and expense report. This rule recognizes that financial data is not of much use by itself and that related statistical information must be available. For example, to determine the average charge per patient per admission, the number of admissions must be known. The statistical requirements of the rule are minimal and include items that hospitals normally collect. At the hearing, the Board offered three amendments to the proposed rules which are reasonable, non-substantial charges (T. 263). To the requirement for the number of inpatient days for the hospital, "and each appropriate service center," was added. This is necessary because the System analyzes data on both a total hospital and service center basis. To the requirement for number of beds available for the hospital and for each appropriate routine service center, the Board added three separate "bed" statistics. Namely, the number of licensed beds, the number of beds physically present, and number of beds actually staffed and set up. This reflects the redefinition of "beds" in MHD 472E (see Finding No. 11). It was agreed at the hearing (T. 268 to 269), that the word "routine" should be deleted from the phrase "each appropriate routine service center". The Board also deleted the requirement that the hospital supply the average annual occupancy rate because the System can as easily compute that statistic as can the hospital.

This rule also requires that the hospital submit the number of units of service provided by each of the hospital's other service centers, and it allows the hospital to select the statistic that best measures the level of activity for a particular function

or service center. This section again raises the arguments on uniform accounting, with HIAA arguing that the System must select the best measure in order to operate effectively (Ex. B at 7), and the Board arguing that it is without authority to require uniform accounting (T. 266-268). Again, the Board's position is not unreasonable.

25. MHD 474 B.3. lists the financial information which must be included on the rate revenue and expense report. Interim financial statements in the form previously specified are reasonably required. These are necessary to monitor the consistency of the hospital's estimate of the full current year with that of a portion of the current year that has actually been experienced. The rule also requires a statement detailing the accounting method used to allocate expenses from non-revenue centers to revenue centers, and a statement of total direct and indirect costs for the hospital and for each of its service centers after allocation of expenses. HIAA suggested that the rule should require disclosure of direct and indirect costs before allocation (Ex. B at 8). This suggestion appears to have some merit because, like the statement detailing allocation methods, it would assist in determining whether standards for offsets to costs and allocations of costs are being followed. However, the Examiner is without sufficient expertise to determine whether the required statement of allocation method would, in itself, be sufficient for the purpose, and makes no recommendation on the suggestion other than to to request that the Board study it closely to determine whether it should be incorporated within the rule.

The proposed rule requires a statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of patient days outstanding at the end of each period. These are necessary to assess the adequacy of the hospital's collection effort and as a part of determining each hospital's working capital requirement. As was noted at the hearing (T. 277) and by MHA (Ex. H at 7), the proper terminology should be "days' charges" rather than "patient days". The Board argued that this is common usage and the change should be made.

The Metropolitan Health Board suggested that an additional section be added to the rule requiring "a statement of the capital budget of the hospital". This information is obviously necessary to assess the hospital's financial policy, and the suggested language or something similar to it should be included in the rule. The Board stated that it unintentionally omitted such a statement from the rule.

26. MHD 474 B.4. lists three additional items which the rate revenue and expense report must contain. First is the pricing policy of the hospital, which incorporates the over-all pricing policy and financial objectives of the institution. The Board realizes that not all hospitals have such policies, but by this requirement is encouraging them to be established. In a complex financial venture such as a hospital, it is simply prudent management to have financial objectives. The proposed rule lists no criteria for items which must be included in such a policy statement. At the hearing, MHA raised the question of whether the rule requires the hospital to disclose in advance its plan for adjusting charges in the budget year. Such information is needed in order to analyze and comment on the rate review and expense report (T. 273-274). The Board replied that it considered this to be implied in the rule and that specific details would be incorporated in the forms to be drawn by the Board. Nonetheless, MHA requests that it be made express within the rule and has offered an amendment which would eliminate any ambiguity, and confirm the intent of the Board (Ex. H at 8). The proposal is reasonable and should be incorporated within the rule in the form proposed except that the word "rates" should be replaced by the term "aggregate rates" where it appears in the proposal.

This section also requires attestation that rates are set equitably and submission of copies of reports used to obtain any Certificate of Need for expansion. These are reasonable requirements.

27. MHD 474 C. states that an interim increase report is required whenever a hospital desires to amend or modify its rates

for the budget year except where such increases do not exceed limits prescribed elsewhere in the rule. Minn. Stat. § 144.701, subd. 5, requires this report and the exception.

28. MHD 474 C.2. further excepts the Commissioner of Public Welfare from filing the interim increase report where changes in rates during the budget year are the result of legislative policy and appropriations. This provision is necessary because the Commissioner of Public Welfare has no control over increases in "rates" caused by legislative policy and appropriations. HIAA argues that such changes in rates should still be reviewed by the System to assure that rates properly reflect the legislative changes (Ex. B at 8). There is some merit to that suggestion, but the Board's proposal is not unreasonable. The Board might consider the suggestion for future amendment to these rules.

29. Because this report is essentially an amendment to the budget year portion of the rate revenue and expense report, the rule requires the report be in the same form and contain the same information as required for the rate revenue and expense report. The rule reasonably requires information indicating any change in the budget year from the projected information already on file with the System and a narrative statement describing the reasons for amendments or modifications to the hospital's rates.

MINN. RULE MHD 481 - ADMINISTRATIVE PROCEDURES

30. This rule generally governs the basic administrative handling and processing of the various reports required by the rules or by the Act, as well as the handling and issuance of comments and other reports by the System.

30. MHD 481 A.1. states that the System shall design and issue forms as necessary for meeting the requirements of reports established by these rules. This is reasonable because such a form set will make it easier for the hospitals to file the required reports in the manner prescribed by these rules. The rule does not say that the Board's forms must be used. At the hearing, the Board stated that it would solicit comments of all interested parties in developing the form set (T. 275). MHA

requested that this stated intention be made definite by adding a provision to the rule that reads: "The hospitals under the system will be allowed to comment on the forms prior to their adoption." The Board felt that this would require additional rulemaking to specify such matters as notice and manner of submitting comments. The rule is reasonable as written.

32. MHD 481 A.2. and 4. describe the requirements for filing of the required reports. They state that the documents may be filed personally or by mail, and that no report shall be deemed filed until the System has ascertained its completeness in accordance with provisions of the rules. Since filing constitutes the commencement of such time periods as the 60-day requirement of Minn. Stat. § 144.701, subd. 5, it is necessary that the term be clearly defined. It is further reasonable to require that the required report be sufficiently complete to allow the System to make its analysis and review before the time period begins to run. Standards for determining completeness are provided in MHD 487 C.

33. Minn. Stat. § 144.698, subd. 4, states that all reports (except privileged medical information) filed with the System shall be open to public inspection. MHD 481 A.3. implements this statute by requiring the System to establish a method of record-keeping that facilitates easy public access to these records. The Examiner would note that the word "filing" or a form of it is used three times throughout this section. Each time it has a different meaning, none of which correspond to the meaning with which it is used in other portions of the rules (namely, legally served and accepted). Because this part of the rule deals primarily with the term "filing" in its legal sense, the Examiner recommends that MHD 481 A.3. be amended to read as follows:

> "The system shall establish a method of record-keeping which shall insure that reports and other documents are ordered, stored, designated and dated in such a manner that facilitates easy public access to the contents of those reports, documents, and other information as required by these rules. These records shall be open to public inspection during normal business hours."

34. MHD 481 B. requires that the report of annual financial information be filed within 120 days after the close of the hospital's full accounting period. Only Hennepin County Medical Center objected to 120 days as being too short (Ex. D). None of the hospitals represented at the hearing nor the MHA objected to this provision. The Board stated that the standard practice of institutions such as hospitals and their auditing firms is to have this type of fiscal information audited and available within a 120-day period. The Examiner finds that it is reasonable. The rule provides an exception for the Medicare cost report which may not, in fact, be filed with the Medicare Fiscal Intermediary within 120 days.

35. MHD 481 B.2. is entitled "Failure to File". It provides generally that a hospital which fails to file the annual financial information report within the time required or within the time allowed pursuant to an extension granted under the rules shall be deemed in violation of the rules. It requires the system to notify the Board and appropriate health systems agency of the violation. The Foundation for Health Care Evaluation requested that this and subsequent similar rules be modified so that the notice of violation will also be given to the appropriate professional standards review organization (PSRO). (Ex. E). PSROs were established to fulfill the requirements of Public Law 92-603, which mandates review of health care provided to patients under Medicare and Medicaid and other federally supported health care services. While the primary duties of the PSROs are different from those of the rate review system, it is undeniable that the efforts of all agencies and quasi-agencies involved in the health care delivery system be coordinated. For this reason, the rule should be amended as suggested by the Foundation.

MHD 481 B.2. further provides, "Pursuant to Minnesota Statutes § 144.55, the board may consider this violation as cause to revoke, suspend or deny reissuance of that hospital's license to operate." MHA was very concerned about the severity of this penalty (Ex. H at 9). The Board admits that the Act itself contains no specific remedy or penalty provision, and that this statement

is simply an attempt to re-state the powers that the Board has had under its general licensing authority. Minn. Stat. § 144.55, provides in relevant part:

> "The state board of health may refuse to grant, refuse to renew, or may suspend or revoke a license on any of the following grounds: (1) violation of any of the provisions of sections 144.50 to 144.56 or the rules, regulations, or standards issued pursuant thereto; (2) permitting, aiding, or abetting the commission of any illegal act in the institution. . . ."

Failure to file a required report under the Act or these rules clearly does not fit within clause (1) of the section quoted because the Act is not within the statutes enumerated. The application of clause (2) is tenuous at best. The Board admits in its Statement of Justification that revocation or other action against a hospital is not practically or politically feasible unless a hospital is blatantly acting in a manner which can be demonstrated to be contrary to law or rules. The Board further admits that this situation is unlikely to arise. The provision is unreasonable because it is beyond the statutory authority of the Board. It should, therefore, be deleted.

36. MHD 481 C. deals with filing of the report of rate revenue and expense. The proposed rule requires that each hospital file the report 60 days prior to the commencement of its accounting period. The 60-day requirement was based on the presumption that most hospitals raise their rates on the first day of their fiscal year. Because the Act requires 60-day notice before raising rates, the arrangement allows the elimination of a duplicate interim increase report. However, the MHA stated that most hospitals would prefer to accumulate the financial data necessary to compile these reports during the last 60 days of the fiscal year and would not object to postponing any rate increases until 60 days after the start of their fiscal year (T. 280-281). In that light, MHA has offered a reasonable modification to the proposed rule that would require filing of the report "on or before" the commencement of any accounting period of the hospital. It would also add the provision that "No change in rates shall be made until 60 days have elapsed from the date of filing." These changes should be incorporated in the rule. HIAA suggested that

the time period be extended to 90 days to provide the System more time to review proposals and to allow hospitals to resubmit reports on the basis of the System's decision (Ex. B at 8). While 90 days would be convenient for the System, it would place additional burdens upon the hospitals. The 60-day figure is not unreasonable because it corresponds to the 60-day requirement of the statute.

37. MHD 481 C.2. contains a failure to file provision similar to that relating to the annual financial information report. The comments of Finding No. 35 apply.

38. MHD 481 D. reasonably requires that the interim increase report be filed 60 days prior to the effective date of any amendment or modification to rates if (a) the proposed rate exceeds allowable increase limits; (b) the amendments or modifications were not included in the report of rate revenue and expense; (c) it is not filed within 90 days of any other interim increase or rate revenue and expense report; and (d) there are no reports, fees or other documents or information due to the System from that hospital. MHA had some concerns about this section because of the difficulty of projecting what the final rate will be (Ex. H at 10). They suggest that because a hospital only controls "charges", the rule should only apply to charges. That is apparently what the Board intended (T. 286). The suggested change is not absolutely necessary, however, because this is one place where the word "rates" will not be changed to "aggregate rates" (See Findings 12 and 15). Still, the MHA suggestion makes this intent more clear and might be included.

Sections "c." and "d." (not within 90 days or when other information is outstanding) are actually instances where interim increase reports may not be filed. They are presently worded as "negative requirements", which is awkward and possibly confusing. Further, section "e." allows a waiver of these two sections, which might be read to apply to sections "a" and "b" also. The Examiner would suggest that sections "c", "d", and "e" be combined in one section and renumbered as MHD 841 D.2, to read:

> "An interim increase report may not be filed within ninety (90) days of any other interim increase or

rate revenue and expense report filed by that hospital or when there are any reports, fees or other documents due to the system from that hospital. This provision may be waived by the system if the hospital can show cause therefor."

MHD 281 D.2. and D.3. would have to be renumbered. These changes could improve the clarity of the provision.

MHA suggested that the waiver provision should apply to all of MHD 481 D. (Ex. H at 12). That would be unreasonably broad.

39. MHD 481 D.2. states that failure to file a required interim increase report is a violation of the rules. If the violation is discovered during the budget year, the System may require the hospital to adjust its rates consistent with allowable increased limits until 60 days after the hospital properly files the report. If the violation is discovered after the budget year in which the violation occurred, the System may investigate the violation in order to determine its effect upon the rates of the hospital. The System may recommend a reduction in the rates of the hospital and require that the hospital submit interim increase reports for every increase in rates, irrespective of the allowable increase limits, for the next two accounting periods. No comments were made on these sections and they are reasonable because the Act specifically requires filing of amendments or modifications to rates at least 60 days in advance of their effective date.

40. MHD 481 D.2.d. recognizes that differences may occur between projections and actual budget year history such that a hospital may exceed allowable increase limits when it had not intended to do so and therefore not filed an interim increase report. The rule states that such a variation should never exceed 1.1 times the allowable increase limit. HIAA suggested that any excesses should be taken into account in the next accounting period (Ex. B at 8). That suggestion seems to be encompassed within the preceding section. MHA requested that the ten percent allowable variance be deleted from the rule because of the unpredictability of the variance and due to the fact that the hospital itself controls only charges. Charges are but one small part of the aggregate rate. The section is not unreasonable as proposed.

The rule does not provide an absolute standard. The system still must assess the effect of the violation upon the aggregate rate, and if the excess is caused by unpredictable and uncontrollable factors such as patient mix, no remediable action would be appropriate.

41. MHD 481 D.3. provides the mechanics by which the hospital can determine its allowable rate increase; that is, the amount by which it may increase its rates without submitting an interim increase report. This provision is necessary to allow the hospitals to do their budgeting and planning.

42. The Board withdrew MHD 481 E. at the hearing.

43. MHD 481.F. provides that an entity operating more than one hospital may act as the reporting organization for each hospital but must submit separate reports for each hospital and provide a statement detailing the financial relationship between it and its hospitals. This is necessary because the System must assess whether the rates of each hospital are set equitably. do so, it must have separate information on each hospital.

44. MHD 481 G. allows the System to grant extensions to a hospital which so requests and shows cause why such extension is necessary. This is necessary and reasonable because conditions may exist from time to time which legitimately prevent a hospital from meeting the time requirements.

MINN. RULE MHD 487 - INVESTIGATIONS, ANALYSIS AND REVIEW STANDARDS

45. MHD 487 establishes the basic criteria concerning the procedure employed to assess reasonableness of rates and increases. The standards set are purposely broad and flexible because the concept of hospital rate review is relatively new and still in an experimental state. The standards were established by reviewing existing rate review programs in other states and related literature dealing with financial requirements of hospitals and public utility rate-making. The standards will be subject to review and amendment as data from the System is compiled. It must also be remembered that the Legislature intended to establish a system of hospital financial disclosure (rate review) as opposed to a system of financial control (rate setting).

Therefore, the standards in these rules were designed to reflect and gather information about current financial practices of hospitals; not to set "desirable" financial practices.

46. MHD 487 A.1. lists the standards for financial requirements of hospitals. It states generally that rates charged to patients or their insurers must be adequate to maintain the solvency of the hospital; that they should provide adequate funds to meet certain expenses. This is a reasonable introductory statement to the categorization of expenses which follows.

47. The first major category of expenses is, "Current operating needs related to patient care." The first item in this category is direct patient care. The rule provides that rates should provide finances to meet expenses such as salaries, wages, employer fringe benefits, services, supplies, normal maintenance, minor building modification and applicable taxes. The rule also recognizes that an amount should be included representing the value of services of members of religious orders and other voluntary groups equivalent to the amount that would be paid to employees for similar work (with certain limits). There was no comment on direct patient care expenses and they are clearly reasonable.

48. MHD 487 A.1.a.(2) provides for the second category of current operating needs, "interest expense." This rule reasonably recognizes the generally accepted fact that the financial needs of hospitals include payment of interest charges at a reasonable rate arising from the use of necessary funds borrowed from external sources for operating and plant capital needs. The rule defines interest as "necessary" if it is incurred on a loan made to satisfy a financial need of the hospital or a loan reasonably related to patient care. Under the amendment offered at the hearing by the Board (Ex. 15), a specific statement is made that loans made to expand facilities that have been determined to have excess capacity under the rule are not considered reasonably related to patient care. The Metro Health Board has proposed a similar statement (Ex. C), that the Board might consider for adoption. No objection was made to the concept of

these sections, but MHA did suggest that the exception for facilities having excess capacity should be limited to loans made to expand bed capacity in such facilities rather than expansion in general (Ex. H at 13; T. 44-46). MHA stated that even where a facility had excess bed capacity, it might legitimately expand its "facility" by adding needed new services or equipment. The Board maintains that such a modification is not necessary because the entire facility is generally geared to bed size; where there is excess bed capacity, there is generally excess facility in the broader sense. The Board's position is not unreasonable.

The rule reasonably states that interest is "proper" if not in excess of the rate a prudent borrower would have to pay in the existing money market at the time.

49. MHD 487 A.1.a.(3) provides for educational program expenses. This rule states that rates should provide the finances necessary to recover the net cost to the hospital of providing educational activities which directly contribute to the care of patients currently in the hospital or which contribute to the preventive health education of the population in the area the hospital serves. The second provision ran into opposition from insurers (Blue Cross and HIAA). They argue that hospitalized patients should pay only for the net costs of educational activities which directly contribute to their care and that the costs of those educational programs conducted for the benefit of non-patients should be paid by those participating in the program or from funds the hospital may have available for such a purpose (Exs. A and B at 9; T. 50, 53 and 54). The Board generally agreed that available funds should be utilized first, but stated that the intent of the provision is to encourage long-range cost containment. Health systems agencies and the State Health Planning and Development Agency are currently encouraging hospitals to engage in such community health education. In the long run, this should reduce the need for hospitalization, and thus, overall hospitalization costs. The Board recognized that the approach is unique and that there may possibly be short-run minor increases in expenses, but maintained that the possible long-run

benefits would be substantial as a result of less hospital utilization. The Board suggested that, in order to insure that hospitals utilize what other funds might be available, it would be appropriate to amend the section on net costs by adding the following provision:

> "All possible non-inpatient revenue sources, including fees from those receiving educational benefits, should be investigated and utilized prior to the inclusion of the costs of community preventive health education in financial requirements."

With such a provision, the proposed rule is reasonable.

MHD 487 A.1.a.(3)(e), as proposed, contains the provision that the costs for provision of community health education should not include any payments in excess of the normal salary or remuneration to professional employees and consultants to the hospital. This provision was originally proposed to recognize the responsibility of health professionals to provide educational services as a part of their duties in the hospital and to encourage hospitals to, whenever possible, collect fees from the people taking the courses or use other funds. MHA pointed out that many small hospitals do not have the professional employees on staff to provide these educational activities and must employ their services for that particular purpose. Further, in hospitals that do use their own staff, it is typically an additional duty after normal hours for which the health professionals reasonably expect additional remuneration. For these reasons, MHA urges that the provision be deleted. The Examiner agrees because the provision could unreasonably prevent a hospital from recovering reasonable expenses.

50. MHD 487 A.1.a.(4) provides for research program expenses. These expenses are limited to those which directly relate to daily patient care and only to the extent that non-patient revenue is unavailable to offset the costs. Unlike community health education, there are generally no state or federal requirements to provide research that are not adequately funded.

51. MHD 487 A.1.a.(5) provides for bad debt, charity allowances and contractual allowances. The proposed section also included "courtesy discount allowances", but at the hearing, the

Board deleted all reference to such allowances because they would either be "cost-justified" or "non-cost justified" discounts as defined elsewhere (T. 58-59). This section generally identifies and defines three major sources of losses experienced in the conduct of normal hospital operations and defines how the System will determine acceptability of financial practice with regard to each of these expenses.

52. MHD 487 A.1.a.(5)(a)(i) defines bad debts as they are defined in the Medicare regulations. It then prohibits reclassification of charity care expenses as bad debts and requires that hospitals maintain records reflecting expenses in each of the other categories which are not, by definition, bad debts. Blue Cross suggested that the rules should set a limit on the amount of loss due to bad debts a hospital may include in patient charges. They offered the following modification to this rule:

> "Bad debts may be included in patient charges in an amount up to the median of its peer group but this amount shall not exceed one and one-half percent of the gross billings to patients as recorded by the hospital."

It should first be noted that the rules generally provide for determining reasonableness by comparison to the mean of the peer group rather than the median. It is appropriate that the System eventually develop more specific standards and limits; once sufficient data has been collected. Applying a figure such as one and one-half percent of gross billings at this point would be arbitrary for no data exists to support that particular figure. The rule as written is reasonable at this point in time.

53. MHD 487 A.1.a.(5)(a)(ii) provides a very narrow definition of charity allowance and includes only the provision of care at no charge to patients where such free care is required in connection with a Hill-Burton grant. The comments of Hennepin County Medical Center (Ex. D) and Blue Cross (Ex. A) highlight both sides of this issue. Hennepin County states that it will provide approximately $4,500,000 worth of charity care this year; approximately $370,000 of that is required under the Hill-Burton Act. If the System does not allow Hennepin County to pass along some of this obligation to patients and third parties in

the form of rates, they will be obliged "to rely upon the regressive and repressive property tax to meet our statutory and moral obligations." Blue Cross argues that patients and their insurers should not have to pay even for the charity care provided under the Hill-Burton program. Blue Cross points out that because of depreciation expense, price level adjustments and a charity care requirement of twice the original grant amount, patients and their insurers may, in fact, have to pay four times the original Hill-Burton grant amount. The Board took a middle ground, stating that generally the costs of those who cannot pay for their hospital care should not be borne by the remaining hospital population in the amount that they pay for hospital care or health insurance, but allowing Hill-Burton obligations because of the requirements placed on the hospital by the program. The rule is reasonable, but in view of Blue Cross's argument, the Board might consider limiting even this allowance, perhaps to the amount of the original grant.

54. MHD 487 A.1.a.(5)(a)(iii) allows hospitals to claim two types of discounts; governmental contract adjustments and cost-justified discounts. "Governmental contract adjustments" are defined as those discounts from the established charges required due to governmental reimbursement practices. It is necessary to recognize these discounts because, by law and regulation, such programs as Medicare and Medicaid do not fully reimburse hospitals for their actual costs. Because it is improper to require hospitals to operate at a loss, these differentials must be passed along to other patients or those who pay those other patients' charges. Blue Cross argues that it is unfair to include the amount of governmental discounts in patients' charges (Ex. A). That may be so, but it is what the law requires. The rule will have the effect of making this "hidden tax" more visible.

55. The provision allowing "cost-justified discounts" was among the most controversial provisions of the rule. Minn. Stat. § 144.701, subd. 1, after requiring the Board to assure that total costs of a hospital are reasonably related to total services offered, and that aggregate revenues are reasonably related to

aggregate costs states:

> "The Board shall prohibit hospitals from discriminating among insurers in its rates."

It seems clear that the statute uses the word "rates" in this sense of the word "charges" in this particular provision. It must also be remembered that the statute defines "insurer" as a person selling policies of accident and health insurance or a non-profit health service plan. In other words, it does not include HMOs, self-insured or governmental payors. Thus, the statute does not require the Board to prohibit hospitals from discriminating among these types of payors. In the proposed rule, the Board has essentially interpreted the word "discriminating" to include only unfair discrimination. It thus provides that discounts may be provided to certain patients, groups of patients, or third-party payors where the hospital can demonstrate that the value of services or other benefits provided by these persons or groups is at least as great as the discount granted. The effect of the rule is to treat all payors, not just insurers, alike. MHA argues that the Legislature intended to prohibit discounts to all payers and urges that the section be amended to allow only discounts required by law; the governmental contractual allowances (Ex. H at 15). HIAA and North American Life and Casualty Company (NALAC) argue that the statute quite clearly and explicitly prohibits any discrimination among insurers as that term is defined and that the proposed allowance of cost-justified discounts is contrary to the statute (Exs. B at 9 and G). One hospital supported the rule (Ex. K), though that was because HMOs could reduce its cost. HMOs are not subject to the non-discrimination requirement of the Act. Similar arguments were advanced at the hearing (T. 61-65, 69-76 and 83-100). The Examiner believes that the term "discrimination" is open to interpretation and that the cost-justified discounts provision of the rule interprets it in a manner consistent with the purposes of the Act. In the first place, such discounts are includable only to the extent that there is an actual and demonstrable savings to the hospital in terms of real money. Second, the provision provides an

incentive to all payors to take steps that will reduce the cost to the hospital. The net savings are then passed along to members of the group represented by that payor. There is some argument that this "benefit" should be passed along to all payors. The practical effect of that would be to eliminate any incentive and there would be no "benefit" for anyone. Third, the Board promises an on-going evaluation of the reasonableness of these discounts.

56. MHD 487 A.1.a.(5)(b) provides that losses in revenues due to bad debts, charity losses and contractual allowance must be offset against available non-patient income before they are included in rates. HIAA, logically proceeding from its argument that no discounts should be allowed, argued that this provision should be deleted (Ex. D at 9). Because the preceding sections are not unreasonable and should be included in the rule, this provision is necessary to insure the minimum impact of allowing those costs.

Blue Cross also suggested that the rule provide that under no conditions may courtesy discounts be included in patient charges (Ex. A). That provision does not appear to be necessary because courtesy discounts would not, by definition, be cost-justified and thus would not be allowable.

57. MHD 487 A.1.b. provides the next major category of expenses - plant capital needs. These provisions recognize the need for hospitals to generate funds to purchase and replace capital items, prescribe a method of accounting for such funds, describe permissible uses of the funds, and describe a method of determining the magnitude of the hospital's plant capital needs.

58. The introductory portion of this rule states that plant capital needs must be funded to be included in the rates and that funding of depreciation shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund. Blue Cross suggested that an additional provision be added stating:

> "In order to include depreciation expense and inflation factors in patient charges, the hospital must have received certificate of need approval when required (Ex. A)"

The Board agreed that that was its intent and that Blue Cross's suggestion would make it more explicit (T. 107). This change should be adopted so that the rules do not encourage conflicts with Certificate of Need requirements.

59. MHD 487 A.1.b.1. requires that finances related to building, building equipment and movable equipment be placed in an identifiable fund and that the annual increment to this fund should be the amount of the annual debt principal payment (adjusted as level payments over the life of the debt instrument), or the annual straight-line depreciation, whichever is greater, plus inflation factors.

MHA and Blue Cross both suggested that restrictions on the use of the fund should be incorporated in the rule (Ex. H at 17 and A). The MHA proposal contains references to the requirement for Certificates of Need in appropriate situations, and for that reason is somewhat better than Blue Cross's proposal. MHA further suggested that plant capital needs include funding for land and land improvements because these items are often financed with debt, and, in the case of land improvements, are subject to depreciation. Further, there is no practical way to separate these items from building and equipment for reporting purposes. MHA lists a number of places within the rule in which the words "land" and "land improvements" should be inserted. The Board should consider these suggestions for inclusion within the rule because they could clarify the use of the plant capital needs funds.

Blue Cross suggested that the provision allowing for annual increment to the fund in the amount of the adjusted annual debt payment should be deleted (Ex. A). Blue Cross feels that straight-line depreciation plus inflation factors provides a reasonable allowance for annual debt principal payment requirements. Blue Cross visualizes a situation where a loan includes a large balloon as the final payment. Under the rule, the hospital would be able to include the entire balloon payment in its rate for that year. The Board justified its provision allowing either the greater of depreciation or adjusted principal payment in recognition of the fact that the debt instrument may have a shorter life than the

asset and may produce a demand for cash which cannot be met by depreciation allowances. While the concern about a balloon payment urged by Blue Cross could not occur because payments are required to be computed as level over the life of the instrument, it seems clear that the rule will tend to encourage financing on short-term instruments. The Board stated that it was not intending to encourage such borrowing and that the reasonableness of the debt instrument itself is always open to review (T. 102-103). It appears to the Examiner that the Board is encouraging what it intended not to encourage and that the temptation will be difficult to resist by the hospitals. Further, there are no standards anywhere in the rule for determining the reasonableness of the debt instrument. For these reasons, the Examiner believes that the provision is unreasonable as written. This defect could be cured in one of three ways. First, eliminate the provision entirely. Second, provide some standard for measuring the reasonableness of the term of the debt instrument (for example, one-half of the life of the related assets), or third, allow some form of accelerated depreciation where principal repayment exceeds straight-line depreciation allowances.

HIAA also points out that the alternate wording of the provision would allow recapture in excess of the cost of the asset. In other words, the accelerated principal repayment amount could be taken until the debt was repaid, and then the remaining straight-line depreciation expense could be taken for the life of the asset. The Board stated that this was not intended and that the provision should be modified to exclude the possibility.

60. MHD 487 A.1.b.(1)(b) describes the inflation factors that will be allowed as an annual increment to plant capital funds. These factors are provided to recognize the impact of inflation upon capital assets and the desirability of allowing hospitals to purchase new assets or replace existing assets without incurring overly large amounts of debt. The factors allow hospitals to accumulate cash to be used to purchase building and building equipment and movable equipment. HIAA considered these inflation factors to be the single most questionable financial

requirement in the proposed rules. They regard this approach to the problem of providing sufficient capital for replacement and expansion as completely arbitrary. Funds will be provided to hospitals regardless of the need of a particular hospital and will result in underfunding some hospitals and grossly overfunding the needs of other hospitals. They further argue that such funding will in itself create pressure for expansion by the mere availability of such resources. HIAA points out that because Medicare and Medicaid do not recognize price level depreciation, the entire burden of this allowance would be borne by non-government financed patients. HIAA urges consideration of an alternative method of meeting the needs of hospitals to generate sufficient revenues to meet future community health care needs and points to the method used by the State of Washington.

> "The Washington Hospital Cost Commission gives separate consideration to the hospital capital requirements, which include:
>
> 1. The principal payment on debt;
> 2. Needed additional capital expenditures; and
> 3. Working capital needs.
>
> These requirements are delineated annually in the hospital budget submission. The Commission, in reviewing these financial needs, looks then to the sources of funds available to cover these requirements. Such sources include funded historical cost-depreciation as well as other nonpatient revenue sources. If the sources of funds available are not sufficient to meet the capital requirements of the institution, then the Commission will allow a growth and development factor to be included in the rates. We believe such an approach is entirely reasonable in that it ties the growth and development factor to specific purpose of projects and, therefore, eliminates the danger created by arbitrarily assigning price level depreciation, which will allow some institutions to obtain greater payments than necessary, and others not enough. In addition, the danger of perpetuating an institution or part of an institution, which is not needed, is also eliminated. Therefore, we would suggest this as a more reasonable alternative than price level depreciation." (Ex. I)

The Board did comment at the hearing that it had considered alternatives similar to that suggested by HIAA. One of the reasons for not adopting any of the other alternative methods was a fear of being unable to draft the rule in a form that would withstand the requirements of rule-making; apparently because it would be difficult to prescribe standards to be applied to a case by case review of capital needs and funding methods. This is of

particular concern to the Examiner because the Administrative Procedures Act, like this Examiner's function, is purely procedural. That is, it merely provides a mechanism for the adoption of reasonable rules. These procedures should have no effect on the substantive content of rules except to the extent that more open procedures provide more input and considered argument resulting in better rules. If the procedures discourage the adoption of the "better" rule, there is something amiss. If the "better" rule requires a lack of specificity and standards, then it is reasonable under the standards of the Adminstrative Procedures Act. Inflation factors were fully discussed and argued at the hearing (T. 112-158). The evidence and arguments presented demonstrate that the Board's proposal is not unreasonable. It contains sufficient controls to prevent over-funding and encourages use of alternate funds where available.

61. MHA suggested that the words "inflation factors" be replaced with the term "price level depreciation" because that is a more commonly understood term. However, the term "inflation factors" is somewhat broader and would provide more flexibility in the rule.

62. The proposed rule has a provision requiring that annual interest earned from an investment of this fund should be used to reduce the inflation factor requirements. HIAA argued that interest income should be used to reduce or offset plant capital needs. This logically follows from its argument that inflation factors should not be included (Ex. B at 14). MHA argued that earned interest should be allowed to accumulate in the fund to a specified point and then be applied to reduce the inflation factor requirements (Ex. H at 20). In a similar vein, Blue Cross suggested that consideration be given to placing a limitation upon the amount of funds that may be accumulated (Ex. A). All these suggestions deal to some degree with controlling excess funding. It would be reasonable to include some form of control in the rule, but it would seem appropriate that the control be placed on the accruals to the fund rather than the accumulated total. Otherwise, it would be possible for a hospital

to pass a great deal of money through the fund without ever accumulating an unreasonable amount. The Examiner suggests that the Board consider an appropriate restriction for inclusion within the rule.

63. MHD 487 A.1.b(5) provides for a hierarchy of sources of funds to which the hospitals should turn if it has a plant capital need and insufficient funds in the identified fund. First, the hospital should rely on sources other than charge-paying patients (e.g., grants, gifts, funded capital). Second, to the extent such sources are inadequate, borrowed funds or leases. Third, to the extent these two sources are inadequate, then approved inclusion in rates when it can be demonstrated that such inclusion in rates will result in a lower cost to current patients than would result from the borrowing of funds or leasing of plant capital assets. The stated intention is reasonable, but, as stated by the Board, the language used may not clearly carry out that intent. The Examiner recommends that paragraphs MHD 487 A.1.b.(5)(b) and (c) be could be amended to read as follows:

> "(b) Borrowed funds or leases to the extent income from sources other than patients can be demonstrated to be inadequate; or
>
> "(c) Approved inclusion in rates to the extent it can be demonstrated that insufficient resources exist from (a) and (b) above, and that inclusion in rates will result in a lower cost to current patients than would result from the borrowing of funds or leasing of plant capital assets. Approval of inclusion in rates shall be by the system upon demonstration by the hospital of both of the conditions herein stated. Once approved, the inclusion in rates of these additional financial requirements may be considered reasonable. Any portion of the annual equal amortized historical costs of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated."

Such a change would clarify the rule.

64. MHD 487 A.1.c. provides for the third major category of financial requirements, incremental operating cash needs (otherwise known as working capital). There is no doubt of the necessity for working capital, and this section reasonably outlines the method for calculating working capital requirements.

HIAA's general comment on this section was that it contains no norms for calculating acceptable parameters for working capital.

The Board again stated that at this point in the development of the System, reasonableness will generally be determined by peer group comparisons. Again, as data is compiled and analyzed, more specific standards can be set (T. 165-168). MHA and Blue Cross both addressed the issue of considering the amount of finances held in specific funds in assessing the reasonableness of working capital. MHD 487 A.1.c.(3)(b) provides that the reasonableness of the working capital allowances depends, inter alia, upon "The amount of finances that a hospital may hold in reserve funds." MHA was concerned that the term "reserve funds" was ambiguous and that such funds as the depreciation fund and other restricted funds should not be considered in determining the reasonableness of working capital (T. 164). Blue Cross felt that it should be made certain that unrestricted cash and investments should be included in determining working capital needs (Ex. A and T. 170-171). The proposed rule is reasonable for it allows the System the degree of flexibility necessary to make overall assessments of the reasonableness of the working capital requirements of a hospital.

65. MHA suggested that a clarification of MHD 487 A.1.c. (2) was necessary to insure that accounts receivable were broken down by a third party payor category (Ex. H at 22-21). That suggestion is helpful and could be included within the rule. Breakdown by category of payor may be useful in assessing the effect of each category of payor on the hospital's financial condition.

66. MHD 487 A.2. deals with income from sources other than patients. Generally, such income should be used to offset the hospital's expenses, but there are exceptions, and this section specifies the treatment of such income.

67. MHD 487 A.2.a. generally states that restricted funds must be used for the purpose for which they are restricted. The rule also recognizes that it may be more prudent to borrow or finance a building or equipment purchase than to expend monies restricted for that purpose. The rule reasonbly treats such a transaction as unreasonable unless the hospital can demonstrate that the financing method used is to the economic benefit of current patients.

68. MHD 487 A.2.b. provides that unrestricted funds from non-patient sources should be used to reduce the total financial requirements of a hospital. This is the one provision of the rule to which the MHA has serious objections (Ex. H at 21; T.181-184). MHA opposes it primarily because it would pre-empt the authority of local hospital boards who, they allege, can best determine what the intent of a donor may be and what the needs of a hospital's community may be. They argue that such a rule would have a serious and adverse effect on philanthropic giving in the future. They also note that, eventually, patients in general will benefit from such funds regardless of whether they are applied to current operations or future needs. The Board stated that it felt it was appropriate to offset unrestricted funds to financial requirements because: (1) it is in the current patient's best interests to do so; (2) if a donor intends to restrict the funds for future use, he can well do so; (3) the system of price level depreciation and funded depreciation provide adequate funds for future expansion; (4) under generally accepted accounting principles, unrestricted donations are classified as current income, and therefore, should offset current expenses; and (5) that any savings on future interest is small when compared to the dollar for dollar offset if applied to current expenses. The Board stated that the provision should be applied in a reasonable manner; that is, they would not intend to immediately include the corpus of substantial existing unrestricted funds and that they would deem it reasonable to treat very large donations in a manner that would spread out the benefit over a number of years. Even HIAA, which generally felt that the entire section was too liberal, agreed that some reasonable approach should be taken in evaluating the use of these funds (T. 184-193). It appears to the Examiner that the provision is unreasonably restrictive. There may be situations in which not applying unrestricted funds to current operations could result in overall cost savings to the community. If a hospital can demonstrate that such a situation exists, it should be allowed to so restrict the funds. It might be appropriate to relate such a provision to the

hierarchy of desirable means of meeting plant capital needs stated in MHD 487 A.1.b.(5). The Board should consider such a modification.

69. MHD 487 A.2.c. deals with auxiliary enterprises and states essentially that profits from such enterprises should primarily be used to offset financial requirements and that such enterprises should be self-sufficient and profitable. It would allow losses incurred from such enterprises only to the extent it can be demonstrated that such enterprise is a fringe benefit to employees or of direct economic benefit to current patients. MHA argues that this is a one-way street; that it is unfair to require the hospital to include profits from such enterprises, but not to include losses. They offer an amendment that would require that gains or losses from such enterprises not be considered in the financial requirements of the hospital (Ex. H at 22) (It might be noted that MHA would leave in the provision that any losses related to fringe benefits or direct economic benefit can be included; effectively reversing the direction of the one-way street.) The Examiner finds that the Board's proposal is reasonable. If a hospital chooses to operate an auxiliary enterprise, the benefits of that should accrue to the hospital and through the hospital, to the current patients. On the other hand, since these enterprises are not directly necessary to patient care, the patient should not be charged for losses which are incurred because of imprudent management.

70. MHD 487 A.3. recognizes that changes in rates may be necessary due to variations from projected volumes of activity and services and states that the financial requirements of a hospital for a budget year should reflect adjustments for volumes of activity and service realized during the prior and current years. There are some difficulties with the precise wording of the section which should be corrected, but the rule provides that if a hospital over or under-projects its volume in a service center, its next year's financial requirements should be respectively increased or reduced by the percentage of fixed to total costs of that service center multiplied by the difference between the

actual and budgeted income of that service center. The general concept in prospective rate setting is that the rate is set at the beginning of the budget year, and no retrospective adjustments are made at the end of the year for variations from projections. This provision provides a limited exception to that general rule. MHA argued that this approach needs more study before it is implemented (Ex. H at 22-25). They point to the fact that there are variables other than volume that are difficult to predict and to the difficulty of defining and determining fixed to variable cost ratios for service centers. The Board admitted to the lack of evidence and difficulty of computing this ratio, but stated the hospitals would be able to use any of three methods in determining it. The alternatives are described in the Statement of Justification. The Board has demonstrated that its proposed method is not unreasonable and it should be adopted with some wording changes to clarify the provision. Further, the three alternative methods of determining fixed to variable cost ratios stated in the Statement of Justification should be included in the rule so that it is clear that they are available. These can be incorporated with slight wording changes from the form in which they appear there.

71. MHD 487 A.4. treats excess capacity. This section relates to the plant capital needs section where price level factors are applied to depreciation. It states that in hospitals where excess capacity exists, the annual inflation factor will be reduced by the proportion of excess beds to total beds available. Excess capacity is determined by comparing that hospital's occupancy rate based on staffed and set-up beds to the average occupancy rate of other hospitals with common characteristics; in other words, the average of the peer group. When the System makes a preliminary determination that there is excess capacity, the determination will be submitted to the appropriate Health Systems Agency and to the State Planning and Development Agency. These agencies may then comment to the System regarding the consistency of the preliminary determination with health planning standards regarding occupancy rates.

HIAA argued that these requirements were too liberal. NALAC stated that peer group comparisons were not valid when the entire peer group has excess capacity and urged that some minimum standards be set. MHA stated that the whole problem of excess capacity is so enormous that it is beyond the scope of the rate review system to resolve (T. 215-233). MHA suggested that the preliminary determination of excess capacity be based on hospitals having an occupancy rate more than 20% below the average of the peer group. The Board's position is a reasonable middle ground between these arguments. The Foundation for Health Care Evaluation also suggested that the appropriate PSRO be included among the agencies notified of a preliminary determination of excess capacity. The Foundation also suggested the rule state the scope of review by the PSROs. Their suggestion is rather lengthy and the purpose might better be served by modifying the last sentence of MHD 487 A.4.a. to read:

> "These agencies may comment to the system regarding the consistency of this preliminary determination with health care standards regarding occupancy rates in their areas of expertise."

The Foundation suggests a parallel modification to the MHD 487 A.4.b. which should be adopted (Ex. E). The Board should consider these suggestions for possible inclusion in the rules.

72. MHD 487 B. implements the provisions of Minn. Stat. §§ 144.698, subd. 5; 144.699 and 144.701 authorizing the Board to investigate hospital rates. The Board reasonably interprets the statutes to require that such investigations be supplemental to the regular review of reports submitted as otherwise required by the Act and rules. It may be necessary on certain occasions to undertake a longer and more detailed investigation of existing rates than is allowed by the normal 60-day review. The rule reasonably requires notice to the hospital of the investigation, application of the standards established by the rules, and a subsequent investigative report detailing the findings. No comments were offered on this section.

73. MHD 487 C. is necessary to describe the administrative standards for the review of reports required by the Act.

74. MHD 487 C.1. deals with completeness. Its provisions are necessary because the System cannot make a lengthy review unless the required reports are substantially complete. The provisions reasonably place the burden upon the hospital to submit adequate data for the System to be able to commence its review. As mentioned previously, a report is not deemed to be "filed" until the System has ascertained that it is complete. "Complete" means that the report contains adequate data for the System to commence its review. The rule reasonably allows the System ten days to determine whether the report is complete. The System may also, within ten days, notify the hospital that it will require up to 30 additional days to determine completeness. The rule provides that if the System has not responded to the hospital within ten working days, the report is deemed to be complete and filed as of the initial day of receipt by the System. The Board stated that the same rule would apply to reports deemed complete during a 30-day extension period (T. 236). The Examiner believes that the rule is not clear on this point and that a provision should be added to the end of 487 C.1.b. stating, "If a report is not found to be incomplete during such additional period, it shall be deemed to be complete and filed as of the initial day of receipt by the System." Such a provision would clarify the Board's intent.

MHD 487 C.1.c. provides that a report determined to be incomplete shall be returned immediately to the hospital "stating the need for more data." As stated in the Statement of Justification, the Board requires that the report be returned to the hospital with a specific statement of how the report is incomplete. The rule, as written, does not make that clear. The Examiner would suggest that the phrase quoted above be modified to read, "describing the deficiencies specifically."

MHD 487 C.1.e. provides for the situation where a hospital discovers errors in any of its submitted reports which have been deemed to be complete. It requires the hospital to inform the System of the error and submit an amendment to the report. Because it is necessary to determine whether such an amendment

should affect the 60-day period, the rule provides that in the case of an interim increase report or a rate revenue and expense report, the submittal of an amendment shall not affect the filing date if the hospital informs the System of any errors within 30 days of the initial filing and the amendment is submitted to the System by a date determined by the hospital and System to be acceptable. If either of these conditions are not fulfilled, the report will be deemed to be filed as of the date the amendment is submitted (thereby re-starting the 60-day period before which the hospital can increase its rates).

MHD 487 C.1.f. addresses the same problem from the view of the System discovering the error. It states that if the System discovers an error which will have a noticeable impact upon its ability to render fair comment, it may require the hospital to amend and re-submit the report. If the error is discovered within 30 days of filing, the filing date will not be affected if the amended report is submitted by a date which is acceptable to the System and the hospital. If the discovery of the error occurs more than 30 days after the filing date of the original report, the filing date will be set back to the date the amendment is submitted.

These provisions recognize some basic concepts. First, the hospital is required to submit complete and accurate reports, and if it discovers an error, it must inform the System. Second, if the errors are promptly discovered and corrected, or if they are not of such great magnitude so as to affect the System's ability to make a fair comment, the hospital should not be penalized by having its rate increase delayed. Third, the hospital should not be penalized if the System unreasonably delays in discovering a significant error. Fourth, the hospital should not unreasonably benefit from a delay by it in submitting an amended report. That is, if the hospital unreasonably delays in submitting an amended report, its rate increase should be delayed until the System has had reasonable opportunity to make comment. The Examiner believes that the two sections as written are unreasonable because they are not sufficiently flexible; section "e" does not allow for correc-

tion of insignificant errors after 30 days and section "f" does not protect hospitals from unresonable delay by the System in detecting significant errors. MHA offered some amendments to increase the flexibility of the rule (Ex. H at 26-27). These amendments would result in a rule that would allow rate increases to go into effect even though amendments were not filed by a date acceptable to the System. These two sections should be re-worded to more accurately and appropriately meet the objectives stated by the Board.

75. MHD 487 C.2. states the general rules for reviewing rate revenue and expense reports and interim increase reports. They shall be reviewed on a basis of the rate and cost history of each hospital on an institutional and a service center basis. Comparisons between hospitals may be made on an institutional and service center basis when it can be shown that those hospitals and service centers share common characteristics. This has been noted before. HIAA argued that the System should establish norms (Ex. B at 15) NALAC's comment that comparison by peer group is of little value when the entire peer group is unreasonable applies here as well. Again, these rules are but a first step and it is impossible at this time to establish meaningful norms and standards. The rule is not unreasonable.

76. Minn. Stat. § 144.701, subd. 5, authorizes the Board, and thus the System, to review and publicly comment on any rate increases. MHD 487 C.2.b. implements this authority by stating that the System shall comment on interim increase reports and rate revenue and expense reports to the hospital, the Board and the public, and that the comment shall state that a hospital's existing or proposed rates are reasonable or are in question. A comment that a hospital's rates are in question may be based upon a determination that the rates deviate from the average of other hospitals in the peer group; the rates provide revenue which is in excess of expenses which deviate from past practices of the hospital, of peer hospitals or from the reasonableness standards stated in MHD 487 A.; or if the hospital has not demonstrated that its rates are necessary and consistent with the

standards established in MHD 487 A. The only question on this section of the rules was on the timing of the comment (T. 243-244). It is apparently the intent of the Board that the comments would be issued prior to the implementation of proposed budgets or proposed rate increases. That seems to be the primary intent of the Act; the Board might consider clarifying that intent by including appropriate language within this portion of the rule.

77. MHD 487 D. states that all official meetings of the System, including executive sessions, which occur for any purpose related to completion of an investigation, release of the results of an analysis, or issuance of a comment shall be open to the public and that public notice shall be given one week in advance of any such official meetings. The Minnesota Open Meeting Law applies to the Board, and since any voluntary review agency which may operate the System is acting in the Board's stead, the law should apply to it, too.

78. MHD 487 E. provides that the burden of proof shall be on the hospital to establish reasonableness, equity and lack of discrimination in its system of proposed rates. It is reasonable to require a hospital to justify its rates and that appears to be a primary purpose of the Act.

79. MHD 487 F. states that the System may, when two or more investigations, analyses or reviews involve common questions of fact, address the common questions of fact and make comments applicable to all hospitals under consideration. This is reasonable because it provides for uniform application of the standards and is administratively convenient. It imposes no burden upon the hospitals.

80. MHA suggested that an additional section be added describing an appeal mechanism (Ex. H at 27). This is a subject that should be addressed in future amendments. To include it now would be a substantial change from the proposed rules as noticed.

MINN. RULE MHD 494 - APPROVAL FOR OPERATION OF THE SYSTEM.

81. Minn. Stat. § 144.702, subd. 2, states that the Board may approve voluntary reporting and rate review procedures which

are substantially equivalent to the reporting requirements and rate review procedures adapted by the Board and shall, by rule prescribe standards for giving such approval. This rule is necessary to implement that statutory directive. The rule reasonably provides for application procedures by describing the application period, the required contents of the application, and a time limit upon the Board for approving or disapproving the application. As required by the statute, the rule requires that the applicant demonstrate that reports and procedures are substantially equivalent to those established by the Board. The rule also provides that the Board may fail to renew or revoke its approval if the reporting and review procedures of the applicant are no longer substantially equivalent to those established by the Board. The only comment on this rule was that MHA felt comfortable with it (T. 253).

MINN. RULE MHD 504 - BOARD DETERMINATION OF ALLOWABLE INCREASE LIMIT.

82. Minn. Stat. § 144.701, subd. 5, allows the Board to exempt rate increases which have a minimal impact on hospital costs from the 60-day advance notice requirement. The rule provides that the Board shall establish the quarterly increase limits for the next six quarters. Such projections are necessary to allow the hospitals adequate time for financial planning. The allowable increase is reasonably expressed as a percentage based upon the consumer price index. The allowable increase limits are threshhold values to be used by hospitals in determining whether they must file interim increase reports. It is not a standard to measure the reasonableness of rate increases. The rule as written is sufficiently flexible to allow the Board to establish the limit on a general basis or on a peer group basis. These provisions are reasonable.

83. MHD 504 H. provides for a separate category of increases which are exempted from the 60-day requirement. These are increases in rates due to increases in certain relatively uncontrollable expenses of a hospital which, because they are uncontrollable, should not require the submission of an interim increase

report. The rule does require the hospital to notify the System by letter at the time of such increases. These increases are increased costs of malpractice insurance, increased cost of any government mandated pension funding requirements, increased costs of salaries and related expenses resulting from labor negotiations, increased costs resulting from change in federal or state laws or regulations and changes in rates in acute care beds in hospitals operated by the Commissioner of Public Welfare due to legislative action. HIAA argues that such significant costs should not be allowed to be passed through without scrutiny by the program. Nothing in the rule would prevent the System from making a comment on these increases at the time they go into effect it may be somewhat unfair to require a hospital to delay implementing a rate increase due to increased expenses over which it has no control and was unable to accurately predict. Nevertheless, it appears to the Examiner that this provision is contrary to the statute. The Board stated in its Statement of Justification that these uncontrolled expenses may be considered as "increases of minimal impact" for the purposes here. That is taking extreme liberty with the rather clear language of the statute. The Examiner finds that MHD 504 H. is unreasonable because it is contrary to the statute.

MINN. RULE MHD 509 - FEES

84. Minn. Stat. § 144.701, subd. 6, authorizes the Board to set filing fees for the rate revenue and expense reports and interim increase reports that are filed with the Board. This rule establishes those fees and is graduated according to the number of licensed acute care beds in the hospital. The statute requires the Board to consider the length and complexity of the report being filed in setting the fee. Bed size may generally be related to the expected length and complexity of the report. The rates set in the rule are based on those charged by the MHA in its current voluntary program. No objection was made to this rule. MHA did request that a provision be added to make it clear that the rates set by the rule applied only to reports submitted

to the Board and not to the rates of any voluntary review organization approved by the Board (Ex. H at 28; T. 250-253). The Board agreed that the suggestion was reasonable and should be included within the rule.

MINN. RULE MHD 510 - OFFICIAL OFFICES.

85. This rule states that, for the purposes of the rate review system, the official offices of the Board are those located at the Department of Health Building in Minneapolis. It is necessary and reasonable to designate this office because the several district offices of the Board of Health are not involved in the review system and it would be inappropriate and confusing if reports were filed in any other office.

MINN. RULE MHD 511 - SEVERABILITY.

86. This rule is a standard severability provision which insures that the entire set of rules is not rendered void if any particular section is declared unconstitutional or invalid.

OTHER

87. The Board offered a number of minor changes and modifications to the proposed rules at the hearing. Except as expressly found otherwise above, these changes are reasonable, necessary. and non-substantial.

CONCLUSIONS

1. Due, timely and adequate legal notice of the hearing was properly served and published by the Board. All other substantive and procedural requirements of statute and rule have been fulfilled.

2. The Board has demonstrated its statutory authority to adopt the proposed rules.

3. With the exceptions noted in the Findings, the Board has demonstrated the need for and reasonableness of the proposed rules.

4. The Examiner has offered several suggestions which would appear to correct some of the provisions which were found to be unreasonable or that would improve already reasonable provisions.

They are not intended to preclude the Board from making its own changes and improvements.

RECOMMENDATIONS

The Hearing Examiner recommends that the proposed rules be modified as suggested in the Findings and that so modified, they be adopted.

Dated this 25th day of February, 1977.

STEVE M. MIHALCHICK
Hearing Examiner

STATE OF MINNESOTA)
(ss.
COUNTY OF RAMSEY)

AFFIDAVIT OF SERVICE

Eileen A. Gaiovnik, being first duly sworn, deposes and says that on the 25th day of February 1977, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice to Interested Persons HLTH-77-035-SM

unstamped, by placing in the designated tray to be collected by messenger for delivery to the central mailing station as required by Minn. Stat., § 16.54 (1974), a true and correct copy thereof on all persons at the addresses shown on the ~~attached mailing list~~ Hearing Register who indicated thereon that they wishes to be notified when the Examiner's Report was submitted to the Agency.

Eileen A. Gaiovnik

Subscribed and sworn to before me
this 25th day of February, 1977.

Sandra A. Haven

SANDRA A. HAVEN
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires July 29, 1983

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS
ROOM 300 – 1745 UNIVERSITY AVENUE
ST. PAUL, MINNESOTA 55104
(612) 296-6910

February 25, 1977

TO ALL INTERESTED PARTIES:

RE: In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System.
Our File No. HLTH-77-035-SM

The Report of the Hearing Examiner in the above-entitled matter has been submitted to the Board of Health. Please note that the Report is a recommendation only and that the Board may accept, modify or reject any part of it. However, the Board may not take any final action on the proposed rule until at least ten days have expired. During that time, the Board and the Office of Hearing Examiners will make a copy of the Report available for review by any interested individual. Copies will be furnished by the Office of Hearing Examiners for $ 6.85 each. Please use the enclosed order form.

A copy of the Report has also been filed with the Legislative Reference Library.

Yours very truly,

Susan K. Derus

SUSAN K. DERUS
Administrative Assistant

SKD/eag
Enc.1

AN EQUAL OPPORTUNITY EMPLOYER

TO: Office of Hearing Examiners
Room 300
1745 University Avenue
St. Paul, Minnesota - 55104

Please send me _____ copy(ies) of the Report of the Hearing Examiner in Docket No. HLTH-77-035-SM I have enclosed a check in the amount of $_____ made payable to: State Treasurer - Hearing Examiners' account.

_____ (name)

_____ (address)

_____ (city)

(Please type or print the above information clearly.)

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Proposed Rules for the
Minnesota Hospital Rate Review System

MHD 471 B. (Page 1)

Beds located in these hospitals, which are not licensed as acute care beds pursuant to Minnesota Statutes, Sections 144.50 to 144.58, are not subject to the requirements of the Minnesota Hospital Rate Review System. Where costs incurred through the operation of these beds are co-mingled with the costs of operation of acute care beds in a hospital subject to the system, associated revenue and expenses and other related data shall be separated in a manner consistent with the normal ~~step-down~~ requirements for allocation of costs as stated by 20 CFR 405.453 (Medicare).

MHD 472 E. (Page 2)

~~"Beds"-means-the-average-number-of-beds-in-a-hospital-which are-in-place-and-operating-with-staff-regularly-assigned to-them-during-an-accounting-period.--This-number-need not-be-equivalent-to-the-licensed-or-constructed-bed-capacity-but-it-shall-be-equivalent-to-the-average-number-of these-beds-commonly-considered-to-be-set-up-and-staffed during-an-accounting-period.~~ "Beds" means the number of

acute care beds licensed by the Minnesota Department of Health, pursuant to Minnesota Statutes, Sections 144.50 to 144.58.

MHD 474 B.2.a. (Page 15)

a. The number of inpatient days for the hospital and each appropriate service center.

MHD 474 B.2.d. (Page 15)

d. ~~The number of beds available for the hospital and for each appropriate routine service center.~~ The number of beds (licensed), the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital and for each appropriate routine service center.

MHD 474 B.2.e. (Page 15)

~~e. The average annual occupancy rate for the hospital and for each appropriate routine service center.~~

MHD 474 B.3.d. (Page 17)

d. A statement of total direct and indirect costs for the hospital and for each of its service centers after ~~the step-down~~ an allocation of expenses.

MHD 481 D.3.c. (Page 25)

c. Amendments or modifications which do not exceed the allowable increase limit or provide for rate decreases may take effect immediately upon determination by the hospital's governing authority or its designee. Notice of these amendments or modifications at the time they become effective shall be given to the Board. These amendments or modifications shall also be noted in the hospital's next subsequent rate revenue and expense report.

MHD 481 E. (Page 25)

~~Application for Variance in Rate Determination. If a hospital desires to adopt an alternative method of accounting, cost control, rate determination or payment which may affect the way in which the system proceeds in its assessment of that hospital's rates, it shall notify the system sixty days in advance of the effective date of this new method. Such notification shall detail the new method, including expected impacts upon hospital revenues, expenses and rates as well as the impact of the new method on the equity with which rates are set.~~

MHD 487 A.1.a.(2)(d)(ii). (Pages 28-29)

Incurred on a loan made for a purpose reasonably related to patient care. ~~Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost and which has been determined to have excess capacity, pursuant to MHD 487 A.4., or whose services have been determined to be inappropriate, pursuant to Public Law 93-641, §1523(a)(6) (National Health Planning and Resources Development Act of 1974), are not considered to be for a purpose reasonably related to patient care.~~ Loans made for the following are not to be considered to be for a purpose reasonably related to patient care: to expand facilities that have been determined to have excess capacity, pursuant to MHD 487 A.4.

MHD 487 A.1.a.(3)(a)(i). (Page 29)

(i) Are approved educational activities and can be demonstrated to directly contribute to the care of patients who are in hospitals during the time the cost is incurred; ~~and~~ or

MHD 487 A.1.a.(3)(e). (Page 30)

The extent of costs incurred for the provision of educational activities contributing to the preventive

health education of the population of the hospital's areas of patient origin should not exceed that amount necessary to provide activities recommended appropriate for hospitals by the State Health Planning and Development Agency and appropriate health systems agency, pursuant to Public Law 93-641, §1523~~(a)(6)~~ and §1513, respectively. In any instance, these costs should not include any payments in excess of the normal salary or remuneration to professional employees of the hospital or health professionals who maintain consultative, contractual, or patient relationships with that hospital.

MHD 487 A.1.a.(5). (Page 31)

Bad Debt, Charity Allowances, ~~Courtesy-Discount Allowances,~~ and Contractual Allowances ~~Expenses~~.

MHD 487 A.1.a.(5)(a). (Page 31)

Rates should provide finances necessary to recover losses in revenue due to bad debts, charity allowances, ~~courtesy-discount-allowances,~~ and contractual allowances.

MHD 487 A.1.a.(5)(a)(i). (Pages 31-32)

"Bad debts" mean amounts considered to be uncollectible from accounts and notes receivable which

were created or acquired in providing services. Accounts receivable and notes receivable are designations for claims arising from the rendering of services, and are collectible in money in the near future. These amounts should not include any amount attributable to a reclassification of any expenses incurred due to the provision of charity care. Income reductions due to charity allowances, ~~courtesy discount allowances~~ and contractual allowances should be recorded as such in the records of a hospital and not as bad debts.

MHD 487 A.1.a.(5)(a)(iii). (Page 32)

"Contractual allowances", ~~and "courtesy discounts" are those governmental contract adjustments to or other cost justified discounts or differentials from the established charges of a hospital.~~ "cost justified discounts" and "non cost justified discounts".

MHD 487 A.1.b.(5)(c). (Page 37)

Approved inclusion in rates, when the hospital can demonstrate that insufficient resources exist in the ~~(i) or (ii) above,~~ plant capital fund(s), or when a hospital can demonstrate that inclusion in rates will result in a lower cost to current patients than would result from the borrowing of funds or leasing of plant capital assets. Approval of inclusion in rates shall be by the system upon demonstration by the hospital of either or both of the

conditions herein stated. Once approved, the inclusion in rates of these additional financial requirements may be considered reasonable. Any portion of the annual equal amortized historical cost of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated.

MHD 487 A.1.b.(7). (Pages 37-38)

If a hospital can demonstrate that the ~~inclusion in-the-fund~~ assumption of any specific capital debt will result in a greater cost to current patients than depreciation or retirement of that debt under consistent financial practices of that hospital which differ from the ~~funding~~ determination of plant capital needs as stated by these rules, then a hospital may choose ~~not-to-fund-the-specific-capital debt.~~ an alternative method of meeting its plant capital needs. In this instance, the hospital should provide complete information to the system regarding the precise method which will be used to meet such a plant capital need. Direct inclusion of plant capital needs in rates requires approval by the system as provided by MHD 487 A.1.b., above.

MHD 487 A.2.a.(5). (Page 42)

~~(5)--If-funds-or-the-income-therefrom-are-restricted to-the-provision-of-charity-care,-these-funds or-their-income-should-be-annually-budgeted to-offset-charity-care-requirements-prior-to-the budgeting-of-the-use-of-any-patient-generated revenue-for-charity-care-for-any-accounting period.~~

MHD 487 A.3.b. (Page 44)

If a hospital under-projects its volume in a service center, in the next year its financial requirements should be reduced by the percentage of (fixed) costs of that service center and multiplied by the differences between the actual and budgeted income of that service center.

MHD 487 A.4. (Page 44)

Excess Capacity. For hospitals with occupancy rates, based upon staffed and set up beds, below the average occupancy rate of other hospitals determined by the system to share common characteristics, rates set on the basis of costs may produce unreasonable charges to patients. The system may assess the rates of such hospitals where the criteria of need for beds shall be consistent with the demand for

beds as indicated on a hospital or a service center level by occupancy rates. In cases where low occupancy appears to affect hospital rates, the hospital shall be considered to have excess capacity.

MHD 487 C.2.b.(1)(b). (Page 50)

~~(b)--Prospective-rates-represent-a-minimal-increase which-is-consistent-with-the-principles-of-the bases-for-judging-established-by-MHD-487-A.;~~

RECEIVED
NOV 9 1976
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

NOTICE OF HEARING

NOTICE IS HEREBY GIVEN that a public hearing in the above-entitled matter will be held in the Board Room, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on January 5, 1977, commencing at 9:00 a.m. and continuing until all persons have had an opportunity to be heard.

All interested or affected persons will have an opportunity to participate. Statements may be made orally and written materials may be submitted at the hearing. In addition, written materials may be submitted by mail to Steve Mihalchick, Hearing Examiner, Office of Hearing Examiners, Room 300, 1745 University Avenue, St. Paul, Minnesota (Telephone: 296-8112) either before the hearing or within twenty (20) days after the close of the hearing.

~~A summary of the proposed rules is attached hereto.~~ These proposed rules, if adopted, will establish a system for the review of any rate change proposed by hospitals in this state. Copies of the proposed rules are now available and one free copy may be obtained by writing to Kent Peterson, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota 55413. Additional copies will be available at the door on the date of the hearing. The agency's authority to promulgate the proposed rules is contained in Minn. Laws 1976, ch. 296, Art. II. A "Statement of Need" explaining why the agency feels the proposed rules are necessary and a "Statement of Evidence" outlining the testimony they will be introducing will be filed with the Hearing Examiner's Office at least twenty-five (25) days prior to the hearing and will be available there for public inspection.

Please be advised that pursuant to Minn. Stat. § 10A.01, subd. 11 (1974)

Bd's Exhibit No. 2
File No.
Date

any individual engaged for pay or other consideration for the purpose of representing persons or associations attempting to influence administrative action, such as the promulgation of these rules, must register with the State Ethics Commission as a lobbyist within five (5) days of the commencement of such activity by the individual.

Dated: November 9, 1976

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

AFFIDAVIT OF RECEIPT OF THE SECRETARY OF STATE'S LIST

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

Kent Peterson, being duly sworn on oath, deposes and says:

1. That he is an employee of the Minnesota Department of Health.

2. That on the 12th day of November, 1976, he went to the Secretary of State's office for the State of Minnesota and requested a current list of all representatives of associations or other interested groups or persons who had registered their names with the Secretary of State for the purpose of obtaining notices of public hearings relating to the promulgation of rules pursuant to Minn. Stat. § 15.0412.

3. That on the 12th day of November, 1976, in response to the above request, the Secretary of State provided him with such a list, a copy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Kent Peterson
Kent Peterson

Subscribed and sworn to before me
this 10 day of December, 1976.

Christine A. Kuderka

CHRISTINE A. KUDERKA
Notary Public, Ramsey County, Mn.
My Commission Expires, Nov. 4, 1978

Bd's Exhibit No. 7
File No.
Date

STATE OF MINNESOTA

COUNTY OF RAMSEY

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

CERTIFICATE

I hereby certify that the 502 general labels and 3 lists for the Minnesota Department of Health all of which are attached and made a part hereof, constitute the complete lists of persons, associations, and other interested groups who as of 1:25 o'clock P.M., this 12th day of November, 1976, have requested pursuant to Minn. Stat. §15.0412 subd. 4(1971), that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

SECRETARY OF STATE

JOAN ANDERSON GROWE

by Virginia Daniels

Bd's Exhibit No. 8

File No.

Date

STATE OF MINNESOTA

COUNTY OF HENNEPIN

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

AFFIDAVIT OF MAILING

Katherine Tekster, being first duly sworn, deposes and says:

That on the 23 day of November, 1976, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A, to all persons and associations at the addresses listed on Exhibit B, attached and made a part hereof, as well as to all members of the Minnesota Legislature as of the date of mailing.

Katherine K. Tekster

Subscribed and sworn to before me this 24th day of November, 1976.

Marie B. Tromiczak

MARIE B. TROMICZAK
NOTARY PUBLIC - MINNESOTA
HENNEPIN COUNTY
My Commission expires O.L.S. 1980

Bd's Exhibit No. 9
File No.
Date

Ex IV

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

COMBINED STATEMENT OF NEED AND STATEMENT OF EVIDENCE

For its combined statement of need and statement of evidence the Board notes as follows:

1. Rules relating to the Minnesota Hospital Rate Review System have never before been promulgated by the Board.

2. The following statutes will be cited in support of these proposed rules:

Minn. Laws 1976, ch. 286 Art. II;
Minn. Stat. § 144.50 - 144.58;
Minn. Stat. § 15.0412

3. A Statement of Justification will be introduced to support both the need for and reasonableness of the proposed rules. A copy of this document is attached hereto and incorporated herein by reference.

Dated: December 10, 1976

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Bd's Exhibit No. 12
File No.
Date

STATE OF MINNESOTA

BOARD OF HEALTH

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

In the Matter of Proposed Adoption of Rules of the Minnesota State Board of Health Governing the Minnesota Hospital Rate Review System

STATEMENT OF JUSTIFICATION

This Statement of Justification is the Board's explanation of the reasoning behind the proposed rules including support for the necessity and reasonableness of these proposed rules. These rules are based upon specific authority in Laws of Minnesota (1976), Chapter 296, Article II, Section 9 (The Minnesota Hospital Administration Act of 1976), for the Board to adopt rules to implement the Minnesota Hospital Rate Review System. The fundamental basis for these rules is that the board shall publicly disclose the budgets of hospitals, it shall review and comment upon any proposed increases in hospital rates, and it shall monitor the institutional solvency of hospitals.

Another factor which is pertinent to note is that hospital rate review, as authorized by the aforementioned statute, is simply a review process; it is not a process as in several other states whereby hospital rates must conform to the recommendations of the reviewing body. Consequently, the standards for reasonableness contained in these rules do not constitute strict bases upon which rates must be set; these standards simply suggest what would appear to reflect the reasonable use of finances in a hospital setting. To guard against any future strict (and restricting) interpretation of these rules, the standards have purposefully been left as fluid as the Administrative Procedures Act permits.

This flexible construction recognizes that, although 2[illegible] states currently have some form of hospital rate review or rate setting (governmental or private, voluntary):

(a) hospital rate review is still in its infancy as an effective regulatory mechanism;

(b) changing economics and governmental regulations could easily render a highly specific set of standards for assessment useless within a very short time, indeed; and

(c) the statute does not mandate a system of uniform accounting and reporting and it is the policy of the Board to not propose such a system at this time. Pending uniform reporting from the federal level and better development of rate review techniques, uniform reporting and accounting is not being recommended.

The Board prepared these rules with input from affected parties including insurers (including Blue Cross and Blue Shield), providers (including representatives from the various hospitals and their organizations), planners (including representatives from the State Health Planning and Development Agency and the Health Systems Agencies), and consumers. A complete chronology of the consultation process employed is attached to this justification.

This statement of the evidence in support of the Board of Health's proposed rules will be presented section-by-section. Broadly speaking, the sections of rules fall into four broad categories:

(a) Scope and Definitions: MHD 471 and MHD 472;

(b) The Minnesota Hospital Rate Review System: MHD 473 through MHD 495;

(c) Standards and Controls of the Board of Health: MHD 496 through MHD 510; and

(d) Severability of the various sections of rules, MHD 511.

Each of these broad areas will be thoroughly examined in turn.

Part 1: Scope and Definitions

MHD 471 and MHD 472

MHD 471. Scope. The purpose of this category of the rules is to define the parameters of the rules.

MHD 471 A. This rule is authorized by: Minnesota Laws 1976, Chapter 296, Article II, Section 4, Section 5, Section 6, Section 7, and by the definition of "hospital" in Section 2, Subdivision 3, which states:

> "Hospital means any acute care institution licensed pursuant to Minnesota Statutes, Sections 144.50 to 144.58, but does not include any health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination."

MHD 471 B. This rule recognizes that not all the beds licensed pursuant to Minnesota Statutes, Section 144.50 to 144.58, are acute care beds. The category of non-acute care beds generally found in a hospital are nursing home and/or boarding care beds. The Board feels that the clear legislative intent is for the rate review to apply to acute care beds only. In fact, another statute passed by the 1976 Legislature, Minnesota Laws (1976), Chapter 173, will provide for a new licensure process for nursing home or boarding care beds located in hospitals, resc nding applicability of Minn. Stat. Section 144.50 to 144.58 to these categories.

As costs for these beds, and care in these beds, is often co-mingled with the costs of all other beds in the hospital, for administrative

ease, we must provide an indication that these costs should be separated for reporting purposes. In this rule, it is important to note the words "in a manner consistent with". We understand that hospitals are all accustomed to performing departmental cost allocations for Medicare on a retrospective basis. We recognize that the full process of performing new and separate prospective cost allocations, as described by the Medicare regulations, is tedious and, in fact, the process does not generally differ a great deal from year to year. It was thus felt that a percentage approximation which would be consistent with what was reported for Medicare requirements would suffice in this regard.

MHD 471 C. As there are several references to Federal Regulations and Federal law in these rules, especially regarding Medicare, Hill-Burton and the new Federal Health Planning and Resources Development Act, it is necessary to specify the date for which the context of these federal rules and federal laws used in rules are effective. Subsequent updates of these federal rules and federal laws do not affect the federal laws and federal rules then in effect on April 1, 1976, unless the Board modifies this rule at some future date.

MHD 472. Definitions. This rule defines 28 separate terms and phrases which are used in the Act and in these rules but which were not previously defined by the Act. These definitions are discussed individually below and are necessary to effect a uniform interpretation of the Act and the rules governing the Minnesota Hospital Rate Review System.

MHD 472 A. "Accounting period." This definition clarifies the interpretation of the hospital's fiscal year established by Section 4, Subd. 1, of the Act. Since these rules do not propose a system of uniform accounting and reporting, confusion might have arisen over the general use of the term "fiscal year." To avoid such confusion, a hospital's fiscal year is always referred to as an "accounting period"; the Board's fiscal year is always referred to as a "fiscal year". "Accounting period" is a common term of the art of accountancy and is readily understood. The definition is important for the distinguishing purposes herein described.

MHD 472 B. "Admissions." In order to fully implement the intent of Section 7, Subdivision 1 of the Act, where the system must assure all purchasers of hospital health care services that ". . . the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs . . .", a basis for such an assessment

had to be established. The units used for such assessments have predominately been:

(a) cost per patient day;

(b) cost per admission (or discharge, or stay);

(c) cost per procedure;

(d) overall increases in budget.

All units can be demonstrated to have advantages and disadvantages. The cost per admission basis seems the best for this system since it places the theoretical restrictions on length of stay and the use of extensive--and perhaps unnecessary--ancillary services. It also may have the effect of encouraging pre-admission testing. A shortcoming of this basis is that it does not fully account for significant change or variation in case mix. The rules do provide some acknowledgment of this problem in their allowance for variance from budgeted volumes of activity and service (see MHD 487 A.3.).

MHD 472 C. "Applicant." This definition is used to replace "a voluntary nonprofit rate review organization whose reporting and review procedures have been approved by the board," in Section 8, Subd. 1 of the Act. The purpose of the definition is that it enhances clarity in the rules.

MHD 472 D. "Auxiliary enterprises." Some hospitals, especially larger hospitals, maintain enterprises which are not directly related to the delivery of health care services to patients. These enterprises are often run by a hospital

for the benefit of hospital employees (e.g., employee cafeterias) or patient visitors (e.g., gift and card shops). It is necessary to specifically identify these enterprises since these enterprises may produce revenue which can be used to offset rates or they may incur lossess or expenses which, in the practice of some hospitals are being passed on to patients as a portion of the charges.

The criteria for significant and businesslike is the criteria used by the State of Maryland for the same purposes of identifying auxiliary enterprises. The criteria has proven to be reasonable by Maryland's experience and we consider the $0.20 and 25% standards to be better than any other alternative.

MHD 472 E. "Beds." The Act allows assessments of the total costs of hospitals and the relationship of these costs to total services offered (Section 7, Subd. 1 of the Act). This can be taken to imply that certain costs may exceed that required by services offered. In Minnesota, we know that the overall occupancy rate of our hospitals is approximately 61.1 percent. This is below a national average occupancy rate of 76.7 percent. Minnesota is somewhat unique in this regard as we have 5.0 beds per 1,000 population, compared to a national average of 4.4 per 1,000 population and we have a great number of hospitals with less than fifty beds. Hospitals with less than fifty beds cannot be expected to have high occupancies. Given these facts, the assessment of occupancy rates is imperative--empty beds incur costs which must be born by someone.

State hospital bed licensing laws currently license on the basis of square footage available for beds (Hospital Statistics, 1976 Edition, American Hospital Association) and not on an actual number of beds being used. It probably is more equitable for the hospital rate review system to look at the number of beds actually being used in the assessment of occupancy. For this reason, the definition of "set-up and staffed beds" recommended and used by the American Hospital Association is used in this rule.

MHD 472 F. "Burden of proof." The intent of the Act comes very close indeed to the concept of public utility regulation, wherein the burden of proof of reasonableness of rates is on the regulated. This definition clarifies this relationship.

MHD 472 G. "Charges." This definition relates to the definition of "admissions" and is justified by Section 7, Subdivision 1 of the Act. This definition helps establish the level of aggregation at which rates will be assessed (see definition of "rate") and helps establish a basis for judging whether or not a hospital is "discriminating among insurers in its rates."

MHD 472 H. "Cost." This is a standard definition of cost as used by the American Institute of Certified Public Accountants (i.e., term of the art").

MHD 472 I. "Emergency services." This is the definition

of emergency services used by the regulations governing Medicare (i.e., 20 CFR 405.152 (b)). Since much of the data in the required cost report conforms to this definition, it is reasonable for the system to use the same definition.

MHD 472 J. "Emergency visit." Since the rules require the collection of data on the number of emergency visits in an accounting period, it is necessary to establish a basis on which hospitals can collect data.

MHD 472 K. "Expanded facility." This is the definition of expanded facilities utilized by the planning agencies in their determination of requirements for certificate of need. Since expansion in facilities can cause increases in rates due to new incurred debts, it is important to define this term. Since planning agencies are the state designated agencies for certificate of need procedures, it is important to maintain consistency with their interpretation of this term.

MHD 472 L. "Expense(s)." This definition is one used by the American Institute of Certified Public Accountants and is commonly accepted (i.e., term of the art).

MHD 472 M. "Fiscal year." This definition is to distinguish for purposes of clarity that "fiscal year" as used in the rules means only the state's fiscal year; "accounting period" is the term for the fiscal year of any other institution.

MHD 472 N. "Inpatient hospital services." This is the definition used by the regulations governing Medicare (20 CFR 405.116) and, again, is used to maintain consistency with definitions that hospitals are already familiar with.

MHD 472 O. "Loss." This definition is one used by the American Institute of Certified Public Accountants and is commonly accepted (i.e., term of the art).

MHD 472 P. "Non-revenue center." It is important to distinguish revenue and non-revenue centers of hospitals in order that allocations of non-revenue-center expenses to revenue centers for purposes of establishing rates can be followed.

The specific service centers mentioned in the definition are those commonly identified as non-revenue centers by:

Hospital Audit Guide (AICPA, 1972, N.Y.)

and,

Chart of Accounts for Hospitals (Chicago, American Hospital Association, 1976).

MHD 472 Q. "Outpatient services." This definition is consistent with the definition of outpatient services offered by the regulations governing Medicare (20 CFR 405.141 et. seq.) and is used for consistency with definitions with which hospitals are already familiar.

MHD 472 R. "Outpatient visit." Since the rules require the collection of data on the number of outpatient visits in an accounting period, it is necessary to establish a basis on which hospitals can collect this data.

MHD 472 S. "Program." This definition is included to simplify the wording in the section relating to the Board approval of the proposed reporting and review procedures of a voluntary nonprofit rate review organization.

MHD 472 T. "Quarter." This definition is necessary to clarify that quarterly allowable increase limits are established on the basis of the quarters of the State fiscal year. Since quarters vary with each hospital's own fiscal year and there is a need to clarify which is applicable for limit determination, this definition is essential.

MHD 472 U. "Rate." The definition of rate as used in these rules is consistent with the use of the word rate in the Act. The rules specify that rates shall be a function of total revenue, which is directly related to hospital's total costs. The rate is an average revenue figure based upon admissions (see the rationale for admissions). The rate may be adjusted for outpatient activities and, therefore, more accurately expresses the relationship of total revenue to patients treated.

The rate is an average and, therefore, reflects charges in an aggregate sense and can then be related to average (aggregate) hospital costs. Note the language in Section 7, 144.701 of the Act, "The Board may initiate reviews or investigations as necessary to assure all purchasers of hospital health care services that the total costs of a hospital are reasonably related to the total services offered, that the hospital's aggregate revenues as expressed by rates are reasonably related to the total services offered, that the

hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs, ..."

MHD 472 V. "Restricted funds." Hospitals have two basic types of funds available to them--restricted and unrestricted. (See Chart of Accounts for Hospitals [Chicago: AHA, 1976]). Restricted funds are those which donors of funds restrict to specific purposes. Funds which are "restricted" by the hospital's governing authority are not truly restricted as that governing authority has the same ability to "unrestrict" the funds at some future date. This definition is necessary for reporting purposes (report of annual financial information) as monitoring of institutional solvency must include monitoring of the size of a hospital's various types of funds.

MHD 472 W. "Revenue(s)" or "Income(s)." This definition conforms to one recommended by the American Institute of Certified Public Accountants (See Hospital Audit Guide (NY: AICPA, 1972) and is a necessary definition for accrual accounting methods. For hospital accounting, this term is essential for conformance to acceptable accounting principles.

MHD 472 X. "Revenue center." See MHD 472 P., "non-revenue center."

MHD 472 Y. "Service center." This definition is essential when speaking collectively about all organizational units of a hospital. This terminology is common among hospitals and is the terminology used by the American Hospital Association in its Chart of Accounts for Hospitals (Chicago: AHA, 1976).

MHD 472 Z. "System." The rules create a system of rate review which must be used by the Board and any approved voluntary program. The system is, as the rules indicate, composed of report requirements, administrative procedures and review standards. This definition is necessary to minimize confusing language.

MHD 472 AA. "Third party payors." This definition is necessary in order that reporting requirements can encompass more than the definition of "insurers" than the Act includes. It is desirable to know the impact H.M.O.s and Medicare and Medicaid upon hospitals and to establish a firm quantitative basis for studying this impact.

MHD 472 BB. "Unrestricted funds." See MHD 472 V. "Restricted funds."

Part 2: The Minnesota Hospital Rate Review System.
MHD 473 through MHD 495.

The purpose of this category of rules is to establish a uniform system of hospital rate review which must occur whether the hospital rates are reviewed by the Board or by a voluntary, nonprofit rate review organization. Not only does this prevent conflicting methods of analysis and application of standards between the Board and any voluntary nonprofit rate review organization; it also gives the Board a precise basis upon which it may judge the acceptability of reporting and review procedures established by the voluntary rate review organization. At the same point, these standards, called the "system," do not prevent the program of the voluntary nonprofit rate review organization from being more restrictive than that of the Board.

MHD 473. This rule simply establishes the system, defines its composition (reports, administrative procedures, and standards) and decrees that the system shall be the basis for hospital rate review:

(a) By the Board, and

(b) By a voluntary nonprofit rate review organization whose reporting and review procedures it approves.

MHD 474. Report Requirements. This rule describes the three basic reports authorized by it and by the Act:

(a) Annual financial information report; specifically authorized by Section 4 of the Act;

(b) Rate revenue and expense report; specifically authorized by Section 7, Subdivision 2 of the Act; and

(c) Interim increase report; specifically authorized by Section 7, Subdivision 5 of the Act.

MHD 474. A. Annual Financial Information Report. This report forms the basis for the disclosure of hospital budgets and assessments of institutional solvency. This rule reiterates the specific requirements established by Section 4 of the Act and clarifies several points.

MHD 474 A.1.a. suggests that the balance sheet required by the Act should include detailed information covering numerous broad areas common to hospital business. These suggested categories are, specifically, those recommended by the American Hospital Association's Chart of Accounts for Hospitals (Chicago, AHA, 1976) and all entries are consistent with terms of the art of accountancy in hospitals.

MHD 474 A.1.b. notes that, as the "system" cannot require uniform accounting or reporting, a hospital keeping a balance sheet which does not conform to that

suggested by MHD 474 A.1.b. should submit its own balance sheet as regularly compiled; but, it should also tell the "system" the scope and type of differences from the entries prescribed by MHD 474 A.1.a. This narrative requirement is designed to protect the hospital from unfair comparisons and to protect the system from making faulty assessments based on "appearance" but not "fact."

MHD 474 A.2.a. suggests that the detailed statement of income and expenses should include detailed information on numerous types of information relating to income and expense in a hospital setting. These categories, including the category for natural classification of expenses, are those specifically recommended by the American Hospital Association's Chart of Accounts for Hospitals (Chicago: AHA, (1976) and the American Institute of Certified Public Accountants, Hospital Audit Guide (New York:AICPA, 1976). All suggested entries are consistent with terms of the art of accountancy in hospitals.

MHD 474 A.2.b. -- see the provision for MHD 474 A.1.b. The same principle here applies to the detailed statement of income and expenses as applied in that rule for the balance sheet.

MHD 474 A.3. This rule clairfies what is meant by Section 4, Subdivision 1(c) of the Act. The rule has the effect of clarifying the language in the Act referring to "most recent cost report" by stating that what is desired is an unaudited copy of the cost report for the same accounting period as that used for the other data in the report of annual financial information.

MHD 474 A.4. This rule implements Section 4, Subdivision 3 of the Act, permitting the Board to require attestation by the responsible officials of the hospital that the contents of the annual financial information report are true. As this information occurs after the expiration of the fiscal year of the hospital and the usual 120-day period is allowed for ascertaining the correctness of the information in the report, this can be considered usual fiscal practice of institutions.

MHD 474 A.5. This rule asks that a qualified, independent public accountant (not necessarily a <u>certified</u> public accountant) examine the balance sheet and income/expense statement and testify to its accuracy and to its conformance with the bases for reasonable use of finances in a hospital, established by MHD 487 A.

<u>MHD 474. B. Rate Revenue and Expense Report</u>. This report forms the basis of the regular assessment of reasonableness of rates and charges and any increases in the rates or charges (Sec. 7 of the Act).

MHD 474 B.1. This report is required annually, (Sec. 7, Subd. 2) and requires statistical and financial information for three full accounting periods:

(MHD 474 B.1.a.)--the last full and audited accounting period ["prior year"]; and

(MHD 474 B.1.b.)--the accounting period during which the report is filed ["current year"]; and

(MHD 474 B.1.c.)--the hospital's next subsequent full accounting period which is all projected data ["budget year"].

This is consistent with the requirements of other hospital rate review programs around the country and with that review program currently sponsored on a voluntary basis by the Minnesota Hospital Association, and therefore, this type of system is widely recognized and many hospitals are already familiar with using it.

The rationale for three time-periods is as follows:

(1) Information for the prior year is required because it is the latest year for which audited statements are available and can be considered accurate;

(2) The current year information (a combination of actual and estimated) is the basis for projecting the budget year and judging the reasonableness of those projections;

(3) The budget year projections are the basis for determining the rates and charge levels of the budget year.

MHD 474 B.2. This rule recognizes that financial data is not of much use by itself unless related statistical information is available. Indeed, if one is assessing the average charge per patient admission, one must know the number of admissions. An attempt has been made to minimize the statistical requirements of rules, given that the current licensing regulations provide considerable amounts of data which are available to the "system." Inspite of this, and as a result of numerous consultation with hospital representatives and others, certain data may vary with the time period for which it is collected. Therefore, for some uniformity for assessment, the following statistical requirements are specified for the same accounting period as that of the financial information:

MHD 474 B.2.a. The number of inpatient days for the hospital. The inpatient day is a standard measure of hospital utilization that enjoys a wide range of acceptance throughout the health care industry. It is also the fundamental building block of other utilization measures and an important statistic for analytical purposes.

MHD 474 B.2.b. See the definition of "admissions."

MHD 474 B.2.c. The largest expense in the hospital setting is for labor costs. To relate costs to services (Sec. 7, Subd. 1) it is also necessary to assess within and among hospitals the available staffing complements. 2080 hours is based upon a standard forty hour work-week.

MHD 474 B.2.d. See the definition of "beds."

MHD 474 B.2.e. See the definition of "beds."

MHD 474 B.2.f. As ambulatory care is a substantial part of hospital business, the care of ambulatory patients is important to assess because of cost and because treatment of a certain number of ambulatory patients results in confinement of those ambulatory patients as inpatients.

MHD 474 B.2.g. As many patients are admitted to hospitals as emergency admissions, it is important to see the financial and activity impact of the emergency service center upon the hospital as a whole.

MHD 474 B.2.h. As the "system" cannot require uniformity of reporting beyond the obvious categories established earlier in this part, this general section asks for the statistic already commonly compiled by a hospital for its several other service centers as a measure of activity.

MHD 474 B.3.a. The unaudited financial statement is necessary to monitor the consistency of the hospital's estimate of the full current year with that of a portion of the current year that has been actually experienced. Hospitals normally complete balance sheets on a quarterly basis. This information is currently required of hospitals by the rate review program operated by the Minnesota Hospital Association.

MHD 474 B.3.b. See MHD 474 B.1.

MHD 474 B.3.c. The method used to allocate expense from non-revenue centers to revenue centers affects the level of revenue required by each department to meet its expenses. This process also incorporates the allocation of funds from other sources to revenue producing departments (offsets) in order to reduce the amount of revenue required from patients. Without detail of this allocation procedure, the system does not have a complete picture of how finances are used in a hospital setting. This information is necessary if the system is to assure purchasers of services that total costs are reasonably related to total services, that the hospital's aggregate revenues (rates) are reasonably related to the hospital's aggregate costs, and that rates are set equitably.

MHD 474 B.3.d. This statement details the cost components (direct and indirect) that are being assigned to a service center which directly affects the size of the service center's rate.

MHD 474 B.3.e. This statement is necessary for two reasons: to assess the adequacy of the hospital's collection effort; and, to determine each hospital's working capital requirement.

MHD 474 B.3.f. This general statement, recommended by the American Hospital Association and used by the Minnesota Hospital Association in its rate review program, is normally provided by public accounting firms as part of their annual audit of hospitals. The statement is an aid to both rate reviewers and hospital management in assessing the dynamics of a hospital's financial status.

MHD 474 B.4.a. It is necessary to have planning objectives in the management of money in complex financial ventures like hospitals. This type of policy also gives the system some basis to assess how close a hospital comes to meeting its fiscal objectives. The State of Washington also requires such a statement of financial policy and it is suggested in the American Hospital Association's "Statement on Financial Requirements of Health Care Institutions and Services" (approved by the House of Delegates on February 12, 1969).

It is recognized that not all hospitals may have such a policy. This requirement should be taken as encouragement for hospitals to establish pricing policies. Since no criteria for such a policy are defined, it is recognized that such a policy statement could be anything. For the hospital's own benefit, the system would anticipate that such a policy would be a studied document of the hospital's governing authority.

MHD 474 B.4.b. To minimize the other data requirements of these rules, the system shall basically rely on the good faith assurances of a hospital's governing authority that hospital rates are equitable and set without discrimination among insurers. Presumably, the use of investigative power could be used to randomly assess these assurances as time permits.

MHD 474 B.4.c. As new facilities of a hospital may not be fully operational for a number of years after their opening, they may not be able to fully recoup the revenues necessary for thier operation. In instances like this, other existing facilities of a hospital may have to cover such expenses. It is reasonable that the hospital should be able to document when the new facility will be operating at its full capacity and providing as much revenue to meet expenses as it practicably can.

MHD 474. C. Interim Increase Reports. This report is amendatory to the budget year portion of the rate revenue and expense report of the hospital then on file with the system. It is required to meet the requirements of Section 7, Subdivision 5 of the Act.

MHD 474 C.1. This provision clarifies that this report is only required when a hospital exceeds the allowable increase limit (MHD 504).

MHD 474 C.2. This provision is necessary to exempt hospitals operated by the commissioner of public welfare from the requirement to file this report due to increases in "rates" caused by legislative policy appropriations.

MHD 474 C.3. This provision is necessary to clarify that data is required for both the period which has expired prior to the submission of the report (actual minus sixty days which is projected) and the period remaining for the budget year, which shall be projected and reflect the differences caused by an interim rate increase. This provision is necessary in order to assess the differences between the budget year as projected by the filed rate revenue and expense report and the new financial status resulting from an increase in rates.

MHD 474 C.4./MHD 474 C.5. To ensure that the data is in the same form and comparable to that already on file

with the system in the rate revenue and expense report, it is necessary to relate the specific provisions of this report regarding statistical and financial information to those established for the rate revenue and expense report.

MHD 474 C.6. There should be a concise reason why an interim rate increase is necessary. This statement should relate to the pricing policy of the hospital and should help the system in assessing basic reasons for cost increases.

MHD 481. Administrative Procedures. This rule, as part of the Minnesota Hospital Rate Review system, governs the basic administrative handling and processing of the various reports required by rule or by the Act as well as the handling and issuance of comments or other reports by the system.

MHD 481 A.1. In order to enhance the ease with which hospitals can comply with the requirements of these rules and the Act, it is desirable that a general set of forms and instructions be designed by the system. A hospital may choose to submit data in a form which differs in a minor way from that provided by the forms, these forms only serve a guideline function.

MHD 481 A.2. As the Board (when acting as the system) has several district offices it is necessary to administratively establish the main office of the Board as the official office (See MHD 510). It is also necessary to specify how forms may be submitted and filed for purposes of such restrictions as the sixty-day time limit imposed by Section 7, Subdivision 5 of the Act.

MHD 481 A.3. The Board or any voluntary nonprofit rate review organization must by law provide public access to all pertinent records, except those which might be considered "privileged medical information." As no treatment of individual patients is required by these rules, there is no attempt to define "privileged medical information" (see Section 4, Subdivision 4 of the Act).

MHD 481 A.4. Since the actual acceptance of a report constitutes the commencement of such "time clocks" as the sixty-day period established by Section 7, Subdivision 5 of the Act; and, since the system has an obligation to issue a studied comment on such reports so filed; hospitals have the obligation to ensure that reports filed with the system contain accurate and complete information, at least to an extnet permitting the commencement of a legitimate report review (see MHD 487 C.1.).

MHD 481 B. This section of this rule outlines procedures necessary for the filing of the annual financial information report, required by Section 4 of the Act.

MHD 481 B.1. This part of this section indicates that the report is, as the law requires, an annual submission and it is tc be submitted 120 days after the close of a hospital's "full accounting period" (fiscal year). It is unreasonable to expect hospitals to have audited financial information available immediately after the close of a fiscal year. Standard practices of institutions such as hospitals and of their auditing firms is to have this type of fiscal information audited and available within a 120-day period.

An exemption is made herein for the submission of the Medicare Cost Report, required as part of this Act pursuant to Section 4, Subdivision 1, clause (c) of the Act. This exemption recognizes that, due to differing accounting requirements, this cost report must oftentimes be prepared separately from annual financial statements of the hospital. This separate production often causes the cost report to be completed after the 120-day period. Late submissions of this part of the report may be acceptable for a number of reasons:

MHD 481 B.1.a. In no case should the hospital submit this cost report later than the time required by its

designated "Medicare Fiscal Intermediary" (established according to 20 CFR 405.651 et. seq.). In order that the system can consciously monitor this date, the hospital must inform the system of this date when it submits other data.

MHD 481 B.1.b. Technically, the report must be considered to be incomplete without the unaudited cost report in order to guarantee that the cost report is not forgotten at the appropriate future date. This state of "incompleteness" is, contrary to other rules governing other reports, not considered a violation of rules unless the hospital also misses the date required by the Medicare Fiscal Intermediary.

MHD 481 B.1.c. The audited Medicare Cost Report may not appear for two to three years after the fiscal year for which it is required. In order to check the accuracy of the data which the system may have used in its assessments of that hospital's rates on the basis of the unaudited Medicare Cost Report, it is desirable to assess data accuracy when the audited report is available.

MHD 481 B.2. Failure to File. The law provides no enforcement mechanism itself. In the absence of specific sanctions, the Board, as the enforcing agent for hospital rate review in this State has two statutory options--neither of which is particularily practical or effective:

(1) The Board may file a complaint with the appropriate county attorney alleging that the hospital is guilty of a misdemeanor, pursuant to Minnesota Statutes, Chapter 144.49.

(2) Pursuant to Minnesota Statutes, Section 144.55, hospitals must be in compliance at all times with all other State law or they may have their licenses to operate revoked, suspended, or not reissued.

Neither of these penalties is particularly effective. A hospital as a major form of business could readily absorb a $300.00 misdemeanor assessment as they do absorb dues for their large professional organizations (such as the American Hospital Association). Revocation or other action against a hospital is not practically or politically feasible unless a hospital is blatantly acting in a manner which can be demonstrated to be contrary to law or rules. It is unlikely this situation would arise.

MHD 481 C. The rate revenue expense report filing is designed to meet the requirements of the Act relating to the securing of a current rate schedule and the securing, sixty days in advance of any modifications to that rate schedule. It is also designed to meet

the requirement of the Act that the Board (system) may review projected annual revenues and expenses of hospitals and comment upon them. (Section 7, Subd. 2). The result of the structuring of this report is to limit its full submission to once a year.

MHD 481 C.1. This part of this section of this rule clarifies that the rate revenue and expense report is an annual report due sixty days before the commencement of any accounting period of a hospital.

There is a presumption built in to this administrative arrangement. That presumption is that most hospitals raise their rates on the first day of their fiscal year. Such "modification of a current rate schedule" would automatically require the submission of extensive data at this point anyway.

The major advantage of the requirement stated as it is, is that a hospital desiring to alter its rates, say, six months into its new fiscal year can tell the system about that---providing relevant data---at the time it submits a rate revenue and expense report and, thus, avoid the necessity of submitting the amendatory "interim increase report." The design is such that hospitals which are successful fiscal planners should never have to submit an interim increase report.

MHD 481 C.2.a. Failure to File. The system again must state its options for enforcing the filing of this report. The same reservations must be held about the actual utility of these present enforcement mechanisms as those expressed in the justification for MHD 481 B.2.

MHD 481 C.2.b. As the rate revenue and expense report is the only one for which the Board may charge a fee (Section 7, Subd. 6), and since the fee is to reflect the complexity of a review, it is reasonable to assume that a late filing, which requires a more expeditious yet accurate review is significantly more complex to justify a moderate "late fee."

MHD 481 C.2.c. This provision is necessary to clarify that a submitted report which is not complete does not constitute a filed report; and, for the sixty-day "time clock" to commence, the report must be submitted and filed. The prohibition against modification of rates without submitting the report also helps establish adequate grounds for the sanctioning of hospitals which purposefully violate these rules and the Act.

MHD 481 D. This section of this rule establishes procedures for the filing of the third type of report required of hospitals. As has been explained earlier, a hospital which successfully plans its budget year should never have to submit this report. In any case, this report is designed as an amendatory report to the "budget year" portion of the rate revenue and expense report then on file with the system.

MHD 481 D.1. This part of this section again conforms to the requirement of Section 7, Subd. 5 of the Act which states that amendments or modifications to current rate schedules must be filed with the system sixty days in advance of their effective date. There are several conditions on this filing:

MHD 481 D.1.a. The law states that "increases which have a minimal impact on hospital costs" may be exempt from this sixty-day requirement. This provision allows hospitals to increase their rates at will within certain limits, established by MHD 504 as the "allowable increase limits." But, it is expected that the hospital will notify the "system" by letter of <u>any</u> changes in rates.

MHD 481 D.1.b. Again, if significant (e.g.,over allowable increase limits) rate increases were not anticipated in the annual rate revenue and expense report, a hospital must submit this report.

MHD 481 D.1.c. It is the intention of the system to limit such increases to once, quarterly if at all possible. Recognizing the effect of unanticipated rises in inflation, labor costs, and the like, this provision may, on occasion have to be waived as provided by MHD 481 D.1.e.

MHD 481 D.1.d. This provision would allow the system

to refuse a filing, thus prohibiting a raising of rates, if a hospital owes the system any reports, fees or other documents or information.

MHD 481 D.1.e. Given that certain events, social or economic, may justify the waiver of certain of these restrictions on mid-year filings, the hospital may seek to justify such filings by showing the social or economic cause for such an increase. The onus of proof is on the hospital. Given that considerable latitude is provided for increase statements in the rate revenue and expense report and quarterly during the budget year, there is little reason,other than emergency from natural disaster, why hospitals should have to seek more frequent rate increases.

MHD 481 D.2. Failure to File.

MHD 481 D.2.a. See the statement for failure to file provisions in the justification for MHD 481 B.2.

MHD 481 D.2.b. A hospital which has not submitted an interim increase report or has not included the details of an increase during the budget year in its last rate revenue and expense report has not filed amendments or modifications of its current rate schedule with the Board pursuant to Section 7, Subd. 5, and, therefore cannot increase its rates until it has so filed.

MHD 481 D.2.c. This provision allows investigations of increases in hospital rates during a budget year which were not acknowledged in the last rate revenue and expense report and were not acknowledged by a filing of an interim increase report which, by the prescribed standards was required.

This provision allows the system to suspend the applicability of the "allowable increase limit" for that violating hospital for the next subsequent two full accounting periods in order that the system may completely monitor any and all increases and effects of increases over that period of time.

MHD 481 D.2.d. This provision recognizes a natural difference between projections and actual budget year history in assessing compliance with the allowable increase limit.

The reasonable amount of variation is established liberally at 1.1 times the allowable increase limit. In our consultations, this amount was felt to be very adequate a safeguard.

MHD 481 D.3. Allowable Increase Limits: Hospital Calculation. This part of this section spells out the administrative procedure whereby a hospital calculates what its allowable increase limit is for a particular budget year.

This quarterly method is necessary since many hospitals have differing fiscal years and the absence of an ability of the system to compel conformity to a uniform accounting period requires the system to provide for an equitable formulary determination.

The allowable increase limit is a single percentage figure applicable to any increase in rates of a hospital in the budget year over the current year.

MHD 481 D.3.a. The Board prospectively establishes allowable increase percentages for each quarter of its fiscal years for a minimum of six quarters in advance of the present quarter (see MHD 504).

The hospital selects the four quarterly allowable increase percentages appropriately corresponding to its budget year as recorded in the rate revenue and expense report then on file with the system.

This aggregation provides the hospital with a specific percentage amount which the system expects may be necessary for increases during the budget year for that hospital.

MHD 481 D.3.b. This subtraction calculation provides the hospital with a residual percentage, if any, by which rates can be increased during the budget year without the necessity of filing an interim increase report with the system.

MHD 481 D.3.c. This provision simply interprets the outcome of the subtraction calculation above and requires that the next report of rate revenue and expense incorporate details of these increases.

For example:

Hospital A -

Increases rates 5% for the budget year in the rate revenue and expense report; calculates its allowable increase limit as (2% + 2% + 1% + 2%) or 7%; subtracts 5% from 7% leaving 2%. Hospital A may then increase its rates a further two percent at any point during the budget year without filing an interim increase report.

Hospital B -

Increases rates 8% for the budget year in its rate revenue and expense report; calculates its allowable increase limit as (2% + 1% + 3% + 1%) or 7%; subtracts 8% from 7% leaving -1%. Hospital B must then always file an interim increase report if it increases rates during the budget year since it began the budget year in excess of the allowable increase limit.

MHD 481 E. This provision is designed to keep the system aware of any new innovations regarding accounting, cost control, rate determination or payment (see Section 7, Subd. 3) which may affect the way the system assesses the rates of a hospital.

The sixty-day limit is designed here to provide ample time for the system to convert data on a particular hospital to correspond to these new methods and to guarantee the hospital against misjudgments by the system.

MHD 481 F. Filing of Reports: Multi-Hospital Corporations and Other Organizations Operating More Than One Hospital. This allows multi-hospital organizations to act as reporting organizations to the system on behalf of the hospital but in any event, also requires a statement detailing the financial relationship between hospitals and the organizations.

The reason this provision is included is to guard against patients from one hospital of an organization subsidizing patients in another hospital owned or operated by the same organization. This impinges upon the requirement that hospital rates must be set equitably (see Section 7, Subd. 1).

MHD 481 G. Filing of Reports: Extensions. This section of this rule recognizes that conditions may exist from time to time which may legitimately prevent a hospital from meeting certain filing time requirements. The extension cannot,however, be indefinite.

MHD 487. As indicated in Section 7, Subd. 1 of the Act, the assurance of reasonableness of rates is a primary goal of the rate review procedure authorized by the Act. In order to make assessments of reasonableness of rates in a manner which will be consistent over time and across a number of hospitals, it is necessary to establish basic criteria concerning reasonableness and the procedure employed to assess reasonableness. This rule establishes these broad, and somewhat flexible standards. The breadth and flexibility of some of these standards is important since the concept of hospital rate review is relatively new and is still in an experimental state--based upon the assumed successes of the Economic Stabilization Program. As a new concept, there are no hard and fast rules guaranteeing its success or failure in any particular area. It is necessary to prevent the strict establishment of some standards on the basis that new knowledge in the near future might render strict construction of certain standards dysfunctional with regard to judgments of reasonableness.

MHD 487 A. Bases for Judging the Reasonable Use of Finances in a Hospital. Assessments of the reasonableness of rates must be based on the reasonable use of finances in a hospital. Without some knowledge of the financial position and use of monies by a hospital, the rate, as we have defined it, tells us nothing useful or comparable. The

use of finances in hospital settings has been studied extensively over the years to such a degree that certain uniform uses of hospital money have been identified. The standards employed here reflect those basic categories of standards already recognized by hospitals and by third-party payors as the major categories of financial transactions in hospital settings. Examples of the great similarity of these standards with other standards can be found in:

(a) The Medicare Regulations, subpart D (see 20 CFR 504.401 et. seq.)

(b) The Chart of Accounts for Hospitals (Chicago: The American Hospital Association, 1976)

(c) The Hospital Audit Guide (New York, American Institute of Certified Public Accountants, 1974)

(d) The Financial Requirements of Hospitals as stated in the guidelines of the Minnesota Hospital Rate Review Program currently operated by the Minnesota Hospital Association

(e) The financial requirements of hospital rate review programs in other states (see: Financial and Legal Manual for Hospital Administrators (Maryland: Health Services Cost Review Commission, 1975), and Sattler

and Burns, Abstracts of State Rate Review and Prospective Payment Legislation, (Inter-Study, May, 1976).

(f) Also, see: Lerner and William, Rate Setting (Maryland: Aspen Systems Corporation, 1974).

It is from these guides that the standards for the system were derived. These guides represent guides with which hospitals are generally familiar.

Finally, as the clear intent of the legislature was to establish a system of hospital financial disclosure (rate review) as opposed to a system of financial control (rate setting), these standards were designed to reflect current financial practices of hospitals--not necessarily a code of "desirable" financial practices of hospitals. In an effort to recognize what does exist in the hospital setting (regardless of what some will contend should exist) these standards are designed to provide categories of financial transactions actually used by hospitals. For instance, theoretically many will agree that charity care provided by hospitals should not be paid for by paying patients without their knowledge (as with bad debts) but should be treated as an overall reduction in revenue to meet classical interpretations of the word "charity." On the other hand, hospitals do pass on charity care charges to other patients. To not recognize this occurrance or to deem it "illegal" might force hospitals to conceal this information--thus defeating one of the purposes of the system--disclosure.

MHD 487 A.1. Financial Requirements of Hospitals. Expenses of hospitals can be categorized with some degree of uniformity. The purpose of this section of this rule is to establish the basis for reasonableness of expenses (and therefore, the reasonableness of rates) for each of the broad area of expenses. In addressing each category, it must be remembered that the lack of uniform accounting/reporting provisions and the absence of conformance enforcing provisions require that some degree of latitude be assured in each category and the pertaining assessment of reasonableness.

MHD 487 A.1.a. The purpose of this provision is to identify one major type of expenditure categories in hospitals--that of current operating needs.

MHD 487 A.1.a.(1). Direct Patient Care. The purpose of this provision is to recognize that the financial needs arising out of providing patient care services account for the major portion of the dollar volume necessary for the operation of health care institutions. (See American Hospital Association statement on Financial Requirements.)

MHD 487 A.1.a.(1)(a). See above.

MHD 487 A.1.a.(1)(b). This provision recognizes that the amount included as representing the value of the services of members of religious orders or other voluntary groups should be equivalent to the amounts paid to employees for

similar work and should be identifiable in the records of the institution. This amount is constrained by:

MHD 487 A.1.a.(1)(b)(i). See above.

MHD 487 A.1.a.(1)(b)(ii). The amount included in rates should not exceed that actually paid to the group by the hospital. Without this rule, it may be possible for hospitals to recoup more through rates than actually pid out for services. This would occur when the amount is set equal to standard employee pay rates, without regard to cash payments to an organization.

MHD 487 A.1.a.(1)(b)(iii). This provision recognizes that, under certain circumstances, the cash payments to such groups should reflect a deduction for room and board expenses, if provided to members of the religious order or similar organization. Therefore, room rates would include financial requirements for such an offset expense.

MHD 487 A.1.a.(2) Interest Expense. Financial needs of hospitals include payment of interest charges at a reasonable rate arising from the use of necessary funds borrowed from external sources for operating and plant capital needs.

MHD 487 A.1.a.(2)(a). See above.

MHD 487 A.1.a.(2)(b). This provision recognizes that funds borrowed for operating capital is usually for the short-term and the interest amount will be different than for long-term encumberances. The hospital should, then, distinguish short-term loan interest from longer term responsibilities in its records. This is consistent with Medicare requirements (20 CFR 405.419).

MHD 487 A.1.a.(2)(c). This provision distinguishes long-term loan interest; see above.

MHD 487 A.1.a.(2)(d). As the standards for interest rely on a criterion of necessity, it is necessary to define standards for need. These standards conform to those required by Medicare 20 CFR 405.419.

MHD 487 A.1.a.(2)(d)(i). This provision conforms to 20 CFR 405.419 (b)(2)(i) [Medicare]. The Medicare standard if generally accepted by hospitals for that class of patients and we consider this provision reasonable for all other classes of patients.

MHD 487 A.1.a.(2)(d)(i). This provision conforms to 20 CFR 405.419 (b)(2)(i) [Medicare].

MHD 487 A.1.a.(2)(d)(ii). This provision conforms to 20 CFR 405.419 (b)(2)(ii) and provides a method whereby limits can, for assessment purposes, be imposed on "reasonably related to patient care."

MHD 487 A.1.a.(2)(e). This provision conforms to the interpretation of the word proper to the Medicare interpretation [20 CFR 405.419 (b)(3)] and, makes use of the "prudent borrower" concept (term of the art) as a threshold for reasonableness.

MHD 487 A.1.a.(3). Educational Program Expenses. This provision recognizes that hospitals are a major source of education for health professionals and for the general public. Costs of providing educational activities should be born by patients within certain limits. This provision indicates that hospitals must distinguish and justify in their reports the costs of any pertinent educational activities.

MHD 487 A.1.a.(3)(a). See above; this provision is necessary to set limits upon allowable amounts (for assessment purposes) attributable to educational activities.

MHD 487 A.1.a.(3)(a)(i). This provision seeks to limit educational expenses to those which are "approved" and which contributed to the care of present patients. As it is arguable that all training contributes to the care of patients at some time, it is important to recognize that it is inequitable to permit present patients to pay educational activities directly related to their care as well as the care of future patients.

MHD 487 A.1.a.(3)(a)(ii). This provision recognizes that it is current policy of certain planning groups to encourage the hospital to be more active in performing a community preventive health education role. It also indicates that these types of expenses should, as with other expense categories, be distinguished in the records of the institution.

MHD 487 A.1.a.(3)(b). This definition of "approved educational activities" is the one used by Medicare [20 CFR 405.421 et. seq.]; and, since hospitals are familiar with this definition and the related chart of programs and approving bodies, it is reasonable to use that basis here.

MHD 487 A.1.a.(3)(c). This definition is the one employed by Medicare [20 CFR 405.421 (b)(2)] and recognizes that students or participants have an obligation to pay tuition for their training.

MHD 487 A.1.a.(3)(d). As with Medicare [20 CFR 405.421 (d)] these are recognized normal costs which may be included in rates and should be distinguished in the records accordingly.

MHD 487 A.1.a.(3)(e). This provision recognizes that the planning agencies should establish standards for what is expected of hospitals in performing their community preventive education role. This provision also recognizes a professional responsibility of health professionals to provide educational services as a part of their duties in relation to a hospital without necessarily expecting excess remuneration over salary.

MHD 487 A.1.a.(4). Research Program Expenses. Medical research is a vital element in improving the quality of medical care. But, unless a hospital can demonstrate benefits to present patients commensurate with the costs of research, those costs in excess of such benefits should not be included in rates. Generally speaking, research should be supported by non-patient funds, including funds from educational institutions, grants, foundations, etc.

MHD 487 A.1.a.(5). Bad Debts, Charity Allowances, Courtesy Discount Allowances, and Contractual Allowance Expenses. This provision identifies and defines four major sources of losses experienced in the conduct of normal hospital provisions and defines how the system will determine acceptability of financial practice with regard to each of these.

MHD 487 A.1.a.(5)(a). See above.

MHD 487 A.1.a.(5)(a)(i). Bad Debts. The first part of this provision is the definition of bad debts employed by 20 CFR 405.420 (b)(1), Medicare.

The rest of the provision is intended to ensure that hospitals do not simply reclassify charity care expenses as bad debts, and that hospitals should maintain records reflecting expenses in each of the other categories which are not, by the definition, bad debts.

MHD 487 A.1.a.(5)(a)(ii). Charity Care. Often times hospital services must be provided to individuals who do not have the means to pay for them. For example, hospitals must treat emergency patients irrespective of their ability to pay.

The State pays for services to the indigent. Those patients who do not qualify for State assistance are generally assumed to have the means to pay for services. Nevertheless, some of the people not covered by State aid programs will incur charges for necessary services in excess of their own ability to pay.

Traditionally, benevolent individuals have donated monies so as to keep hospitals solvent. The primary reason that donations were required by hospitals was to offset the cost of charity care. Thus, ample monies should be available from non-patient sources to sponsor charity care (not bad debt care).

The cost of those who cannot pay for their hospital care should not be borne by the remaining population by means of the amount they pay for hospital care or health insurance. General tax revenues are a more equitable payment source for this care. But hospitals do not have taxing power and if all paying patients paid only for the cost of their own care, most hospitals would quickly become insolvent.

Expenses, formerly considered charity care, which are passed on to paying patients or their insurers should, in the future, be considered bad debt expenses. There must be recognition for "free care" ("Charity") allowances by hospitals with Hill-Burton obligations, but in no other instance should charity care expenses be paid for by patients in hospitals.

MHD 487 A.1.a.(5)(a)(iii). This provision recognizes that certain governmental programs and third-party payors do not pay (reimburse) expenses at the fully established rate. The system (Board) is charged explicitly by law with "prohibiting hospitals from discriminating among insurers in rates" (see Section 7, Subd. 1 of the Act).

According to the definition of insurers, governmental programs (such as Medicare and Medicaid) and Health Maintenance Organizations (H.M.O.s) are exempt from this prohibition. This provision will, however, provide for the disclosure

of data regarding the amount of "discount" or "differential from established rates" granted to governmental programs and H.M.O.s as well as other insurers.

For guidance in the construction of this provision, an informal opinion was sought from the Attorney General's office regarding the interpretation of the term "discrimination" and the application of this provision to insurers. The full context of this opinion follows:

> Hospital Rate Discrimination
>
> You have inquired as to the legality of a proposed hospital rate review rule which prohibits hospitals from discriminating among insurers in its rates. The question you pose relates to a provision in the proposed rule which permits cost-justified differentials in rates charged to various insurers. As you point out, Minn. Laws 1976, ch. 296, Art. II, §7 subd. 1 imposes a flat prohibition against hospitals from discriminating in rates charged to insurers. I believe that the Board may properly interpret this statute as permitting rate differentials which are demonstrated to be cost-justified.
>
> There are frequent instances in both state and federal statutes in which government prohibits a seller from engaging in price discrimination among buyers. For example, Minn. Stat. §325.03 (1974) prohibits sellers from discriminating among purchasers in different sections of the state if the intent of the discrimination is to injure a competitor or destroy competition. That statute, however, does permit price differentials based upon grade, quality or quantity of the product after equalizing freight rates. Likewise, the Robinson-Patman Act, a federal unfair trade practices statute, provides an example of government permitting various types of cost-justified price differentials while nevertheless prohibiting price discrimination generally. That statute

has been interpreted, for example, to prohibit quantity discounts unless, like other price differentials, they make no more than due allowance for cost differences in sales to different buyers. Further, the full amount of a particular discount must be based upon the costs savings to the seller of the particular sale. See generally, 54 Am Jur. 2d, §§153-159.

In view of the above, it is reasonable to interpret a price discrimination statute as permitting cost-justified price differentials so long as the wording of the statute does not prohibit such an interpretation. There appears to be nothing in Minn. Laws 1976, ch. 296, Art. II, §7, subd. 1 which indicates a legislative intent to prohibit such differentials. I do, however, have one concern regarding the proposed rule. If possible, I believe it should be made more specific by listing the areas in which a hospital may be permitted to show a cost benefit in justifying a rate differential. Such a listing could be of value in insuring that hospitals examine identical areas of potential cost savings in determining any price differential to be applied to insurers.

MHD 487 A.1.a.(5)(a)(iii)(aa). See above; provides for the disclosure of discounts granted to governmental programs.

MHD 487 A.1.a.(5)(a)(iii)(bb). See above; see Attorney General's informal opinion. In addition to defining "cost-justified discounts or differentials" according to the informal opinion of the Attorney General, this provision specifies the types of discounts which are permissible (cash, trade, quantity) and consistent with the provisions of the Robinson-Patman Act from which this provision takes its lead.

MHD 487 A.1.a.(5)(a)(iii)(cc). This provision clarifies that it is not reasonable for discounts or differentials which are not cost-justified according to aforementioned criteria to be included in rates. Although there is no legal prohibition against offering discounts to payors who

are not defined as insurers (see Section 7, Subd. 1 of the Act), e.g., H.M.O.s, if the discounts are not cost-justified, the value of those discounts could not be included in rates.

487 A.1.a.(5)(b). This general offset provision states that losses in the categories just discussed should be offset by available other monies of non-patient origin before any amount of these losses is includable in rates. Since Medicare will, however, pay only the lower of cost or charges, there is a guarantee provided so that hospitals will always recoup enough to cover basic expenses from Medicare.

MHD 487 A.1.b. Plant Capital Needs. These provisions recognize the need for hospitals to generate funds to currently purchase and replace capital items, prescribes a method of accounting for the funds, the use the funds can be put to, and the method of determining the magnitude of the hospital's plant capital needs. These monies must be funded to ensure that they are used for the purposes for which they are being provided.

MHD 487 A.1.b.(1)(a)(i) and (ii). Monies that are to be used to meet plant capital needs shall be placed in funds so that they can be accounted for and the need shall be based upon the hospital's annual adjusted requirement to meet debt repayment or the annual straight-line depreciation expense. The adjustment to the debt principal need is made to equalize the burden to patients over the life of the debt instrument.

The fund increment will be the greater of the depreciation or adjusted principal payment in recognition of the fact that the debt instrument may have a shorter life than the asset and produce a demand for cash that cannot be met by depreciation over the life of the debt instrument.

MHD 487 A.1.b.(1)(b)(i) and (ii). Inflation factors are provided (one for building and building equipment and one for moveable equipment) to recognize the impact of inflation upon capital assets and the ability of hospitals to purchase new assets or replace existing assets without incurring

overly large amounts of debt. There is a serious public policy question associated with the health care delivery system's use of large amounts of borrowed funds (see Sattler, "A Rational Look at the Hospital and Debt Financing," Hospital Topics (Jan/Feb. 1975, Vol. 53, #1) and Dowling, William L., Ph.D., "Technical Aspects of Prospective Rate Setting," Hospital Prospective Payment: Issues and Experiences, ed. Sattler (InterStudy, June, 1976). At this time, the State of Minnesota has not come to grips with the issue and, therefore, the "system" will not persume that it was legislative intent to have hospitals incur large annual debt service obligations as a result of these rules without undertaking a thorough analysis of the implications of such an action for the cost of hospital care and the viability of the hospital industry in the State.

MHD 487 A.1.b.(2). The full inflation factor shall be applicable to only those facilities that are deemed to be free of excess capacity. There is no need to provide for full replacement of a facility that has full capacity.

MHD 487 A.1.b.(3). The "system" has no responsibility to provide for current or future capital needs that result from a hospital's action prior to establishment of the system (e.g., prior underfunding of the depreciation fund).

MHD 487 A.1.b.(4). In as much as the "system" recognizes debt service obligations, depreciation and inflation, it is not reasonable for the "system" to allow hospitals to accumulate interest earned on the capital fund which may allow hospitals to accumulate substantially more funds than they may require. There is general concern with the high cost of hospital care. At the same time the "system" is concerned with the level of debt the hospitals of the state must assume, it is also concerned with the level of hospital charges patients must bear. It is, therefore, appropriate that all interest income on funded depreciation should be an offset to the inflation factor adjustment and/or the adjusted annual debt principal payment requirement.

MHD 487 A.1.b.(5). This provision is in recognition that Health Systems Agencies and the State Health Planning and Development Agency may require hospitals to expand funds that they don't currently have in order to come into conformance with the state and area-wide health plan (as prescribed by P.L. 93-641), and can obtain needed funds from the following prioritized sources:

MHD 487 A.1.b.(5)(a). Sources other than charge paying patients (e.g., grants, gifts, funded capital).

MHD 487 A.1.b.(5)(b). Borrowed funds or leases will spread the financial burden to patients over the life of the debt instrument or lease and provide an equitable financing vehicle.

MHD 487 A.1.b.(5)(c). If it is in the patient's best financial interest, patient charges may be increased to meet the

hospital's capital need, but assets purchased from funds raised via charges may not be included in future plant capital requirements.

MHD 487 A.1.b.(6). This provision allows the "system" to accommodate a hospital that requests a rate increase on emergency, such as roof repair or replacement, may do so.

MHD 487 A.1.b.(7). This provision allows the hospital and the "system" to at all times and under any circumstances act in the patients best financial interests.

MHD 487 A.1.c. Incremental Operating Cash Needs. Oftentimes hospital patients, or the third party payors who represent them, do not pay bills promptly. This payment lag may be measured by the number of day's charges in accounts receivable. In theory, if each patient paid for his services as he received them, i.e., if there were no investment required by the hospital, the hospital would have little need for working capital. Thus, it is logical to assess working capital requirements on the basis of the number of day's charges in receivables stated by class of purchaser.

Comparing days in receivables among various hospitals is also a good indicator of hospitals' collecting processes.

MHD 487 A.1.c.(1). Establishes, for assessment purposes, the amount of working capital available as recorded in the first report of annual financial information.

MHD 487 A.1.c.(2). This re-states, for clarity, how a hospital shall compute its working capital requirement.

MHD 487 A.1.c.(2)(a). This permissive language suggests to hospitals payor categories of accounts receivable which may be useful in assessing which classes of third party payors are most troublesome to the maintenance of a hospital's sound fiscal condition.

MHD 487 A.1.c.(2)(b). This provision establishes a standard formula for the determination of number of days charges in accounts receivable.

MHD 487 A.1.c.(3). This provision clarifies that hospitals cannot include in accounts receivables amounts which they have no expectation of collecting by contract and amounts held in reserve to cover uncollectibles.

MHD 487 A.1.c.(3)(a). An increase in days charges is evidence that patients or payors are paying bills more slowly thus causing a greater need for working capital.

MHD 487 A.1.c.(3)(b). This provision recognizes that payors who accelerate their reimbursement also cause a reduction in the amount of required working capital. This also implies a specific ground upon which payors could claim a cost-justified discount or differential.

MHD 487 A.1.c.(4). Although a necessary part of the formula determining the working capital allowance, there is no established reason why the amount of money in inventories should drastically change unless the hospital is experiencing significant and documented changes due to inflation or alterations in scope or volume of services offered.

MHD 487 A.1.c.(5). This provision is necessary to clarify that all other items included as "net payables" cannot include debts to third party payors--since these debts mean the hospital has that money on hand--and the current portion of plant capital expenditure, since this is recovered under provisions relating to the plant capital fund.

MHD 487 A.1.c.(6). This provision establishes the basic factors which may be considered in determining the reasonableness of the working capital allowance.

MHD 487 A.1.c.(6)(a). This establishes the legitimacy of comparing days in accounts receivable among different hospitals which are alike. It is reasonable that hospitals with similar size, geographic location and types of services should be compared for similarity of accounts receivable and that the system should be able to consider the reasonableness of working capital allowances based upon accounts receivable.

MHD 487 A.1.c.(6)(b). The size of the bad debts incurred by a hospital--as a result of geographic location, collection factors, etc.,--may be an indicator of the need for a sizeable working capital allowance which might otherwise appear inordinately large.

MHD 487 A.1.c.(6)(c). This provision recognizes that it is not in the interest of the hospital or its patients, to maintain large working capital allowances and large reserves simultaneously. This provision also establishes a basis for the disclosure of the size of hospital reserve funds.

MHD 487 A.2. This provision recognizes that hospitals have income for financing their operations from sources other than patients. For purposes of disclosure and assessments, these monies should generally be used as offsets to what would otherwise be the expense-demands upon patients or their insurers as delineated in MHD 487 A.1.

MHD 487 A.2.a. Certain funds a hospital receives are restricted or otherwise directed to specific purposes (see definition of restricted funds, MHD 472 V.).

MHD 487 A.2.a.(1) and (2). These provisions simply restate that restricted monies should be used for the purpose restricted and should be applied as offsets to appropriate financial requirements.

MHD 487 A.2.a.(3). This provision recognizes that it may not always be fiscally "prudent" to expend restricted monies as opposed to borrowing and financing. In cases like this, the system must be shown how this practice is more prudent if the system is to consider such incurrance of new debt as reasonable.

MHD 487 A.2.a.(4). This provision brings the assessment of reasonableness with regard to the use of plant capital funds in conformance with state health planning standards regarding certificate of need. It is reasonable that possession of a certificate of need for a facility be a pre-requisite to a judgment of reasonable use of money for plant capital projects.

MHD 487 A.2.a.(5). This applies to charity care requirements (due to Hill-Burton obligations) and requires that patients, again, pay a minimum of charity expenses, after the reduction of these expenses by any available and budgeted amounts from benefactors and donors.

In the case of limited funds, the word "budgeted" is included to prevent hospitals from exhausting all charity gift donations in one accounting period.

MHD 487 A.2.a.(6). This is a restatement of the policy regarding the reasonable use of monies for research (see MHD 487 A.1 a.(4)).

MHD 487 A.2.b. Unrestricted funds from non-patient sources. This provision clarifies that all unrestricted monies should be used to offset all financial requirements of a hospital. See definition of "unrestricted funds," MHD 472B.

MHD 487 A.2.c. Auxiliary Enterprises. Roughly speaking, an auxiliary enterprise is a businesslike activity not directly related to patient care. A precise definition is set forth in MHD 472 D. Since these enterprises generally do not directly benefit patients then in hospitals, any costs associated with their operation should not be born by patients and any profits should accrue to the patient's financial

benefit. This should encourage the hospital to concentrate on its primary business--patient care.

MHD 487 A.2.d. Special Projects Income. This provision notes that special projects income and expense should be recorded distinctly and separately. Any excess income caused by the project should, however, be used to offset financial requirements. An example of such an income generating special project might be a tuition-based community preventive health education program.

MHD 487 A.2.e. This general provision, applicable to provisions for offsets in rates for all income from non-patient sources, is designed, again, to prevent the situation from arising as under Medicare where only the lower of costs or charges is paid. It is a guarantee to hospitals that they will always be able to recover their minimum of expenses and will not have to carry forward any continuing loss due to inadequate reimbursement.

MHD 487 A.3.(a)and (b). Variations from budgeted volumes of activity and services. A hospital's actual volume of service may vary from budgeted volumes for a wide variety of reasons. Usually one associates such variations with increases or decreases in the population of the hospital's service area, a shift in the population so that the percentage of elderly persons changes substantially, changes in the number or composition of the medical staff, or the provision of new services. Other less commonly discussed reasons relate to unnecessary or marginal services, as well as the termination of facilities with excess capacity. For instance, a hospital's pediatric; or social service volume may decrease because an under utilized maternity service was terminated.

The purpose of this provision is to allow for equitable rate adjustment for losses resulting from unrealized budget activity. Consistency then requires that hospitals not be rewarded for exceeding projected volumes.

A word of caution about this provision. Since methods of assessing variations as these are not particularly well developed, the system cannot explicate a more precise rule. It is likely to be several years before a pertinent review system regarding this issue is developed. It is, nevertheless, essential for the system and hospitals to be cognizant of the need to adjust rates to reflect variations from budgeted volumes of activity and source. This current broad provision serves that purpose.

It is widely acknowledged that techniques for volume forecasting lack sophistication and accuracy. In addition, it is recognized that many of the factors influencing volume forecasts cannot be identified or controlled by the hospital. It is therefore expected that actual volumes will vary from the budget forecasts, and a mechanism is necessary whereby the individual hospital can make adjustments in its rate structure to remain within the guidelines established by the "system".

Guidelines for dealing with volume variance must be derived from the year-end data. Since rates prospectively have been established based on volume forecasts by each hospital and the aggregate revenue requirements necessary to provide this volume of services, variance from the forecast may result either in revenue deficits or revenue excesses. Review criteria must allow for increases in overall revenues to reflect the cost associated with increased volumes, and conversely must require reductions in overall revenues when actual volumes are below forecast. The "system's" basic policy is that a hospital should neither be rewarded or penalized for variance in volume above or below forecasts. the "system's" intent, therefore, is to allow sufficient additional revenues to meet the cost associated with volume increases above forecasts, but to require reduction in overall revenues when volumes fail to meet expectations.

Clearly, volume increases above forecast will not incur additional expenses at the same level as costs related to the initial volume expectation. This is the result of all "fixed" costs being included in the total costs estimated at the initial forecase volume. Therefore, additional costs related to volumes above forecast will only reflect those "variable" costs related to the volume increases. Examples of these "fixed" costs include such factors as interest, depreciation, insurance, allocated costs appropriate to a specific revenue center, and staffing and supply costs necessary to maintain minimal services within the revenue center. The "variable" costs which may increase with increases in volume will include certain additional staffing requirements, increases in supply costs, increases in allocated costs such as administration, financial management, accounting, dietary, and housekeeping.

Since the "system" intends to recognize increased costs related to increased volumes, it is then necessary to identify the fixed to variable costs for a given hospital in order to identify the additional revenues appropriate to meet the increased costs due to volume changes.

Empirical studies in the identification of fixed to variable costs is extremely limited in the hospital field. One study by Paul Feldstein found that variable costs range from 21% to 27% of total costs. Studies by Lave and Lave carried out in seventy-four hospitals in western Pennsylvania identified variable costs of 40% to 65% of total costs. Martin Feldstein also published results of studies in which he identified variable costs at 21%. M. Feldstein also identified different fixed to variable cost ratios for a number of services within a hospital. The Federal Cost of Living Council, under Phase IV regulations, adopted a fixed to variable cost ratio of 60/40, with a "range of no adjustment" as a result of volume variance.

The "system" supports the general conclusion that fixed costs are consistently higher in the smaller, less complex institutions than in larger institutions providing a groader mix of more complex services. These observations are consistent with the findings of Lave and Lave and Martin Feldstein, and with the conclusions reached by the Federal Cost of Living Council in developing the Phase IV volume variance criteria.

The system will initially apply fixed to variable cost ratios varying from 80%/20% to 60%/40% to hospitals as they increase in size and complexity of services. Each institution's fixed to variable cost ratio will obviously vary according to the age of the plant, the amount of fixed long-term debt, repayment schedules, and interest as well as the level of utilization of the services provided and the level of productivity attained within each cost center within the hospital.

In recognition of these factors, the "system" proposes three alternative procedures for identifying the costs related to increased volume or reduction in expenses anticipated resulting from decreases in volume as compared to original budget forecast.

Alternative 1

Based on its observations and the limited research available, the Commission has established different fixed to variable expense ratios for different peer groups of hospitals.

The fixed to variable expense ratio will be applied to total patient admissions adjusted for outpatient activity, with the adjustment based on the ratio of outpatient revenues to inpatient revenues.

Alternative 2

If an individual hospital identifies that its fixed to variable expense ratio differs significantly in aggregate total from that established by the "system", that hospital may submit supporting data to the "system" requesting a fixed to variable ratio different than that adopted for its peer group. In such cases, the "system" may approve a fixed to variable expense ratio other than that established under Alternative 1. Under this alternative, the fixed to variable ratio would represent an aggregate average hospital-wide experience and would be applied to adjusted patient admissions, with the adjustment based on the ratio of outpatient revenues to inpatient revenues.

Revenue and rate adjustment based on volume variance within the provisions of Alternatives 1 and 2 can be made on aggregate average annual rates per adjusted patient admissions. These rates, based on total approved budget, are identified at the time of the budget review.

Alternative 3

If a given hospital has identified that its operating expenses by revenue center depart drastically from the fixed to variable expense ratio at the aggregate level, such a hospital may submit supporting data to the "system" establishing a different fixed to variable expense ratio for each revenue center. In such instances, the volume variances would be measured according to the unit of service established for each revenue center, and the expense adjustment allowance would be based on the ratio of fixed to variable expenses for each revenue center, rather than on the aggregate overall average expenses per adjusted patient day and per adjusted admission.

While much more complex, Alternative 3 provides each hospital the opportunity to identify the ratio of fixed to variable expenses explicitly related to each revenue center.

Alternative 3, the application of a fixed to variable expense ratio by revenue center requires a different treatment of variance and revenue adjustment than under Alternatives 1 and 2. It is necessary under this option to identify volume variance for each revenue center, apply the fixed to variable expense ratio to the volume variance, and compute the appropriate adjusted rate and revenue allowance based on the adjusted volumes. The total of these adjustments, both negative and positive in nature, will in total identify the aggregate adjustments appropriate to reflect the volume differences experienced by a hospital.

MHD 487 A.4. Excess Capacity. Excess capacity in hospital facilities is often pinpointed as a reason for excessive hospital costs. Nonetheless, there is no single criteria applicable for its standard determination. Criteria must be considered in such an assessment as the size and varieties of service in an institution and the proximity of the hospital to other institutions. These types of criteria also reinforce the need to assess the bed component size of hospitals on the basis of grouping of hospitals (e.g. comparring like with like).

MHD 487 A.4.a. Due to the sensitivity of this issue, its potential impact on judgments regarding the reasonableness of plant capital allowances, and its interface with health planning issues, it is reasonable that a preliminary determination of excess capacity be forwarded to appropriate health planning agencies, designated according to the new Federal Health Planning Act (P.L. 93-641) for study. If these agencies agree that the funding of excess capacity is compatible with their established standards of appropriateness (pursuant to P.L. 93-641, Section 1513 (g).

MHD 487 A.4.b. This provision states that only on receipt of an affirmative comment from planning agencies that excess capacity exists will the system make a determination of excess capacity. This determination must be quantitative and state its bases in order to provide the hospital with data regarding the judgment.

MHD 487 A.4.c. This provision is necessary to specify how the finding of excess capacity should affect the system's assessment of the size of the hospital's plant capital fund.

MHD 487 B. Investigations. The Board, and thus the system, has permissive authority to investigate hospital rates pursuant to Section 4, Subdivision 5 of the Act, pursuant to Section 5 of the Act (continuing analysis) and, pursuant to Section 7 of the Act.

MHD 487 B.1. It is reasonable to assume that investigations may not exactly parallel the requirements of either the rate revenue and expense or interim increase reports and, even if a parallel situation existed, it is doubtful that the investigatory report would conform to the time space requirements of either of those reports.

MHD 487 B.2. Section 7, Subdivision 1, addresses itself to present rates as well as rate increases. Rate increases may appear reasonable while the basic rate from which the increase is made may be unreasonable, inequitable or discriminatory.

MHD 487 B.3. It is only fair that hospitals be advised that their rates are to be investigated and that hospitals be aware of the research objective of the investigation.

MHD 487 B.4. Investigations must assess rates on the same basis as hospitals expect their rates to be assessed in reviews of other reports submitted to the system.

MHD 487 B.5. Investigative Report. In order to distinguish among the various reports, the investigative report is given a distinguishing label. While this report cannot substitute for other reports, it is reasonable that the findings of this report should be considered in comments issued by the system regarding its review of other reports by that hospital.

MHD 487 C. Review of Reports. The purpose of this section of this rule is to set out a particular set of administrative standards for the review of any and all reports required by the Act and these rules.

MHD 487 C.1. General Provisions: Completeness. Before it is reasonable to commence the lengthy review of reports, it is necessary to ascertain completeness. The effect of this section places the onus on the hospital to submit, in the case of each report, adequate data for the system to be able to commence its review. Logically, this implies that the bulk of the required data is desirable; but in the event a relatively few items of data are missing, the review should commence without penalty while the hospital is supplying the additional requirements.

MHD 487 C.1.a. The purpose of this provision is to define the actual filing of a report with the system (see Section 7, Subd. 5 of the Act) as contingent upon a determination of completeness. This provision, then, prevents the submission of incomplete reports solely for the purpose of beginning such provisions as the "sixty day time clock" established by Section 7, Subdivision 5 of the Act.

MHD 487 C.1.b. This provision places responsibility upon the system for responding expediently to the determination of completeness. The exception in this provision allowing,

under stipulation, the system to respond up to thirty days later with regard to completeness is in recognition of workload. Recognizing that approximately fifty percent of the 180 hospitals subject to these rules have fiscal years which end at the same time (end of the calendar year), the system can anticipate the receipt of 90 rate revenue and expense reports sixty days before the end of the year and ninety reports of annual financial information 120 days after the end of the year. Reasonable, comprehensive reviews may not always be possible in a ten-day period on all reports given the maximum manpower legislatively authorized for this program (the budget allows for approximately 3.5 persons, including secretarial and clerical help).

This provision also permits the date of filing to be set, retroactively, at the date of submission of a report to the system, pending determination of completeness. The purpose of this sub-provision is to minimize the sixty-day period of time for hospitals.

MHD 487 C.1.c. Incomplete reports are not "filed" reports and must be returned to the hospital together with a specific statement of <u>how</u> the reports are incomplete.

This provision is necessary to establish a resubmittal process for incomplete reports and a recording process for the system to monitor delinquencies.

MHD 487 C.1.d. With regard to reports filed prior to the

effective date of rules, no control has been available over form or content. In certain cases, it may be desirable to require hospitals to submit a report of annual financial information or rate revenue and expense report which conforms to these rules which can be used as a basis for assessment. Additionally, a complete data set must be established as early as possible so that the continuing analysis provision (Section 5) of the enabling legislation can be adhered to.

MHD 487 C.1.e. In the normal process of filing of reports, a margin for making errors must be recognized. The purpose of this provision is to instruct hospitals what to do should they discover any error in any provision of any of their reports. Under this provision, it is the hospital's obligation to inform the system of any errors it discovers.

MHD 487 C.1.e.(1). The resubmittal of an interim increase report or a rate revenue and expense report due to hospital-discovered error should not necessarily affect the date of filing or the sixty-day "time clock" under certain circumstances.

MHD 487 C.1.e.(1)(a). It is reasonable, given the sixty-day period and the obligation of the system to review this report before the effective date of rate increases, that the maximum time limit for a hospital informing the system of error without affect on filing or limits should be only half of the entire sixty-day period.

MHD 487 C.1.e.(1)(b). This provision permits some reasonable negotiation between hospital and system regarding when the amendment should be submitted. This provision allows the flexibility for variable amendment submission times given the scope and type of the necessary amendments.

MHD 487 C.1.e.(2). This provision clarifies that any amendment and notification of error not meeting the prior criteria is to be considered a new report to which a "new" "time clock" will apply.

MHD 487 C.1.f. As for the hospital discovering error in its reports, this provision sets similar standards for the system when it discovers errors in hospital reports. The provision states that this error provision should not be used to punish hospitals for insignificant errors.

MHD 487 C.1.f.(1). This provision establishes the first thirty days of the mandatory sixty-day period as the period when refiling may be required without affecting the sixty-day "time clock" then in progress.

MHD 487 C.1.f.(2). This provision states, as for hospitals, that discoveries of major errors in the last thirty days of the sixty-day period will cause the system to require a new filing and a "restarting" of the sixty-day "time-clock."

MHD 487 C.2. This part of the rules establishes the administrative bases and standards for the review of rate revenue and expense reports and interim increase reports. As the two reports are similar, it is more clear to ascribe the same standards to their review.

MHD 487 C.2.a. This provision clarifies that in all instances, the cost history of a hospital with regard to its past institutional and service center costs shall always be a basis for the assessment of the reasonableness of cost increases. The provision also clarifies that comparisons between hospitals may only be made (on an institutional and service center basis) when those hospitals can be shown to share "common characteristics." Several suggestions for these common characteristics are made which are similar to the criteria used by the State of Washington for its grouping of hospitals for rate analysis. These criteria are also considered appropriate by the American Hospital Association and are being used by the Minnesota Hospital Association's Rate Review Program for its grouping method. It is the intention of this provision that grouping of hospitals by common characteristics be used to compensate for the other analytical problems inherent in a system such as this one which lacks the requirement of uniform accounting and reporting.

As the grouping of hospitals is intended to play a significant role in the analysis process, there is a case for the inclusion of more data in reports appropriate for grouping. However, in order to minimize additional data requirements and to utilize existing data which is on file on hospitals from licensing reports, the (6) basis for common characteristics encompass all licensing data, as appropriate for grouping.

MHD 487 C.2.b. Section 7, Subd. 5 provides that the board (system) shall review reports and publicly comment on any increase. This authority is limited to reports of rate revenue and expense and interim increase reports.
This provision clarified that the "comment" of the system shall be that a hospital's existing and proposed rates are:

(a) reasonable; or

(b) in question.

A judgment of "unreasonable" is avoided as:

(a) the comment must be issued within the sixty-day limit; and

(b) further examination of questionable rates may show some rationale for the rates as they are.

The implication of a comment that rates are "in question" suggests that the rates of that hospital should be subject to investigations pursuant to Section 6 of the Act.
MHD 487 C.2.b.(1) The purpose of this provision is to explicate precise, but broad, bases for the comment that rates are reasonable.
MHD 487 C.2.b.(1)(a). This provision recognizes that hospitals which share common characteristics probably will have similar hospital rates.
MHD 487 C.2.b.(1)(b) and (c). These provisions clarify that the judgment of reasonableness is contingent upon compatibility of rates with the bases for judging the reasonable use of finances in a hospital established by these rules.

MHD 487 C.2.b.(2). This provision is necessary to establish the broad bases to be used for a determination that rates are "in question."

MHD 487 C.2.b.(2)(a). The departure of rates of one hospital from rate patterns established by hospitals which share common characteristics with that hospital is, itself, a reason for questioning the rates.

MHD 487 C.2.b.(2)(b). Departures from past financial practices of a hospital; the generation of excess revenue and the deviation from the established bases for reasonable use of finances in a hospital are clearly basic reasons why rates might be drawn into question.

MHD 487 C.2.b.(2)(c). The onus of the demonstration for the need for increases in rates is clearly on the hospital. This is consistent with the theories of public utility regulation upon which the hospital rate review system is based. Failure to demonstrate need and consistency with criteria for reasonableness is clearly a cause for calling rates into question.

MHD 487 D. Public Meetings. Consistent with the Minnesota Open Meetings Law and with Section 4, Subdivision 4 regarding public access to all records and with regard to Section 8, Subd. 4, the system as operated by a voluntary organization or the Board shall maintain open and published meetings.

Since the review of rates by a voluntary agency, as authorized by Section 8 of the Act, amounts to State delegation of a regulatory function, the State should expect the voluntary agency to conform to the same openness requirements in regulation to which the State itself is subject.

MHD 487 E. Burden of Proof. Consistent with the theories underlying the regulation of rates of public utilities, on which these rules are based, the onus of proof must rest with the hospital.

As small rate increases are permitted under the Act and by these rules, increases of greater proportions should be justified publicly.

MHD 487 F. Consolidation. Hospitals may, on occasion, request similar rate increases for similar reasons. If these hospitals share common characteristics, the system should be allowed the administrative convenience of combining questions of fact and issuing common comments.

Part 3: Standards and Controls of the Board of Health;

MHD 496 through MHD 510

The Law is clear that the official agent of the Minnesota Hospital Rate Review System is the Minnesota State Board of Health. The extent to which a voluntary non-profit rate review organization is permitted to conduct reviews of rates under this Act and these rules in place of the state is governed by the Board's ability to set standards for the approval of the voluntary organization's rate review procedures, to properly monitor the voluntary organizations and to govern the overall conduct of rate review in this state, the board maintains exclusive authority to:

(1) approve and dissapprove voluntary non-profit rate review organizations for/from operating "the system";

(2) determine the quarterly allowable increase percentages; and,

(3) establish fees to be charged to hospitals participating in the board-authorized rate review program.

MHD 496. Approval for Operation of the System. This rule establishes the authority of the board as the approval agent consistent with Section 8, Subdivision 2 of the Act.

MHD 496 A. Application. This section of this rule establishes the procedure whereby a voluntary non-profit rate review organization may gain approval to operate the system. The procedure consists of several requirements:

MHD 496 A.1. Open Application Period. Any qualifying organization may apply during the time period prescribed for operation of the system during the next fiscal year of the board. The reason for a March 31 cut off date is to provide ample time for reapplications should initial applications be rejected. It is also in the interest of both the voluntary organization and the state program to know well in advance of the commencement of a new fiscal year how heavy each organization's workload will be (i.e., how many hospitals will be enrolled in each program). This is particularly important for the state to know since, in the first instance, all hospitals are subject to the state's program.

MHD 496 A. 2. Contents of Application. In order that judgment regarding qualifying applications can be rendered objectively, it is necessary to specify the types of information which constitute an application:

MHD 496 A. 2. a. This provision asks for a detailed statement showing that the types of reports and procedures and standards proposed to be used by the voluntary organization are at least as comprehensive as those which the state has established according to "the system".

Since the voluntary organization will be performing what amounts to a delegated regulatory function, it is reasonable to expect conformity to basic requirements of the state program.

MHD 496 A. 2. b. The data collected by the voluntary organization should be available publicly once ascertained to be complete in order that,

among other things, the board might be able to expediently run sample-select parallel assessments of rates and increases in rates as a quality check against procedures established by the voluntary organization. This is justified by Section 8, Subdivision 4 of the Act.

MHD 496 A. 2. c. The state needs to know the balance of workload well in advance of the start of the new fiscal year. The three year requirement is present to prevent the arbitrary switching of hospitals between various rate review programs, a practice which might render the year-to-year assessment of that hospital's rates useless.

MHD 496 A. 2. d. A voluntary organization might propose certain "eligibility requirements" for hospitals desiring to enter its program. The board should assess those criteria in terms of their fairness, rationality and effect on participation.

MHD 496 A. 2. e. The hospital or the board may, from time to time, feel the necessity for additional documentary evidence to be taken in account in the rendering of any judgment regarding the acceptability of an application.

MHD 496 B. Review of Application. This section of this rule provides the administrative procedures for the review of the applications provided for by MHD 496 A.

MHD 496 B. 1. The forty-five day period is designated as a reasonable and fair period of time for review since it will always encompass at

least one of the official and regularly scheduled monthly meetings of the State Board of Health.

An approved application has immediate effect on determination by the board.

MHD 496 B. 2. Disapproval. The grounds of disapproval are solely those that the voluntary organizations proposed reporting and review procedures are not substantially equivalent to those of the board. This is the intent of Section 8, Subdivision 2 of the Act.

MHD 496 B. 3. Reapplication. This provision allows disapproved applicants to attempt to reapply for acceptability on one occasion subsequent to disapproval and prior to the commencement of a new fiscal year of the board.

The limitation to one reapplication per fiscal year is designed to prevent a constant stream of unacceptable applications while recognizing that the re-working of an initially rejected application with board staff would minimize any incidence of a second rejection if the application, in the first instance, could be modified to an acceptable form with minimal changes.

MHD 496 C. Annual Review of Applicant. The Board is required to annually review the reporting and review procedures of an approved voluntary organization to ascertain continued compliance with standards (see Section 8, Subdivision 2 of the Act).

MHD 496 C. 1. Using the same time frame as for an initial application, the system requires the submission of an annual review statement.

The March 31 date is again designed to allow ample time for review and planning for the subsequent fiscal year as well as ample opportunity for an organization whose renewed approval is denied to reapply before the commencement of a new fiscal year.

MHD 496 C. 2. This part details the requirements of the annual review statement.

MHD 496 C. 2. a. If no substantial changes in reporting and review procedures has occurred from the approved application, attestation to this effect is required.

MHD 496 C. 2. b. If the organization has substantially changed its reporting and review procedures, it must show the system that, with these changes, it is still substantially equivalent in its procedures to those required by the state. It is reasonable that such an organization should provide assurances that changes in program do not necessarily cause departure from the written intent of the system.

MHD 496 C. 3. In cases where questions may exist as to the continued substantial equivalence of the voluntary program to the state program, it is reasonable to expect the board to demand any additional evidence of substantial equivalence not provided by MHD 496 C. 2. b.

MHD 496 C. 4. Using the same time frame as that for an initial decision regarding approval of the voluntary organization's reporting and review procedures, the board has a period of 45 days to reach its decision.

Renewed approval, as initial approval is immediately effective.

MHD 496 C. 5. The reason for this provision is the same as for MHD 496 B. 3.

MHD 496 C. 7. This provision is necessary to provide for the transfer of hospitals subject to review by a voluntary organization which loses its approval to the state program or another approved voluntary organization's program.

MHD 496 D. The board must reserve the right to revoke its approval of an organization at any point if the board discovers that the voluntary organization's program has significantly altered to such a point that the reporting and review procedures of the organization are no longer substantially equivalent to those required by the system.

MHD 504. Board Determination of Allowable Increase Limit. The actual percentage figures which constitute the allowable increase limit are the responsibility of the board. The purpose of this limit is to allow for increases in rates which have minimal impact upon hospital costs, as provided by Section 7, Subdivision 5 of the Act.

MHD 504 A. The purpose of this section is to set out a definition of the threshold of what is or what is not an increase of minimal impact.

It should be noted that just because a hospital exceeds the established allowable increase limit is not to say that hospital rates are therefore unreasonable. The allowable increase limit is simply an administrative device designed to limit the mid-year assessment of reports to only those few hospitals which increase their rates the most.

MHD 504 B. To provide quarterly increase percentages to hospitals so that they can plan well in advance of the commencement of their next fiscal year, the board must always have projected quarterly allowable increase limits for the next subsequent six quarters.

The purpose of this provision is to allow the board to establish a projected quarterly allowable increase limit during the first quarter after the effective date of these rules.

MHD 504 C. This provision mandated the board to constantly maintain a six-quarter complement of projected quarterly allowable increase limits. Six-quarter complements are necessary to allow hospitals to plan their budget with full knowledge of the limits which will be in force during the coming year.

MHD 504 D. This provision requires the board to quarterly provide each hospital and each approved applicant all applicable information concerning quarterly allowable information each time that the board establishes such a limit. It is important for them to know such information for their planning of rate changes.

MHD 504 E. Form. The form which the quarterly allowable increase limit is to take is a single percentage figure. This form is designed to make the interpretation of the limit most comprehensible.

MHD 504 F. Basis. The limit is to be based upon the averaged projected monthly Consumer Price Index for relevant previous quarters.

The rationale for using the CPI is based upon the logic that had health care prices risen directly in proportion to the CPI, there would probably not be the concern there is today over the high cost of health care. As the allowable increase limit is not a threshold determining the

reasonableness or unreasonableness of rates, and it is merely an administrative mechanism designed to indicate to the system which hospital's rates need interim assessment, it is reasonable that the board should be able to set this limit quarterly without the necessity for additional rule making procedure.

There is some concern that the medical care component of the Consumer Price Index should be used instead of the whole CPI since it more directly relates to the cost-changes in the delivery of health care.

There is also some concern that states like New York have chosen to 'invent' a hospital price index, based on a hybrid of the CPI and its medical care component. It should be noted that the use of such an index in New York state is for the purpose of determining reasonableness of rates and not, as proposed here, as an administrative selection device. With regard to these two concerns, either or both may be used by the system as the allowable increase limit is to be <u>based upon</u> the CPI, but it does not necessarily have to be that exact percentage. As this limit is only for purposes of administrative convenience, it seems reasonable that the board be allowed to maintain this discretionary limit setting authority.

<u>MHD 504 G. Compensation.</u> It is likely that projections made for a period of six quarters in advance of the present will be too high, or too low from what actually occurs when the projected quarters become historical. To compensate for these miscalculations, it is reasonable to permit the board to adjust subsequent quarterly limits to reflect this discrepancy.

The adjustment of any one quarter's limit will not have any unusual effect as the adjustment will be moderated by the stable "weight" of the three other quarterly limits which must be aggregated with the adjusted quarter's limit to yield the allowable increase limit for a hospital.

MHD 504 H. Exceptions. Increases in rates due to increases in certain relatively uncontrollable expenses of a hospital may also be considered as "increases of minimal impact" for purposes of this limit. This is not to say that these increases have minimal impact; rather, it is to recognize that hospitals have certain needed rate increases which they themselves cannot control and which, therefore, can be construed as not to require the submission of an interim increase report. The information must be submitted in the annual report of rate revenue and expense.

MHD 504 H. 1. Malpractice insurance rates are currently one of the most unstable categories of insurance rates for hospitals. Malpractice rates have increased 200-300% over the past few years and in order to finance their premiums, hospitals have had to increase rates.

MHD 504 H. 2. There may be changes by the Congress or state Legislature in pension funding requirements for hospital employees. Should these occur and cause rate increases, these increases should be permitted as long as the details of this increase are provided in the next submission of the rate revenue and expense report.

MHD 504 H. 3. Labor negotiations may continue past the time required for the submission of the rate revenue and expense report. As at least 60% of the expenses in most hospitals settings are directly attributable to

salaries, etc. for the employment of human resources, it is likely that negotiated wage increases will always directly affect the rates charged to patients for care.

MHD 504 H. 4. In order that government can document legal changes directly causing cost increases and the extent of those increases this divulgence of data is critical. At the same time, hospitals should not necessarily be administratively 'penalized' by having to submit the interim increase report when the cause for rate increases is directly attributable to governmental action.

MHD 504 H. 5. Acute care beds in hospitals operated by the commissioner of public welfare are subject to the system (as operated by the board). As the "rates" of these beds are dependent on legislative appropriation and legislative mandates, it is likely that the appropriations process may not be completed by the time the rate revenue and expense report is required. Since the commissioner has no direct control over this appropriation and other related legislative changes, it is reasonable to exempt these beds from interim review when increases are due to legislative initiative.

MHD 509. Fees.

Section 7, Subdivision 6 of the Act authorizes the collection of a filing fee which is sufficient to cover the costs of any reviews undertaken pursuant to the Act. This fee is also to be graduated on the basis of length or complexity of the report. The fee is only applicable to rate revenue and expense reports and interim increase reports (i.e., those required by Section 7, Subd. 5) and not to annual financial information reports. The assumption made by this rule is that the length and complexity of any report is, in the first instance, directly attributable to the size of a hospital's bed component. There is an additional question of equity and the ability to pay which is incorporated into the ascending fee schedule.

MHD 509 A. Rate Revenue and Expense Report Fee. The amounts herein prescribed for filing fees are based on the amount projected to be required for the complete review, analysis, and administrative processing of a report. These figures are borrowed from the Minnesota Hospital Association schedule of fees for the conduct of hospital rate reviews. Their basis for fees is similar to that required by statute for the Board.

MHD 509 B. Interim Increase Report Fee. This fee is to be one-half of the rate revenue and expense report fee since the completion of and review of this report will not be as lengthy or complex as that of the rate revenue and expense report.

MHD 509 C. "Timely". One major basis for judging the complexity of a review is the time allowed for the review. As the system has an obligation to review changes in rates sixty days before they become effective, late submissions may force the system to expend an inordinate amount of energy to swiftly and thoroughly review the rates of a hospital.

MHD 509 C.1. A ten percent late fee, while not, in most cases, terribly large should act as somewhat of a disincentive to reliance on extensions.

MHD 509 C.2. An incomplete report is not acceptable. As the determination of "completeness" itself requires some considerable administrative time and effort, a five percent late fee is required to cover each occasion on which an incomplete report is received.

MHD 509 C.3. In the cases of hospitals which decide not to comply with the system, there must be a mechanism whereby the required data can be retrieved. Section 4, Subdivision 5 permits the Board to inspect books, audits, records, etc. As this inspection can be construed to

cover the completion of a report by the Board for the hospital not in compliance, it is reasonable that the Board be allowed to recover all auditing costs as a "late fee" in addition to the prescribed filing fees.

MHD 509 D. The payment of fees by hospitals whose financial condition is unsound or otherwise not in a state to permit fee payment without causing a direct increase in rates at the time may have all or a portion of the fee waived for certain reasons:

MHD 509 D.1. (See justification for 509 D.)

MHD 509 D.2. Emergency constructions (e.g., tornado taking the roof off a hospital) or situations where administrative hardship prevents timely completion of reports should not be penalized.

MHD 509 D.3. There may be other reasons unanticipated by the previous provisions which would, given the individual circumstances, justify the suspension of all or a portion of the fees.

MHD 510. Official Offices. As the State Board of Health maintains several district offices which are not involved in the hospital rate review system it operates, the official offices must be established as only those central offices of the Board herein indicated.

Part 4: Severability.

MHD 511.

Court action based on any section of these rules may have the effect of rendering the entire set of hospital rate review rules unconstitutional or void without this provision.

September 27, 1976

TO : Members of the Ad Hoc Committee of the State Board of Health to Review Proposed Rate Review Rules: Mr. John H. Westerman, Dr. Van S. Lawrence, Mr. Joseph Gitis

FROM : Warren R. Lawson, M.D.
Secretary and Executive Officer
by
Stephen M. Jackson
Consultant

SUBJECT: Chronology of Implementation to Date

This memorandum will give you a rough perspective on the number of times to date which drafts have been reviewed and considered by various groups.

I might point out that those who have participated in the voluntary technical advisory group have given very generously of their time and energies, even in the absence of our ability to reimburse their expenses. They all deserve the Board's commendation and praise for such dedicated, and objective investment in helping make the Minnesota Rate Review System the best possible system under the legislative authorization.

Rate Review Chronology:

1 June	Consultant engaged to develop proposed rules.
8 June	Meeting with Director, State Health Planning and Development Agency regarding first preliminary draft and role relationship between the Minnesota Department of Health and the State Health Planning and Development Agency in rate review.
10 June	Meeting with Blue Cross regarding first preliminary draft and relationship between the Minnesota Department of Health and Blue Cross in rate review.
11 June	Meeting with Minnesota Hospital Association regarding first preliminary draft

	and relationship between the Minnesota Department of Health and the Minnesota Hospital Association in rate review.
14 June	Meeting with the Department of Public Welfare regarding first preliminary draft and relationship between the Minnesota Department of Health and the Department of Public Welfare in rate review.
21 June	Review of subsequent draft with Division of Health Facilities, Department of Health.
22 June	Review of subsequent draft with Executive Office, Department of Health.
24 June	Continuation of review with Executive Office, Department of Health.
25 June	Meeting with representatives of the Metropolitan Health Board (Metro Health Systems Agency) regarding subsequent draft and relationship between the Minnesota Department of Health and Health Systems Agencies in rate review.
	Continuation of review with Executive Office, Department of Health.
29 June	Continuation of review with Executive Office, Department of Health.
14 July	Review of another subsequent draft with Division of Health Facilities, Department of Health
16 July	Review of another subsequent draft with Minnesota Hospital Association.
23 July	Review of another subsequent draft with Executive Office, Department of Health.
26-28 July	Review of draft proposals with
	Harold Cohen, Executive Director and Graham Atkinson, Maryland Health Care Cost Review Commission.
	Harold Jackson and William Darrosh, Social Security Administration.

29 July	Presentation of document summarizing implementation status of rate review program to oversight hearing, The Minnesota Senate Sub-Committee on Health, Senator John Milton, Chairperson.
2 August	Meeting with an interested University faculty member, Hospital and Health Care Administration, regarding rate review.
3 August	Meeting with Thomas O'Hare, Associate Director, Health Insurance Association of America, Chicago, and various representatives of commercial insurance companies regarding status of rate review drafts.
6 August	First meeting, voluntary technical advisory group to review draft rules. This group has included representatives from:

The Minnesota Senate Staff
The Minnesota House of Representatives Staff
The Minnesota Health Department
The Minnesota Department of Public Welfare
The Minnesota Insurance Division
The Minnesota Hospital Association
The Minnesota Hospital Financial Management Association
The State Health Planning and Development Agency
The Metropolitan Health Board
Health Central, Inc.
Group Health Plan, Inc.
The State Auditor's Office
The University of Minnesota
Representatives of individual hospitals and certified public accounting firms
Members of the general, consuming public

11 August	Meeting with voluntary technical advisory group.
18 August	Meeting with voluntary technical advisory group.

23 August	Meeting with representatives of Legislative Auditor's Office regarding draft rules.
24 August	Meeting with Minnesota Hospital Association regarding draft rules.
25 August	Meeting with Executive Office, Department of Health regarding review of draft rules.
	Meeting with Blue Cross regarding review of draft rules.
26 August	Meeting with Executive Office, Department of Health regarding review of draft rules.
7 September	News release regarding Informal Public Forum, 22 September 1976, to review draft rules.
8 September	Presentation of draft rules to Health Facilities Advisory Committee
10 September	Presentation of preliminary draft rules to Board of Health at regular September meeting of Board in Duluth.
14 September	Preliminary meeting with the Chairperson of the Ad Hoc Committee of the Board to consider proposed rate review rules.
17 September	Meeting with voluntary technical advisory group; rules review.
21 September	Meeting with Special Assistant Attorney General; rules review.
22 September	Interview with WWTC radio station regarding rules.
	Meeting: Presentation of draft rules to Metropolitan Health Board
	Meeting: Informal Public Forum on rules/ Voluntary technical advisory group.
23 September	Meeting: Voluntary technical advisory group; rules review.

24 September	Meeting: Department of Public Welfare, regarding review of rules and Attorney General's opinion that the Department of Public Welfare's acute care hospitals are subject to rate review.
	Meeting: Voluntary technical advisory group; rules review.
27 September	First meeting: Ad Hoc Committee of the State Board of Health to review draft rate review rules.

cc: Members of the State Board of Health

RECEIVED
DEC 10 1976
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed
Rules of the Board of Health
Governing the Hospital Rate Review
System

AGENCY PERSONNEL
AT HEARING

The Minnesota Board of Health will be represented at the hearing by Stephen M. Jackson, a former consultant to the Minnesota Department of Health, and Fredric L. Sattler, an employee of the Department of Health. The Board will also be represented by John Breviu, Special Assistant Attorney General.

Dated: December 10, 1976

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Bd'g Exhibit No. 13
File No.
Date

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

MATERIALS RECEIVED FOLLOWING NOTICE PURSUANT TO MINN. STAT. § 15.0412 (Supp. 1975)

The following material was received following a notice issued on June 3, 1976 (which notice is herewith filed with the Office of Hearing Examiners) as well as a notice published in the State Register on November 8, 1976, pursuant to Minn. Stat. § 15.0412 subd. 6 (Supp. 1975) seeking information or opinions on the above-entitled matter:

1. Memorandum dated July 7, 1976 from Dave Buelow of the Department of Public Welfare to Steve Jackson.

2. Letter dated October 6, 1976, from Thomas P. O'Hare of the Health Insurance Association of America to Steve Jackson.

3. Letter dated October 15, 1976, from James Q. Regnier of Blue Cross and Blue Shield of America to Warren R. Lawson, M.D.

4. Letter dated November 15, 1976, from Caroll Callaway of the Health Insurance Association of America to Kent Peterson.

5. Letter dated December 6, 1976, from Rodgers Adams from the Minneapolis Star and Tribune to Kent Peterson.

STATE OF MINNESOTA

BOARD OF HEALTH

WARREN R. LAWSON, M.D.
Secretary and Executive Officer

Bds Exhibit No. 11
File No.
Date

DEPARTMENT of Public Welfare

Office Memorandum

TO : Steve Jackson, Consultant
Health Facilities Division
Department of Health
717 Delaware Street S.E.

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

DATE: July 7, 1976

FROM : Dave Buelow, Director
Administrative Management
Residential Services Bureau

PHONE: 296-2635

SUBJECT:

Pursuant to our telephone conversation, the following information is the basis upon which I feel the state welfare institutions should be excluded from the provisions of Laws 1976, Chapter 296:

1. Chapter 296 addresses "acute care" institutions. Only 5 out of 10 of our institutions have "acute care" licensing. The "acute care" is for a very limited portion of those 5 as shown by the following:

Rochester -	104	acute	care	beds	670	total	licensed	beds
Cambridge -	25	"	"	"	723	"	"	"
Fergus Falls-	20	"	"	"	749	"	"	"
Brainerd -	20	"	"	"	931	"	"	"
Faribault -	35	"	"	"	1095	"	"	"

System-wide at all 10 institutions, we have 7021 licensed beds at various levels of care, but only 204 are "acute care". The point here is that the emphasis is not for acute care in our system.

2. The rate-setting method now used by the DPW institutions is established by Statute MS 246.50. It has been modified several times in the past few sessions, but was not amended or repealed by Chapter 296. Because of the several changes in very recent sessions, I cannot believe the Legislature would have "overlooked" the DPW institutions, rather, I feel it must have been their intention to exclude them.

3. The rate-setting method established by statutes for DPW institutions conflicts with Chapter 296. By statute, we are to establish our rate based on the anticipated costs for the upcoming year. Our appropriation is not acted upon until late May, yet our fiscal year begins July 1. There are not 60 days available to file a rate with the Health Department.

RECEIVED
JUL 8 1976
R&D Unit
Minn. Dept. of H-.W

4. The rates charged by the DPW institutions are totally governed by the legislative process; i.e., the rate determination method is established by statute and the appropriation by which we determine the projected expenditures is also. For this reason, I do not think the Legislature desired to have their actions reviewed by another state agency.

5. By reason of No. 2 above (statutory rate-setting procedure) and the fact that the Legislature determines our appropriation, you can see that we have virtually no control of our rates.

Please call if any additional information is necessary. My telephone number is 296-2635. Thank you.

DB:dh
cc Wes Restad
Jim Hiniker
Duane Cooney
Dr. Warren Lawson
Kent Peterson
Duane Johnson

RECEIVED
JUL 8 1976
HMO Unit
Minn. Dept. of Health

RECEIVED
OCT 12 1976
HMO Unit
Minn. Dept. of Health

COPY

October 6, 1976

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

Mr. Steve Jackson, Consultant
Minnesota State Health Department
717 Delaware Street, Southeast
Minneapolis, Minnesota 55440

Dear Steve:

I have to apologize for not making comments on your previous draft of the regulations implementing the rate review sections of S.F. 60. I understand that a new draft of the regulations has been completed, and I will be receiving a copy from Terry Klas of North American Life & Casualty. I will comment on that draft as soon as I receive it.

However, I believe I should make some general comments which reflect my own thinking based on HIAA policy and my reading of the voluntary rate review program and your previous regulations. My comments do not necessarily reflect the attitudes of our industry people in Minnesota.

Voluntary hospital rate review, in my opinion, is minimally effective at best and self-serving at the worst. However, we have become involved in the voluntary program because in fact it was the only ball game in town which has any premise of impacting on hospital cost increases. For whatever else we say as an industry regarding S.F. 60, I, for one, regret the fact that the program of hospital rate review is voluntary and not mandatory.

The only consolation I take in the current legislated situation on this matter is that your department will in fact set the standard for the voluntary hospital review committee. This is the only leverage which will assure the effectiveness of the program. As I said, I have read your previous draft regulations, and because I am not an accountant in the strict sense of the word, I am not sure exactly what they mean. However, I would like to register my specific comments in a few areas:

COPY

Price Level Depreciation

Price level depreciation for plant assets in the hospital setting does not serve the public interest. This is true, because it hampers the effectiveness of the new planning law by providing a substantial source of revenue to hospitals to expand facilities, and in fact, it makes today's patient who is already paying for the facilities he is utilizing pay also for tomorrow's patient through the price level system on plant assets.

Price level depreciation on plant assets is especially inappropriate in Minnesota in light of the fact that according to AHA figures published in 1975, Minnesota had the second largest ratio of beds per 1,000 population in the United States (5.9 beds per thousand in Minnesota vs. 4.4 beds per thousand in the U.S.).

After reading the guidelines in this area, I am not sure exactly what you are driving at, but I would hope it would be something along the lines of the Maryland system which allows the greater of cash requirements (interest and debt amortization) or accumulation of up to 20% of the replacement value of plant assets based on average utilization.

Year End Reconciliation with Budget

Rate review based on applications by hospitals requesting rate increases in and of itself will prove to be a very ineffective means of impacting on hospital cost increases. What is required is that all rate increases be based on hospitals budgets with a reconciliation at year end with those prospective budgets. In the absence of such budget review, hospitals will merely have an incentive to increase their utilization in order to maximize revenue.

Plus Factor

I am under the impression that the current voluntary program utilizes some sort of a plus factor for hospitals over and above their usual financial requirements. I believe this is completely unjustified unless it is placed in the context of an allowance for variance in the budget which will have to be accounted for at year end. After all, the review process should assure the hospitals of their financial requirements which to my mind obviates the need for any inclusion of an unidentified plus factor.

Uniform Accounting

Without some form of uniform accounting system, the basis for evaluating a hospital's request for a price increase becomes a charade. At minimum, there should be some form of uniform system of reclassifying revenues and

expenses for reporting purposes by patient care or revenue centers in order to allow for adequate comparisons between institutions. Any sharp hospital controller has a great deal of latitude in the accounting system he utilizes to fill out his Medicare cost report and will generate an apples and oranges comparison situation.

COPY

Differentials for Patients

Without having the text of S.F. 60 right in front of me, I believe that there is a provision that there should be a single charge structure for all patients under the program. Obviously, we support the basic thrust of that position. Relative to differentials, we believe they should be allowed only upon a demonstrated impact on hospital costs and should be available to all patients who satisfy the criteria for such differentials. In addition, it seems to me that the patient who pays his bill fully upon discharge should be entitled to the maximum differential allowable.

As mentioned, I will return comments to you on your latest draft and look forward to discussing some of the issues as listed above.

Sincerely,

Tom O'Hare

Thomas P. O'Hare
Associate Director

TPO/mjh
cc: Mr. Kent Peterson
Mr. Terry Klas
Mr. Mike Richdorf

Blue Cross and
Blue Shield
of Minnesota

James O. Regnier
President

3535 Blue Cross Road
St. Paul, Minnesota 55165
(612) 456-4000

October 15, 1976

Warren R. Lawson, M.D.
Secretary and Executive Officer
Minnesota State Board of Health
717 Delaware Street Southeast
Minneapolis, Minnesota 55440

Dear Doctor Lawson:

The purpose of this letter is to comment on the potential effect the Financial Requirements included in the proposed rules for the Minnesota Hospital Rate Review System may have on Blue Cross and Blue Shield of Minnesota. We understand the Rules were received by the Minnesota State Board of Health at its meeting on Thursday, October 14, 1976.

For the past several months we have been following the development of the Rules with great interest and have had representatives participating at the meetings conducted by your Department for this purpose. I am advised that our concerns have been stated by our staff at these meetings or otherwise to Mr. Steve Jackson of your office.

Our estimate of the overall effect of the Rules is that hospital rates could possibly increase at an even greater annual rate than has been the experience in the recent past if hospitals choose to fully implement all sections of the Financial Requirements. Conservative projections by my staff indicate that BCBSM payments to hospitals could be increased by as much as 20 percent and could require an increase in rates to our subscribers of $20,000,000 the first year the System is in operation.

The projected rise in cost to BCBSM is based on the assumption that we may not be able to negotiate a continuance of a differential in payments to hospitals. We have been prepared since May of this year to conduct an on-site study in hospitals for the purpose of measuring the economic benefits from our relationship with hospitals, but as yet have not received approval from the Minnesota Hospital Association to conduct this study.

The Financial Requirements included in the Rules that are of particular concern in having substantial impact on BCBSM are:

1. Depreciation adjustments for price level changes.
2. Working capital.
3. Bad debts.
4. Charity care.
5. Discounts and allowances.
6. Education.

We have been concerned that the hospitals have had a predominant influence in developing the Rules under which they would operate and that the definition of costs (Financial Requirements) have been significantly elevated without the benefit of corresponding consumer input. We endorse the concept of Rate Review; however, to be effective, the program must include cost containment provisions and the Rules at this time show little evidence of this element. We suggest the Rules should contain more positive language clearly indicating the intended result of containing costs.

As the Medicare and Medicaid programs are not subject to the law nor the Rules, the full burden of the Financial Requirements will fall on other payors. We now provide health care coverage to approximately 22 percent of the state's population. This means we will become responsible for 40 percent of the costs of the six items shown when Medicare and Medicaid are eliminated. The resulting increase in cost, estimated above to amount to $20,000,000, would be difficult to justify and pass on to our subscribers.

BCBSM is required by statute to maintain free reserves within the range of three to six months of claims and administrative expense. We are currently near the minimum level and if the rules are implemented in their present form, our reserves will fall far below this requirement. This will occur as we now have groups on guaranteed rates for twelve month periods which means that rates cannot be adjusted to accommodate these requirements until late in 1977 in many cases.

The Act as adopted provides for the disapproval by the Commissioner of Insurance of subscriber rates which BCBSM may propose if "the insurer has failed to exercise reasonable cost control." The proposed rules would seem to conflict with this indicated intent of the legislature. We would be pleased to have the opportunity of discussing this with you.

Sincerely,

James Q. Regnier
President

JQR:MFx
cc: Berton W. Heaton, Commissioner of Insurance
Richard T. Faricy, Chairman of the Board
L. Melvin Conley, Chairman, Provider Services Committee

HEALTH INSURANCE ASSOCIATION OF AMERICA
CHICAGO NEW YORK WASHINGTON

LEGAL DEPARTMENT
Caroll Callaway, *Assistant General Counsel*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0801

November 15, 1976

RECEIVED
Hospital Rate
Review System
NOV 17 1976

Mr. Kent E. Peterson
Minnesota Department of Health
717 S. E. Deleware Street
Minneapolis, Minnesota 55440

Dear Mr. Peterson:

This is with further reference to our earlier correspondence regarding the Department of Health's proposed regulations implementing the Hospital Cost Review Provisions in Article II of Minnesota S. F. 60. As I indicated in our July 13 letter, we were interested in reviewing the proposed regulation when drafts were available and we offer the following comment with regard to the proposed regulation:

1. Delete paragraph (iv), page 26. This paragraph, titled "Contract Allowances" talks in terms of "requirements may be required" of a hospital to establish "differentials in rates" which are to be allowed certain governmental programs, other insurers and HMOs. Restriction on such "differentials" are to be defined by "MHD_____", which appears to be a reference to some regulation to be written in the future.

   There are several problems with this paragraph, the most important is that S. F. 60 does not permit "differentials", or "contract allowances" at all. The provisions would appear to allow hospital discounts simply established under another name. Further, the language "governmental programs", other insurers and HMOs does not appear correct since S. F. 60 does not define a governmental program as an insurer.

2. Delete paragraph 5, page 34. This paragraph, titled, "Allowance for Differentials" begins by stating the law that hospitals shall not discriminate among insurers in their rates, but goes on to say that certain differentials, the difference between a hospital's rate and the amount paid by an insurer, may be made. The paragraph closes by stating "Under these conditions discrimination does not exist."

   The law does not define "rates", however, it is clear that "rates" means that amount of money charged by a hospital to a patient for the services rendered. The regulations cannot, without some statutory basis, attempt to define "rates" and "charges" as something totally different for the purposes of allowing hospital discounts when the law states there shall be no discrimination in rates.

In addition to the above comments which reflect concerns of the legal department, the following non-legal concerns have been expressed by our Council staff.

3. No specification is made in the regulations on the composition of rate review panels which will investigate and comment on hospital financial requests under the voluntary nonprofit rate review organization. Such panels should be made up of a balanced input of providers, consumers and third parties (including insurers) in order to render objective decisions. HIAA policy would imply that in this situation the review body composition should be delineated. Under the current voluntary program, hospital representatives whose budgets are reviewed one day are allowed to sit on review panels on the next day. Such a system makes the program less than credible.

4. The regulations in paragraphs 6 through 13 do not call for any meaningful uniform revenue and expense accounting and reporting which is necessary to compare hospitals. The use of Medicare cost reports is not sufficient because they do not produce accurate comparisons. HIAA policy supports a uniform system of cost accounting which would permit comparisons with institutions of comparable size and character.

5. On page 27 under (ii) price level or replacement level depreciation is granted for buildings. Such depreciation is inappropriate for the following reasons:

   A. The historical cost of the facility may be unreasonable.

B. Price level depreciation requires this generation's patients to pay for the facilities they use as well as those to be used in the next generation.

C. Philanthropy is discouraged.

D. Since Medicare and Medicaid will include only standard depreciation in their reimbursement, any allowance exceeding depreciation will have to be unfairly subsidized by private sector patients. Even though S. F. 60 in this area has no direct control over government programs, the obvious intent is to eliminate discrimination in rates. The payment of price level depreciation will increase the discrimination in rates between government and private patients.

6. Page 26 (b) "Plant Capital Needs" does not require approval of capital expenditures for new facilities and services by the appropriate planning authority as a condition for recognition of capital costs by the system. Such planning approval is necessary if the system is to financially support only those facilities and services which the community has judged to be necessary. HIAA guidelines require close cooperation and coordination between the rate review and planning functions.

7. Also, it would be appropriate to establish an ongoing advisory council to the Minnesota State Board of Health which would report on the effectiveness of the program, suggest modifications and serve as a sounding board for the Department on various issues. The advisory council should be made up of an equal number of representatives of consumers, government, third party payors (i.e., private insurance companies and Blue Cross Plans) and providers. HIAA policy supports the establishment of an adivsory council.

We feel these above comments are very significant, particularly the questions of law indicated in the first two numbered paragraphs. It is with regard to these two specific comments that we feel the proposed regulations to not reflect the statutory requirements. Please let us know if we can be of any further assistance.

Yours truly,

Caroll Callaway

Caroll Callaway
Assistant General Counsel

CC:dms

THE MINNEAPOLIS STAR EVENING
425 Portland Avenue Minneapolis, Minnesota 55415

RODGERS ADAMS
ASS'T. TO THE EDITOR

RECEIVED
DEC 8 1976
HMO Unit
Minn. Dept. of Health

December 6, 1976

Kent Peterson
Minnesota Department of Health
717 Delaware St. SE
Minneapolis, MN 55440

Dear Mr. Peterson:

I am chairman of the First Amendment Committee of the Minneapolis Tribune and The Minneapolis Star. Ours is an internal committee, set up to monitor activities affecting our ability to report the news.

In the course of our work, we noticed that a provision of the state's hospital rate review and financial disclosure law doesn't seem to be included in your draft of proposed regulations.

Section 7, Subdivision 5 of the law reads: "The board shall obtain from each hospital a current rate schedule. Any subsequent amendments or modifications of that schedule shall be filed with the board at least 60 days in advance of their effective date. . . ."

This is an important part of the public disclosure of hospital costs that the law is designed to foster. It should be included in the regulations so hospitals will understand that your department intends to enforce all important provisions of the law.

Sincerely,

Rodgers Adams

GRA:ls

RECEIVED
NOV 9 1976
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA
OFFICE OF THE ATTORNEY GENERAL

Address Reply to:
OFFICE OF ATTORNEY GENERAL
Minnesota Department Of Health Building
717 Delaware Street S.E.
Minneapolis, Minnesota 55440
Telephone (612) 296-5294

November 9, 1976

Mr. Steve Mihalchick
Hearing Examiner
Office of Hearing Examiners
Room 300 - 1745 University Avenue
St. Paul, Minnesota 55104

Re: In the Matter of Proposed
Rules Governing the Minnesota
Hospital Rate Review System

Dear Mr. Mihalchick:

I am enclosing an Order for Hearing, Notice of Hearing and a Form 1060 in the above-entitled matter for your review. As you will note, this hearing has been scheduled for January 5, 1977. It is anticipated that approximately 150 people will be in attendance and that the hearing will last for approximately 6 hours.

I am also enclosing for your review, the proposed rules to be presented at this hearing.

Very truly yours,

John A. Breviu

JOHN A. BREVIU
Special Assistant
Attorney General

JAB:ss
enclosures

Bd's Exhibit No. 1
File No. HLRH-77-035-SM
Date

STATE OF MINNESOTA

COUNTY OF HENNEPIN

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

BEFORE THE MINNESOTA STATE BOARD OF HEALTH

In the Matter of the Proposed Adoption, Amendment or Revision of the Rules of the Minnesota State Board of Health

NOTICE OF INTENT TO OBTAIN INFORMATION ON PROPOSED RULES FROM NON-AGENCY SOURCES

NOTICE IS HEREBY GIVEN, pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6 (Supp. 1975) that the Minnesota State Board of Health will propose the adoption of new rules on the subjects noted below (items A through I) and the amendment and revision of existing rules noted below (items J through L).

All interested parties desiring to submit data or views relating to the proposed adoption, amendment or revision of the rules noted below should address their comments (either written or oral) to the Minnesota Department of Health (717 Delaware Street S.E., Minneapolis, Minnesota 55440) by writing or calling the persons designated. Any evidence submitted for consideration should be pertinent to the matter at hand. Any written material received by the Department of Health will become part of the hearing record.

A. Rules Implementing the provisions of Minnesota Laws, 1976, Chapter 173, relating to the licensing and regulation of nursing homes.

Contact: Division of Health Facilities
Attention: H. Michael Tripple
Phone: (612) 296-5418

B. Rules establishing the method by which complaints against health care facilities, health care providers or administrative agencies are to be made to the Office of Nursing Home Complaints pursuant to the provisions of Minn. Laws 1976, Chapter 325.

Contact: Executive Office
Attention: Michael E. Noen
Phone: (612) 296-5403

C. Rules relating to supervised living facilities and out-patient surgical centers with respect to the establishment of levels of assessments for violations of rules pursuant to Minn. Stat. § 144.653.

Contact: Division of Health Facilities
Attention: H. Michael Tripple
Phone: (612) 296-5418

D. Rules relating to requiring employers of 100 or more persons to make available a dual option of health benefits coverage by either an insurer or a health maintenance organization pursuant to Minnesota Laws 1976, Chapter 296, § 17.

Contact: Division of Health Facilities
Attention: Kent E. Peterson
Phone: (612) 296-5365

E. Rules relating to implementation of hospital rate review by the State Board of Health to include financial reporting requirements, rate review procedures, standards for approval of voluntary rate review procedures and establishment of a filing fee to be charged for submission of hospital rate modifications to the Board.

Contact: Division of Health Facilities
Attention: Kent E. Peterson
Phone: (612) 296-5365

F. Rules relating to complaint or grievance mechanisms in hospitals, outpatient surgery centers, and health maintenance organizations.

Contact: Division of Health Facilities
Attention: Janet G. Brodahl
Phone: (612) 296-5441

G. Rules relating to procedures for administrating matching funds and grants for emergency medical services.

Contact: Division of Health Facilities
Emergency Medical Services Section
Attention: Bernard W. Webber
Phone: (612) 296-5281

H. Rules relating to the establishment and approval of education courses in health related subjects such as courses relating to administration of medications in health facilities and courses for food service supervisors and for medical laboratory technicians.

Contact: Division of Health Facilities
Attention: Robert A. Hamilton
Phone: (612) 296-5487

I. Rules relating to procedures for hospital administrator registration.

Contact: Division of Health Manpower
Attention: Collin Eid
Phone: (612) 296-5393

J. Proposed amendments to Minn. Reg. MHD 22 relating to the examination and licensing of morticians and to Minn. Reg. MHD 30 relating to the itemization of funeral costs.

Contact: Division of Health Manpower
Mortuary Science Unit
Attention: Gene Larson
Phone: (612) 296-5491

K. Proposed amendments to rules relating to the licensure and regulation of boarding care homes.

Contact: Division of Health Facilities
Attention: H. Michael Tripple
Phone: (612) 296-5418

L. Proposed amendments to Minnesota Water Well Contractors Code relating to the use of plastic pipe by water well contractors in the construction of water wells.

Contact: Division of Environmental Health
Attention: Edwin Ross
Phone: (612) 296-5339

Any materials submitted shall be reviewed and considered by the Department of Health during the preparation of the proposed rules. Notice of the public hearing on the proposed rules shall be given to all interested parties in accordance with the provisions of the Administrative Procedure Act.

Under the provisions of Minn. Stat. § 10A.01, subd. 11 (1974), any individual representing persons or associations attempting to influence administrative action, such as the promulgation of these proposed rules, must register with the State Ethics Commission as a lobbyist within five days of the commencement of such activity by the individual. The State Ethics Commission is located at Room 401, State Office Building, Saint Paul, Minnesota 55155.

STATE OF MINNESOTA
BOARD OF HEALTH

Dated: May 28, 1976

/s/ Warren R. Lawson, M.D.
WARREN R. LAWSON, M.D.
Secretary and Executive Officer

STATE OF MINNESOTA

COUNTY OF HENNEPIN

RECEIVED

DEC 10 1976

OFFICE OF HEARING EXAMINERS

In the Matter of the Proposed Adoption, Amendment or Revision of the Rules of the Minnesota State Board of Health

AFFIDAVIT OF MAILING

MARIE B. TROMICZAK, being first duly sworn, deposes and says:

That on the 3rd day of June, 1976, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Intent to Obtain Information on Proposed Rules from Non-Agency Sources by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A, to all persons and associations at the addresses listed on Exhibit B, attached and made a part hereof, and all members of the Minnesota Legislature as of the date of mailing.

Marie B. Tromiczak

Subscribed and Sworn to Before me this 1st day of July, 1976.

Frank J. Bigham

FRANK J. BIGHAM
Notary Public, Ramsey Co. Mn.
MY COMMISSION EXPIRES
May 16, 1980

Bds Exhibit No. 10

File No.

Date

RECEIVED
DEC 10 1976
OFFICE OF HEARING EXAMINERS

STATE OF MINNESOTA

COUNTY OF RAMSEY

In the Matter of the Proposed Adoption, Amendment or Revision of the Rules of the Minnesota State Board of Health

CERTIFICATE

I hereby certify that the 493 general labels and 3 page list for the Minnesota State Health Department all of which are attached and made a part hereof, constitute the complete lists of persons, associations, and other interested groups who as of 11:15 o'clock P.M., this 24th day of May, 1976, have requested pursuant to Minn. Stat. § 15.0412 subd. 4 (Supp. 1975), that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

Joan Anderson Growe
SECRETARY OF STATE
JOAN ANDERSON GROWE

By Ceil Dion

Blue Cross and Blue Shield of Minnesota

3535 Blue Cross Road
St. Paul, Minnesota 55165
612/456 4000

STATE OF MINNESOTA Ex VI
OFFICE OF HEARING EXAMINERS
Room 300
1745 University Avenue
St. Paul, Minnesota 55104
JAN 3 1977

December 30, 1976

Mr. Steve Mihalchick
Hearing Examiner
Office of Hearing Examiners
Room 300
1745 University Avenue
St. Paul, Minnesota

Dear Mr. Mihalchick:

The purpose of this letter is to accept the opportunity afforded to interested parties to submit written comments and suggestions regarding the Proposed Rules of the Board of Health Governing the Hospital Rate Review System.

In general, BCBSM is in agreement with the proposed rules and the hospital financial requirements which are a part of the rules. There are certain items in the financial requirement section, however, that cause some concern to BCBSM because of the rise in hospital rates that may result and the impact this will have on the health care consumer. While we agree that reimbursement or payment for hospital services should provide financial equity for hospitals, we also believe purchasers of care deserve like consideration.

We believe our suggested changes to the rules will adequately provide for the financial needs of the hospital, and at the same time consideration will be given to reducing the financial impact the rules may have on all purchasers of health care.

Enclosed please find our suggested changes in the rules and reasons for the suggestions. We have identified each change by the section and page where they appear in the rules.

Public Exhibit No. A
File No.
Date

It is expected that Mr. E. Lamson, Director, Provider Reimbursement Division, and I will be present at the Hearing. We thank you for the opportunity to comment on the proposed rules.

Sincerely,

James E. Dean

James E. Dean
Reimbursement Research Specialist

JED:lo

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS
Room 300
1745 University Avenue
St. Paul, Minnesota 55104

JAN 3 1977

Reference MHD 487 (5)(a)(i) Bad Debts

It is proposed that the following sentence be inserted at the top of page 32 following the sentence ending "near future."

> Bad debts may be included in patient charges in an amount up to the median of its peer group but this amount shall not exceed 1½% of the gross billings to patients as recorded by the hospital.

BCBSM suggests the system should set a limit on the amount of loss due to bad debts a hospital may include in patient charges. As stated in the rules, expenses resulting from the provision of charity care should not be reclassified as bad debts. The purpose of this statement is an effort to assure that patient charges do not include charity care expenses other than as defined in MHD 487 A1a(5)(a)(ii) on page 32. A fair and reasonable limitation on the amount of bad debts permitted for rate setting purposes would be helpful to those responsible for administration of the system and the rate review process.

Reference MHD 487 A1a(3) Educational Program Expense

It is proposed that paragraph (a)(ii) page 29 and paragraph (e) pages 30 and 31 be deleted.

While BCBSM endorses the concept of community preventive health education and the probable benefit such programs may provide to that part of the population that chooses to participate, we believe the required funding should come from sources other than the current hospital patient.

It is the position of BCBSM that patient charges should include only the net cost of educational activities of the hospital which directly contribute to the care of patients who are in the hospital during the time the cost is incurred. The cost of those educational programs conducted for the benefit of non-patients should be paid by those participating in the program or from funds the hospital may have available for such a purpose.

Reference MHD 487 A1a(5)(a)(ii) Charity Allowances

It is proposed that paragraph (ii) on page 32 be deleted and that the cost of charity care not be allowed as an element in patient charges.

Hill-Burton grants have been received by certain hospitals at various times and in varying amounts. The purpose of the grants was to provide financial assistance to selected hospitals for the development of facilities and services. This relieved the hospital of the need to borrow this amount of the funds required to accomplish the construction program and the debt service requirements that would have resulted if a loan had been necessary.

It is BCBSM's position that current patients should not be required to pay for charity care requirements Hill-Burton has imposed on hospitals. Traditionally the hospitals have been allowed to include in patient charges, depreciation expense related to the asset which was constructed from the grant amount. The hospital may now also include an adjustment in patient charges for price level changes for this asset. If the cost of charity care related to the grant amount is included in hospital charges, it could result in the patient paying for the grant at least four times as illustrated below:

Hill-Burton grant of $100,000.00

Depreciation on straight-line basis	$100,000.00
Price level adjustments (100 percent inflation factor)	100,000.00
Charity care requirements (twice the original grant amount)	200,000.00
	$400,000.00

It is suggested that this results in inequitable payment by the patient. To the extent non-patient sources of funds are not available, the needed finances to meet the Hill-Burton requirements should come from the depreciation fund. This would appear to be reasonable as it is the source of funds that would be used to meet principal payment requirements if the money had been borrowed.

Reference MHD 487 Ala(5)(a)(iii) Contractual Allowances and Courtesy Discounts

(1) It is proposed that paragraph (aa) on pages 32 and 33 be deleted and that governmental contract adjustments resulting from Title V, Title XVIII and Title XIX be required to be cost justified and included in paragraph (bb). Wherever mention is made in paragraph (bb) to "certain patients, groups of patients or third party payors" the words governmental contract adjustments should be added.

The governmental programs at the present time do not recognize in their hospital reimbursement programs certain elements of financial requirements included in the rules. The elements are charity, discounts and allowances, adjustments for price level changes and working capital needs, non-patient related education costs and bad debts unless the loss is directly related to Medicare recipient uncollectible amounts and from services normally covered by the program.

BCBSM suggests it is unfair to include in patient charges the amount of governmental discounts which result from reimbursement policies of these programs.

(2) It is proposed that a paragraph (dd) be added on page 34 stating:

Under no conditions are courtesy discounts to be included in patient charges.

This suggestion is based on the belief that the rules do not intend that this form of discount is to be included in patient charges and that those normally receiving such discounts are financially able to pay for services received.

Reference MHD 487 A1b(1)(a) Plant Capital Needs

(1) It is proposed that on page 34 "(a) The greater of:" be deleted and that on pages 34 and 35 paragraph (i) be deleted in its entirety. On page 35 delete Roman numeral (ii) and insert the letter (a) in its place.

BCBSM suggests that straight-line depreciation expense on buildings, building equipment and moveable equipment plus inflation factors provides reasonable allowance for annual debt principal repayment requirements. The situation will occur where a loan includes a large balloon as the final payment. It is believed the system does not intend to make provision for this type payment to be made in full and expects the balloon amount to be refinanced.

(2) It is proposed that on page 37, paragraph (c) the comma and words following "Approved inclusion in rates," and preceding "when a hospital" on line 3 should be deleted. The words are:

> When the hospital can demonstrate that insufficient resources exist in (i) or (ii) above, or."

It is BCBSM's position that including in charges to current patients the total cost of equipment acquisitions would be an unfair practice. The patient charge now includes depreciation expense based on historical cost plus an adjustment for price level changes and patients should not be expected or required to provide funds for this purpose in addition.

(3) It is proposed that on page 34 paragraph b that the following sentence be added at the end of this paragraph:

> In order to include depreciation expense and inflation factors in patient charges the hospital must have received Certificate of Need approval when required.

(4) It is proposed that the following should be added in the Plant Capital Needs section of the rules:

The depreciation fund should be used for the following purposes:

(a) Principal payments on capital debt.
(b) Replacement of buildings, building equipment, movable equipment.
(c) Purchase of new equipment.
(d) Major repairs to buildings and building related equipment.

We believe this is the intent of the rules and the purpose of this suggestion is to clearly state the intent.

(5) It is proposed that consideration be given to the addition of a paragraph which would provide for a limitation upon the amount of funds that may be accumulated to meet the replacement cost of needed facilities.

This suggestion is reasonable on the basis that today's patients should pay for those costs related to the use of today's facilities and tomorrow's patients should pay for the costs related to facilities which they use.

Rates should include only one provision for the costs of facilities for tomorrow's patients; namely, for a reasonable down payment on replacement of buildings.

Reference MHD 487 Alc Working Capital

(1) It is proposed that on page 38 paragraph (1) unrestricted cash and investments should be included in the determination of working capital needs.

The rules now give consideration to Unrestricted Funds from Non-Patient Sources on page 42 2b and state that such funds should be used to reduce the total financial requirements of the hospital. We believe our suggestion is reasonable as it would encompass changes in the cash position of the hospital for all unrestricted funds and would be included on the form which will be provided for calculation of working capital needs.

(2) It is proposed that the system develop parameters for an acceptable rate of annual turnover of inventories by hospital peer groups.

AMENDMENTS

MINNESOTA DEPARTMENT OF HEALTH RULES
CHAPTER TWENTY-EIGHT

Proposed Rules for the
Minnesota Hospital Rate Review System

MHD 471 B. (Page 1)

Beds located in these hospitals, which are not licensed as acute care beds pursuant to Minnesota Statutes, Sections 144.50 to 144.58, are not subject to the requirements of the Minnesota Hospital Rate Review System. Where costs incurred through the operation of these beds are co-mingled with the costs of operation of acute care beds in a hospital subject to the system, associated revenue and expenses and other related data shall be separated in a manner consistent with the normal ~~step-down~~ requirements for allocation of costs as stated by 20 CFR 405.453 (Medicare).

MHD 472 E. (Page 2)

~~"Beds"-means-the-average-number-of-beds-in-a-hospital-which are-in-place-and-operating-with-staff-regularly-assigned to-them-during-an-accounting-period.--This-number-need not-be-equivalent-to-the-licensed-or-constructed-bed-capacity-but-it-shall-be-equivalent-to-the-average-number-of those-beds-commonly-considered-to-be-set-up-and-staffed during-an-accounting-period.~~ "Beds" means the number of

Exhibit No. 15
File No.
Date

acute care beds licensed by the Minnesota Department of Health, pursuant to Minnesota Statutes, Sections 144.50 to 144.58.

MHD 474 B.2.a. (Page 15)

a. The number of inpatient days for the hospital and each appropriate service center.

MHD 474 B.2.d. (Page 15)

d. ~~The number of beds available for the hospital and for each appropriate routine service center.~~ The number of beds (licensed), the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital and for each appropriate routine service center.

MHD 474 B.2.e. (Page 15)

~~e. The average annual occupancy rate for the hospital and for each appropriate routine service center.~~

MHD 474 B.3.d. (Page 17)

d. A statement of total direct and indirect costs for the hospital and for each of its service centers after ~~the step-down~~ an allocation of expenses.

MHD 481 D.3.c. (Page 25)

c. Amendments or modifications which do not exceed the allowable increase limit or provide for rate decreases may take effect immediately upon determination by the hospital's governing authority or its designee. Notice of these amendments or modifications at the time they become effective shall be given to the ~~Board.~~ These amendments or modifications shall also be noted in the hospital's next subsequent rate revenue and expense report.

MHD 481 E. (Page 25)

~~Application for Variance in Rate Determination. If a hospital desires to adopt an alternative method of accounting, cost control, rate determination or payment which may affect the way in which the system proceeds in its assessment of that hospital's rates, it shall notify the system sixty days in advance of the effective date of this new method. Such notification shall detail the new method, including expected impacts upon hospital revenues, expenses and rates as well as the impact of the new method on the equity with which rates are set.~~

MHD 487 A.1.a.(2)(d)(ii). (Pages 28-29)

Incurred on a loan made for a purpose reasonably related to patient care. ~~Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost and which has been determined to have excess capacity, pursuant to MHD 487 A.4., or whose services have been determined to be inappropriate, pursuant to Public Law 93-641, §1523(a)(6) (National Health Planning and Resources Development Act of 1974), are not considered to be for a purpose reasonably related to patient care.~~ Loans made for the following are not to be considered to be for a purpose reasonably related to patient care: to expand facilities that have been determined to have excess capacity, pursuant to MHD 487 A.4.

MHD 487 A.1.a.(3)(a)(i). (Page 29)

(i) Are approved educational activities and can be demonstrated to directly contribute to the care of patients who are in hospitals during the time the cost is incurred; ~~and~~ or

MHD 487 A.1.a.(3)(e). (Page 30)

The extent of costs incurred for the provision of educational activities contributing to the preventive

health education of the population of the hospital's areas of patient origin should not exceed that amount necessary to provide activities recommended appropriate for hospitals by the State Health Planning and Development Agency and appropriate health systems agency, pursuant to Public Law 93-641, §1523~~(a)(6)~~ and §1513, respectively. In any instance, these costs should not include any payments in excess of the normal salary or remuneration to professional employees of the hospital or health professionals who maintain consultative, contractual, or patient relationships with that hospital.

MHD 487 A.1.a.(5). (Page 31)

Bad Debt, Charity Allowances, ~~Courtesy-Discount Allowances,~~ and Contractual Allowances ~~Expenses~~.

MHD 487 A.1.a.(5)(a). (Page 31)

Rates should provide finances necessary to recover losses in revenue due to bad debts, charity allowances, ~~courtesy-discount-allewances,~~ and contractual allowances.

MHD 487 A.1.a.(5)(a)(i). (Pages 31-32)

"Bad debts" mean amounts considered to be uncollectible from accounts and notes receivable which

were created or acquired in providing services. Accounts receivable and notes receivable are designations for claims arising from the rendering of services, and are collectible in money in the near future. These amounts should not include any amount attributable to a reclassification of any expenses incurred due to the provision of charity care. Income reductions due to charity allowances, ~~courtesy discount allowances~~ and contractual allowances should be recorded as such in the records of a hospital and not as bad debts.

MHD 487 A.1.a.(5)(a)(iii). (Page 32)

"Contractual allowances", ~~and "courtesy discounts" are those governmental contract adjustments to or other cost justified discounts or differentials from the established charges of a hospital.~~ "cost justified discounts" and "non cost justified discounts".

MHD 487 A.1.b.(5)(c). (Page 37)

Approved inclusion in rates, when the hospital can demonstrate that insufficient resources exist in the ~~(i) or (ii) above,~~ plant capital fund(s), or when a hospital can demonstrate that inclusion in rates will result in a lower cost to current patients than would result from the borrowing of funds or leasing of plant capital assets. Approval of inclusion in rates shall be by the system upon demonstration by the hospital of either or both of the

conditions herein stated. Once approved, the inclusion in rates of these additional financial requirements may be considered reasonable. Any portion of the annual equal amortized historical cost of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated.

MHD 487 A.1.b.(7). (Pages 37-38)

If a hospital can demonstrate that the ~~inclusion in-the-fund~~ assumption of any specific capital debt will result in a greater cost to current patients than depreciation or retirement of that debt under consistent financial practices of that hospital which differ from the ~~funding~~ determination of plant capital needs as stated by these rules, then a hospital may choose ~~not-to-fund-the-specific-capital debt.~~ an alternative method of meeting its plant capital needs. In this instance, the hospital should provide complete information to the system regarding the precise method which will be used to meet such a plant capital need. Direct inclusion of plant capital needs in rates requires approval by the system as provided by MHD 487 A.1.b., above.

MHD 487 A.2.a.(5). (Page 42)

~~(5)--If-funds-or-the-income-therefrom-are-restricted to-the-provision-of-charity-care,-these-funds or-their-income-should-be-annually-budgeted to-offset-charity-care-requirements-prior-to-the budgeting-of-the-use-of-any-patient-generated revenue-for-charity-care-for-any-accounting period.~~

MHD 487 A.3.b. (Page 44)

If a hospital under-projects its volume in a service center, in the next year its financial requirements should be reduced by the percentage of (fixed) costs of that service center and multiplied by the differences between the actual and budgeted income of that service center.

MHD 487 A.4. (Page 44)

Excess Capacity. For hospitals with occupancy rates, based upon staffed and set up beds, below the average occupancy rate of other hospitals determined by the system to share common characteristics, rates set on the basis of costs may produce unreasonable charges to patients. The system may assess the rates of such hospitals where the criteria of need for beds shall be consistent with the demand for

beds as indicated on a hospital or a service center level by occupancy rates. In cases where low occupancy appears to affect hospital rates, the hospital shall be considered to have excess capacity.

MHD 487 C.2.b.(1)(b). (Page 50)

~~(b)--Prospective-rates-represent-a-minimal-increase which-is-consistent-with-the-principles-of-the bases-for-judging-established-by-MHD-487-A.;~~

TESTIMONY OF PROPOSED RULES OF THE BOARD OF HEALTH GOVERNING THE HOSPITAL RATE REVIEW SYSTEM

St. Paul, Minnesota
January 5, 1977

Submitted by:

Thomas P. O'Hare
Associate Director
Consumer and Professional Relations Division
Health Insurance Association of America

Public Exhibit No. B
File No.
Date

I am Thomas O'Hare, Associate Director of the Consumer and Professional Relations Division of the Health Insurance Association of America (HIAA). The HIAA is an association of over 300 private insurance companies involved in the area of payment of health care benefits on behalf of its insureds.

HIAA member companies account for more than 85% of health insurance benefit payments made by all private insurance companies. (This does not include nonprofit prepayment service plans.) According to our latest figures (1973), private insurance companies paid over $241,000,000 for health benefits in the State of Minnesota. Because of the vast financial resources entrusted to our companies, private insurance companies have an obligation to disperse these funds in the most cost effective manner possible and to maintain premium increases at the lowest level. The concern of insurers in this regard is especially acute in these times of skyrocketing health care costs.

Health care expenditures are annually increasing at multiples of the consumer price index and currently stand at 8.3% of our gross national product (GNP). Experts say that by 1980 more than 10% of our GNP will be dedicated to health care. The single largest component of these expenditures is payment for hospital services. Nationally, expenditures for hospital services will exceed $50 billion in 1976 and are increasing at a rate which will cause a doubling of such expenditures in five years. Minnesota has not been immune from this national phenomenon. Minnesota hospital expenditures have more than doubled in six years increasing from $358,000,000 in 1969 to $744,000,000 in 1975. If the 1975 increase in expenditures of 16.8% continues, hospital expenditures in Minnesota, if unchecked, will double again by 1980.

These astounding increases throughout the nation have placed an increasingly heavy burden on the financing mechanisms, both public and private. The result of this financial strain has given rise to fragmented attempts to control hospital expenditures by the entities, both public and private, which pay under cost reimbursement formulas. For instance, Medicare has implemented limitations on hospital routine service costs. The administration at one point was proposing ceilings on Medicare payments. The Talmadge bill on Medicaid reform promises further limitations. More than a dozen state Medicaid programs have initiated actions to place limits on payment.

The net result of these fragmented attempts is to lessen payment for hospital services and to merely shift costs to the unregulated sector without addressing the key issue of hospital cost increases. What is needed then is a framework, system or program which will guarantee hospitals' needed financial requirements while at the same time providing a broad based public accountability for hospital cost increases and assurance that every effort to contain costs is being made.

Potentially, the hospital rate review section of Senate File 60 can provide at least an approach to such an accountable program. While not mandating hospital rate approval, Senate File 60 does provide a unique opportunity for experimentation with a system that is at the same time mandatory and voluntary. Voluntary because there is no authority to require hospitals to accept the decision of the system and mandatory because the State Health Board will mandate the way in which the system will operate. For this system to succeed, the utmost cooperation between providers, government, third parties and consumers must be maintained.

In New Jersey, a system somewhat similar to that in Minnesota, administered by the New Jersey Hospital Association, was disbanded and taken over by the state. This could happen here unless the system established is credible, effective and accountable. Indeed it is these regulations that will provide the overall credibility, effectiveness and accountability. But they will only do so if they are objective, fair and, yes, even rigorous, because this is a voluntary program which is suspect as to its effectiveness even from the beginning. In many respects, the regulations are not fair and objective and are certainly not rigorous. Nor are they credible in the process by which they arose or in the way they will be finalized.

I am deeply concerned, then, about these regulations and the balanced input (which balances hospital financial desires with the reality of the limitations of community resources) which is so obviously missing as well as the arms-length relaionship which these regulations should have regarding the voluntary rate review system.

The purpose of my comments then is to try to improve these regulations so that they will balance legitimate hospital requirements with the financial resources available and provide some means of an effective public accountability for hospital cost increases.

Specific Comments

MHD 472 G (page 2)

The word insurers is misused in this section inasmuch as insurers do not receive services. Patients are the recipient of services. In addition, it should be recognized that hospital charges form the basis of payment by insurers, prepayment plans and self-insured groups on the patients' behalf. Therefore, this section should read "Charges means the regular amounts charged to patients and/or insurers, prepayment plans and self-insured groups on the patients' behalf".

The deletion of the last portion of this paragraph is necessary since S.F. 60 does not allow any "discounts". To the extent to which the proposed regulations establish discounts or contract allowances, the regulations go beyond the provisions of the law.

MHD 472 U (page 5)

The use of the word "rate" in this section is erroneously defined both as to its commonly accepted meaning and as to the intended meaning of S.F. 60.

The ordinary meaning of "rate" in the context of hospital financial matters is as a payment rate or basis of payment for individual hospital services provided. If so used as defined in this section, it would mean that hospitals wish to be paid by patients and third parties on the basis of average revenue per admission or per case basis. We do not believe this is the intention of these regulations although they could be so construed.

The only meaning to be construed from the use of the word "rate" in S.F. 60, Section 7, is as the basis of payment of services. For example, Subdivision 1 states "The board shall prohibit hospitals from discriminating among

insurers in its rates". Can "rate" mean average revenue per admission? Do hospitals expect to get paid on a charge per case? Obviously not. Do insurers pay on the basis of a charger per case by the hospital? Again, obviously not. Even if such a meaning was being interpreted, payment per case, regardless of type of treatment or length of stay, is nowhere condoned in this Section of the law.

Again, S.F. 60, Section 7, indicates that rates are <u>set</u> by the hospital. Hospitals do not set average revenue per admission, because the exact number of admissions is not known at the time rates are set.

Therefore, MHD 472 U should merely read "Average revenue for each inpatient admission shall be

$$\frac{\text{Total Revenue}}{\text{Number of Inpatient Admissions}}$$

for a full accounting period. Revenue per adjusted admission means

$$\frac{\text{Total Revenue}}{\text{Number of Adjusted Inpatient Admissions}}$$

Average revenue for the budget year shall always..."

As a result, "G" in this Section should read "Rate means the regular amounts charged..." (as amended previously).

MHD 472 AA (page 7)

The definition of "third party payor" should be revised to read as follows:

AA. "Third party payors" means insurers, nonprofit service plan corporations, health maintenance organizations, self-insured or self-funded plans, and governmental insurance programs whether state or Federal including the health insurance programs authorized by Title V, Title

XVIII and Title XX of the United States Social Security Act (Medicaid and Medicare) or any other similar program.

The term "third party payor" has been allowed to grow into misuse by the industry and providers alike. The term correctly applies only to an entity that assumes payment for the patient, not to entities through which the patient has arranged financially for his own payment obligation. The term correctly applies only to government pay programs and not to insurers. Although it is probably too late to attempt correction in the use of this term, at least the definition of "third party payor" should be clarified to include all payment mechanisms as suggested above. Nonprofit service plan corporation certainly must be included along with insurers since S. F. 60 defines a nonprofit service corporation as an insurer.

MHD 474 (page 8)

S.F. 60, Section 7, Subdivision 1, requires reviews or investigations as necessary to assure that total hospital costs are reasonably related to total services, that revenues are related to the hospitals' aggregate costs and that rates are set equitably. As part of the mechanics of this process, Section 8, Subdivision 2a, provides for standards for the filing of appropriate financial information. Appropriate financial information is an absolute must to carry out the charge to the rate review system contained in Section 7, Subdivision 1, cited above.

I submit to you that the annual financial information, rate revenue expense and interim increase reports will <u>not</u> allow the overall system to operate effectively either on behalf of hospitals or the community. This is true primarily because of the failure of the regulations to require a system of at least a uniform system of reclassifying hospital financial information including revenues

and expenses. Without such a system, no hospitals can be adequately compared with one another which is a necessary element in any effective system. For example, one hospital can be on an accrual basis of accounting, another on a cash basis, one hospital can be on a fund accounting system and the other not. The cost of service in a hospital's patient care area cannot be compared to other similar hospitals.

This is a most serious problem which makes the entire reporting requirements nothing but a compilation of financial gobbledygook, mortally affects the promise of any effectiveness from this program to contain costs, prevents the establishment of meaningful evaluative standards for cost increases through departmental comparisons to pinpoint excess cost areas in order to give direction to hospitals as to which areas they should evaluate and promotes hospital comparisons on an inadequate basis. No solace should be taken in the fact that a Medicare cost report will be required by the system. The Medicare cost report is not based on uniform definitions of departmental cost and thereby leads to an inappropriate basis for hospital comparison.

Therefore, there is every good and sound reason and necessary authority in Section 8, Subdivision 2(a), of S.F. 60 to require a system of uniformly reclassifying hospital financial information to produce a meaningful reporting system. Every system worth its salt, including Maryland and Washington, has viewed this as their absolute first priority and essential element for an effective program.

MHD 474 A.1.a.(1) (page 8)

Page 36 of these regulations deals with the use of non-patient income. Such income should be fully disclosed.

Current assets should also disclose donor restricted and unrestricted funds. Such disclosure is necessary for the credibility of the program. For instance, if an institution has substantial but restricted funds available for capital projects, but the hospital decides to finance new construction by insuring debt without utilizing the restricted funds, the system should be in a position to question the appropriateness of that decision. In order to be in a position to ask such a question, the system must know such funds are available. Therefore, they should be reported.

Similarly, funds which have been donated to hospitals for the express purpose of being utilized for patient care or improvements in care should be acknowledged as a current asset and so reported. Although the disposition of such funds is up to the discretion of the board of the hospital, their existence should be acknowledged as being available in order to further establish the credibility of the review system in the eyes of the public.

Although it is acknowledged that there is some difficulty in classifying donor restricted funds as part of current assets, such funds should be footnoted in the balance sheet. A statement of Changes in Fund Balances should also be included.

MHD 474 A. 1. a. (2) (page 8)

Plant capital allowances should <u>not</u> include price level increments for the reasons which will be stated in our comments on MHD 487 A. 1. b. (1)(b) (page 35) on plant capital needs. The purpose of our comments on that section will be to demonstrate that price level factors as contained herein for plant capital needs is unnecessary; unreasonable; contrary to the public interest; and if left in as currently stated, will result in an abdication of the state's responsibility

to assure the credibility of the voluntary rate program. Consequently, if price level increments are not part of the program, they need not be reported here.

MHD 474 (page 8) G

The entire reporting requirements section seems unnecessarily burdensome and cumbersome for hospitals. In particular, the annual financial report and the rate revenue and expense report seem duplicative and should be combined if at all possible. Certainly the annual financial report and the rate revenue and expense report should have identical formats so that a proper reconciliation between projected and actual revenue and expense can be made. Perhaps only the current year and the projected year information could be submitted 90 days before the beginning of the projected year with final figures on the current year being submitted within 120 days after its completion.

MHD 474 A.2.a.(2)(a) and (g) (page 9) H

Land and construction in progress are not depreciable items by anyone's standards and should be eliminated from this listing. Construction will be capitalized and depreciated upon completion of the project.

MHD 474 A.2.a.(2) (page 10) I

This citation should be changed to read "All nonpatient revenues and expenses including nonpatient operating revenue and expense and nonoperating revenue including grants, gifts and donations and the income on such funds".

The point of this change, made primarily to show the true income of the hospital which is more than the amounts generated by operations, is not to dictate the disposition of such funds but to make sure that expenses covered by expenditures of nonoperating revenues are not included as a financial element to be covered by patient rates. The rate review system, to be credible

and effective, must be in a position to determine such activities. To do otherwise would promote double payment for services, with one source coming from the community through philanthropy and the other also from the community through patient rates. This means the community would be paying twice for services which is a misuse of community resources and a subsidy for inefficient operations without any public accountability.

MHD 474 A.2.b. (page 13)

Again, uniformity in reporting is required for the effectiveness of the program.

MHD 474 B.2. (page 15)

Statistical information on classification of type of diagnosis should also be submitted. Variations in case mix can have a significant impact on hospital cost and should be taken into account.

MHD 474 B.2.h. (page 15)

This section should be changed to read that the system will select the best measure of the level of activity for a particular function or service center. In order to operate effectively, the system must establish a uniform basis for comparing hospital expense activity in various areas. To allow the hospitals to select their own measure would destroy this capability. This point again gets back to the absolute necessity of a uniform system of reclassifying hospitals' financial information in order to produce meaningful reports as a basis of comparing hospitals.

MHD 474 B.3.a. (page 16)

The requirement in this section of a minimum of six months actual information for the current year does not coincide with the previous requirement

under MHD 474 B.1.b. which states that the current year information will contain the first eight months actual information with four months estimated.

MHD 474 B.3.b. (page 16)

This section should be amended to require the reporting of direct expenses for each of its service centers and nonservice cost centers such as maintenance and housekeeping as well as revenues for each revenue center.

MHD 474 B.3.d. (page 17)

This section should be amended to clearly indicate that the statement of cost for each of the hospital service centers should break down direct and before step-down allocation of expenses.

MHD 474 C.2. (page 18)

Changes in rates due to legislative policy or appropriations should still be reviewed by the program to assure that rates properly reflect such changes.

MHD 481 C

Reports should be filed 90 days in advance to provide the program more time to review proposals and to allow hospitals to resubmit on the basis of the program's decision.

MHD 481 D.2.d. (page 23)

This section should be amended to read that any such excesses will be taken into account in the next accounting period.

MHD 487 A (page 26)

The system should also be specifically directed to develop norms, standards and criteria, both comparative and normative, for the reasonableness of costs, both direct and indirect, in each patient care area and service areas. Also included should be standards on hospital charity policy, bad debt expense and working capital.

MHD 487 A.1.a.(2)(d) (page 28)

Interest income on invested funds should be used to offset interest expense. Thus it is inappropriate to incur the interest expense of a loan to the extent that other funds are available.

MHD 487 A.1.a.(3)(a)(ii) (page 29)

Educational expenses not related to patient care, improvement of the quality of health care in the institution or to improve administration of the institution should not be paid for by the hospitalized patients. This expense should not be considered a requirement of the hospital.

MHD 487 A.1.a.(5) (page 31)

All references to "Discount Allowances" and "Contractual Allowance Expense", however, defined, in the various subparagraphs of paragraph (5) should be deleted. The provisions of S.F. 60 do not allow for any such discounts. Indeed the language of S.F. 60, Section 7, requires that all purchasers be assured that total costs reasonably relate to total services, that rates be set equitably, and that the Board shall prohibit hospitals from discriminating among insurers. In this context, nonprofit service corporations are defined as "insurers". To attempt to allow discounts of any kind would be in direct contravention of the statutes.

MHD 487 A.1.a.(5) subparagraph (b) (pg 34)

This indicates that "losses in revenue" due to various discounts should be offset by available and applicable income sources other than patients...before they are included in rates. This means that to the extent to which other sources of income (defined in MHD 487 A.2. as charitable, etc.) are insufficient to offset the discounts that the regulations purport to establish, the rates charged to

patients and to the so-called "third party" payment mechanisms, other than Medicare and Medicaid, shall have to bear these deficiencies through discriminatory inflated rates. This means that insurance companies and nonprofit service corporations will be charged inflated rates to make up these deficiencies.

These provisions should be deleted. As pointed out above, there is no basis upon which discounts of any kind can be established extra-legally through the proposed regulations. The language in paragraph (5) above should be deleted since it clearly would attempt to establish an obligation on the part of insurers and nonprofit service corporations to subsidize the deficiencies in hospital rates created by allowing other "payors" to pay something less than the normal hospital "rate".

MHD 487 A. 1. b. (1)(a) (page 34)

The amount of revenue required in this section on funding of plant capital is erroneously and excessively stated. As required in this section, the fund is to be incremented by the greater of annual debt principal repayment or annual straight line depreciation. Because the debt is usually retired in a period of time shorter than the life of the asset, this could result in principal payments in excess of depreciation during the term of the loan with the payments for depreciation after the retirement of the debt amounting to more than straight line depreciation. This section should be amended to read that the total amounts paid to the capital fund should not exceed straight line depreciation over the life of the asset.

In addition, historical cost depreciation in excess of principal payments should not be paid to underutilized facilities. Standards of utilization should be developed by the system. Society should not be asked to continue to pay for unused capacity.

MHD 487 A.1.b.(1)(b) (page 34)

To include price level depreciation in the fashion set forth in this section is inappropriate, inequitable and unnecessary and should, therefore, be eliminated.

Inappropriate

-Price level factors will exacerbate hospital cost increases at a time when they have increased astronomically and are placing a severe strain on financing mechanisms both public and private.

-Price level factors will transfer substantial amounts of money from the community to hospitals for no specific purpose.

-The accumulation and availability of such funds to hospitals will become the driving force behind future capital expenditures which may not be in the community's interest and will increase pressure on HSAs and State Planning Agencies to approve projects which are unnecessary.

-Arbitrarily assigns to each hospital a substantial amount of capital which is unnecessary to meet operating expenses and disregards that facility's current and future needs for plant capital. This is true because the price level factor is applied on the basis of historical depreciation which is a completely inappropriate measure of a hospital's current and future needs. Depreciation expense does not involve any consideration of the reasonableness of the historical cost of the facility.

Thus a facility might have been purchased for $25,000,000; but the community, for one reason or another, paid $40,000,000 (because it wanted more luxurious design). It is not reasonable for the public, through

its taxes and insurance premiums, to pay dollar for dollar for such a facility; and, therefore, it is even more unreasonable to use the historical cost of the factility as the basis for a price level factor.

Inequitable

-This generation is made to pay for next generation's patients by fully funding replacement facilities and would involve a multi-million dollar increase in current health care expenditures.

-Since Medicare and Medicaid will include only standard depreciation computed by generally accepted accounting principles, the private sector patients, including self-pay, and those insured by Blue Cross and private insurance companies will not only be required to pay these unnecessary price level factors but also will be required to pay for these factors which are not recognized by Medicare and Medicaid. This situation is intolerable and shows a complete disregard for the citizens of Minnesota and the funds available for health care services.

Unnecessary

This section on inflation factors on building equipment and movable equipment should be eliminated in its current form as being unreasonable and unnecessary. It is understood that the inclusion in this section of inflation factors is meant to preserve the hospitals' capital assets. However, when one considers that the State of Minnesota has more beds per thousand population (5.9) than any other state in the country, with one exception, and the fact that occupancy levels in Minnesota hospitals are well below the national average (76.7% in the U.S. vs. 72.9% in Minnesota), there is substantial evidence that hospitals in Minnesota are already over

capitalized and, therefore, have absolutely no need to preserve current capital levels, not to mention increasing them. Therefore, the inclusion of price level factors for all hospitals in the State of Minnesota, in such an arbitrary across-the-board fashion, is clearly unnecessary.

-No hospital rate process, either voluntary or legislated, or no contracting agency, either Blue Cross, Medicare or Medicaid, recognize anywhere in the country price level depreciation in the fashion set forth in these regulations. These hospitals, in most areas of the country, are well financed and capable of meeting their communities' needs.

-Let us take a simple example of the results obtained from the use of price level as stated in these regulations.

Assume a hospital capital project of $5,000,000 with 80% debt ($4,000,000) and 20% ($1,000,000) equity financing. If the life of the asset is 40 years and total price level factors are 200%, the hospital will have received payments of $5,000,000 through depreciation plus an additional $10,000,000 through the accumulation of price level payments and interest for a total of $15,000,000. Of the $15,000,000, $4,000,000 was used to retire debt. So at the end of the 40 years, the hospital's equity has grown from $1,000,000 to $11,000,000, an increase of 1100%, to the extent that, now if the facility has to be entirely replaced (which is not likely) at the assumed cost of $15,000,000, the hospital will have $11,000,000 in cash available. The availability of such amounts are unnecessary and not in the public interest.

MHD 487 A.1.b.(4) (page 36)

This section should be amended to read as follows, "The annual interest income earned from an investment of this fund annually will be reduced to offset plant capital needs". Price level factors should not be included for reasons previously stated and interest income from accumulated and funded depreciation is an appropriate offset to capital needs.

MHD 487 A.1.b.(5)(c) (page 37)

This section apparently allows for the expensing in one year of a capital item. It is difficult to see how such a situation could possibly exist under any acceptable accounting practice or could work in the best interest of the community when depreciation funds are being provided by the program. Therefore, this section should be eliminated.

MHD 487 A.1.b.(7) (pages 37 and 38)

This section allows institutions not to utilize accumulated funds for capital purposes in favor of debt financing. Again this is difficult to see how such a situation can arise when the purpose of funded depreciation is to provide resources for capital expense. If this situation should occur, certainly there should be an offset of interest expense with interest income on depreciation funds at some point in time.

MHD 487 A.1.c. (page 38)

As indicated previously, the system should establish norms for calculating acceptable parameters for working capital and should not allow continuation of inefficient billing and credit practices which unnecessarily increase working capital requirements.

MHD 487 A.2. (page 41)

This entire section on the use of income from other than patients is too permissive. Therefore, all the statements about "should be used (or not used)" ought to be changed to "will be used (or not used)".

These funds are derived from the community for the purpose of providing a resource to institutions and are to be used for this purpose. In addition, it should be clearly stated that such funds will not be used to pay for requirements previously included in financial requirement in patient rates so that a subsidy of ineffectiveness or double payment is realized.

Also, hospitals should not only disclose the extent to which such funds are used to offset costs, but also the extent they are available to offset costs so that the program can raise the question about the appropriateness of non-utilization of such funds.

MHD 487 A.4.c. (page 45)

This section is mistated. As indicated previously, price level factors are inappropriate. However, if the hospital has incurred debt with violating any certification of need procedures, that debt must be retired. At the same time, depreciation payments relating to the excess capacity should they exceed principal payments related to those beds should not be paid.

MHD 487 C.(2) (page 49)

General comments are in order here.

-The system should be given positive direction to establish comparative and normative cost and revenue standards among service centers. Norms for working capital, bad debts and charity must also be established.

Pg 11 on Ex # F

-S.F. 60 calls for equity in rates. Such equity should not only be construed to include patients based on third party sponsorship but also patients categorized by the services they receive in the hospital. Therefore, it is inequitable for a patient who receives a certain service to be subsidizing patients who receive other services. Therefore, the patient who uses the pharmacy should not, in effect, pay for the patient using the obstetrical or intensive care units. The program should establish limitations to such subsidies and require justification for any deviations.

-The system must be required to render its findings prior to the implementation of a new budget year or implementation of an interim increase.

MHD 504 (pages 55 and 56)

The allowable increase limits should not be uniform across-the-board for all hospitals, but should be tailored to meet the needs of individual hospitals or at least categories of similar institutions. Hospitals differ in case mix, wage and non-wage costs, etc. All these factors have to be taken into account. The allowable increase limit should also be used as the mechanism for adjusting for revenue deficiencies or excess from prior periods.

MHD 504 H.3. (page 57)

Salaries, wages and fringe benefits to employees constitute approximately 55% of a hospital's annual expense. Therefore, so significant an element of cost should not be allowed to be passed through without scrutiny by the program. What is suggested, at the very least, is that the program develop labor indicators to serve as the basis for comment on negotiated settlements.

Certainly nothing in this section will militate against the program's ability to render judgment on staffing patterns and practices in various hospital departments

Similarly, the impact on rates by legislative action for welfare hospitals should continue to be reviewed to make sure such increases are appropriate.

General Comments

In addition to the specific comments made on these regulations, several other inclusions in the overall system would assist in making the program more accountable.

1. The composition of the rate review panels and the term of service of each of the members on such panels should be determined. It would seem appropriate if the composition of the rate review panels consisted of one-third providers, both doctors and hospitals; one-third consumers, including labor and management; and one-third representatives of third party payors, including Blue Cross, self-insured group representatives and private insurance companies.

2. In addition, the Board of Health should appoint an oversight committee to review the activities of the voluntary program with the express purpose of recommending to the Health Board modifications of the program necessary to more appropriately guarantee hospitals' financial requirements and the cost of effectiveness of the overall system.

The composition of the oversight committee should in similar fashion to the rate review panels be composed of one-third provider representatives, both doctors and hospitals; one-third consumers, including labor and management; and one-third third party payors, including the State Department of Welfare, self-insured groups, Blue Cross representatives and representatives of private insurance companies.

METROPOLITAN
HEALTH
BOARD

300 Metro Square Building, 7th Street and Robert Street, Saint Paul, Minnesota 55101 Area 612, 227-9421

January 5, 1977

Warren Lawson, M.D.
Commissioner of Health
State Department of Health
717 Delaware Street, S.E.
Minneapolis, MN 55440

Dear Dr. Lawson:

The Health Board has appreciated the opportunity to help draft rules for the Minnesota Rate Review System. We look forward to working with the new Director of the System and with you and other members of the staff at the Department of Health as the System begins its operations.

We are submitting the brief set of comments to the proposed rules in the interest of clarifying a few points that seem to have escaped scrutiny during the lengthy process of drafting the rules. Some other points are raised to emphasize our own official policy of cooperation and support.

If any clarification of our comments or suggested amendments is necessary, please contact me or Malcolm Mitchell. We are anxious to provide whatever assistance we can to you in your efforts to implement the Rate Review System.

Sincerely,

Doris Caranicas

Doris Caranicas
Chairperson,
Metropolitan Health Board

DC/es

Public's Exhibit No. C
File No.
Date

Comments of the Metropolitan Health Board
on Proposed Rules for Minnesota Rate Review System

5 January 1977

The Health Board of the Metropolitan Council supports the efforts of the Minnesota Board of Health to implement Article II of Chapter 296, Minnesota Statutes, which authorizes a Minnesota Rate Review System; the staff of the Health Board has participated in the process of drafting these rules and has kept the Health Board informed of progress to date. The Health Board also supports the efforts of the Minnesota Hospital Association to aid in the implementation of this important legislation, and to this end submits the following comments and suggested amendments approved by the members of the Health Board on the 22nd of December, 1976.

COMMENT
Prospective Rate Setting

The Health Board recognizes that the new Rate Review System is intended to be the first step in developing a statewide method of assuring equitability, efficiency, accountability, and economy in the financial operations of health-care institutions. Many experimental and established programs using the techniques of rate review

or prospective rate setting exist across the country, and such methods have become widely recognized as potentially powerful ways of controlling some increases in institutional medical-care costs. The Health Board is also aware that prospective rate-setting programs must be designed with great care, and that many of the current programs must be considered to be experimental. In addition, the Health Board understands that the methods that may prove effective and equitable in other States might not be the best choices for Minnesota, whose health-care industry is unusual in a number of respects.

For these reasons, the Health Board considers it wise to proceed slowly, but deliberately, toward making a decision about establishing a prospective rate-setting system in this State. The Health Board intends to watch the performance of the new Rate Review System and to keep informed about the effects of programs in other States in order to make its own judgment about the desirability of a rate-setting program for Minnesota.

COMMENT
Uniform Accounting

Uniform accounting among health-care institutions is an essential element of a rate-setting system; but even without a rate-setting or reviewing system, uniform accounting should be mandated. Uniform accounting allows each institution to judge its financial status according to the financial stituations of comparable institutions; it makes it possible to set equitable standards for regulatory decisions regarding health-care institutions; and it provides information about the health-care industry as a whole that will bring a better understanding of the true factors behind the inflation of health-care costs. Uniform accounting, therefore, should be as much to the advantage of health-care institutions as it would be to planners and regulating agencies. It is for these reasons that uniform accounting has been made one of the ten priorities listed in the National Health Planning and Resource Development Act of 1974 (PL 93-641). Making possible a uniform accounting system among Minnesota health-care institutions should be a major objective of the Rate Review System in Minnesota.

COMMENT
Scope of the Act and Rules

The Health Board hopes that legislators and members of the Board of Health have plans eventually to include all licensed health-care institutions under the provisions of the Rate Review System. (In this regard, it might be practical to substitute the term "health-care institutions" wherever the word "hospital" now appears in the rules.) It is recognized that such a change in the scope of the System would have to come as a statutory mandate. The Health Board will be exploring this issue in the months to come.

AMENDMENT
Emergency and Outpatient Visits

The definitions of "admissions, " "emergency visits, " and "outpatient visits" are in conflict in the current draft of the rules. The definition of an admission makes it "the number of patients accepted for inpatient services." The definitions of emergency and outpatient visits, however, make them "admissions." The conflict in logic is obvious. The Health Board recommends that the definitions of emergency and outpatient visits read as follows:

<u>On Page 3, item "I."</u>

"I. 'Emergency services' are those inpatient or outpatient hospital services that are necessary to prevent immediate loss of

life or function due to the sudden onset of a severe medical condition."

On Page 3, item "J."

"J. 'Emergency visit' means an acceptance of a patient by a hospital for the purpose of providing emergency services in a distinct emergency service center."

On Page 5, item "R.", substitute:

"R. 'Outpatient visit' means an acceptance of a patient by a hospital for the purpose of providing outpatient services in a distinct outpatient service center."

On Page 15, items "f." and "g."

Delete the word "admissions" and substitute "visits".

AMENDMENT Addition to Required Financial Information

The list of required information on pages 16 and 17 of the proposed Rules is incomplete; no mention is made of the capital budget of the hospital, even though this item would seem to be both relevent and available. It might be desirable to request this budget in some detail, and the Health Board makes the following suggestion for amendment with the understanding that its intent will be put into the most appropriate technical language:

On Page 17, after "f." insert:

"g. A statement of the capital budget of the hospital."

COMMENT Inclusion of PSRO in Rate-Review Notifications

In view of the fact that the Foundation for Health Care Evaluation (the Professional Standards Review Organization for portions of Minnesota) is involved in some considerations related to the rate-review process, it would seem appropriate that they be notified of the same information that the rules specify will be routinely forwarded to health systems agencies. (Examples of these automatic notifications are found on page 21, items "B.2." and "C.2.a." Other examples can be found elsewhere in the proposed rules.)

AMENDMENT Interest Expenses

The text of item ii under (2)(d) on the bottom of page 28 is difficult to read and may cause some confusion. For clarity, it should be rewritten in the following manner:

"(ii) Incurred on a loan made for a purpose reasonably related to patient care. Loans should not be considered reasonably related to patient care when they:
(aa) are made to finance the acquisition of a facility that has been determined to have excess capacity, pursuant to MHD 487 A.4., or
(bb) have been determined to be inappropriate by the relevant health systems agency and the State Health Planning and Development Agency."

The reference in the existing language of this provision to loans that are made to finance that portion of the cost of acquisition of a facility that exceeds historical cost is both unclear and unnecessary, since it is or should be covered under the provisions of item (2)(d)(i) above. For this reason, it has been excluded from the recommended revision.

AMENDMENT Preventive Educational Expenses

The reference to appropriateness review by the State Health Planning and Development Agency in regard to costs incurred for the provision of education activities should be amended to be consistent with other such references.

On Page 30, item "(e)", lines 6-9, substitute:

"activities recommended appropriate for hospitals by the State Health Planning and Development Agency and the relevant health systems agency, pursuant to Public Law 93-641, §1523 (a)(6). In any instance, these costs...."

CONCLUSIONS

The Health Board is responding to the proposed rules in a spirit of cooperation and support. In particular, the Health Board assumes that the Rate Review rules imply a mandate for the System to establish permanent coordinative mechanisms with HSA's and with other pertinent agencies, such as the Foundation for Health Care Evaluation, and that nothing in the proposed rules will put the Rate Review System in conflict with the activities of other state and regional agencies. The value of coordination is obvious: it allows the HSAs to monitor their performance in restraining costs; it reduces the burden on providers to supply redundant sets of data to different agencies; it allows the PSRO to keep informed of overall cost information related to quality-of-care factors; and it helps to protect individual institutions from being caught in unintentional conflicts between the requirements of different agencies.

In the years to come, the Health Board will be working more and more closely with the Rate Review System to bring about a more effective and equitable planning and regulatory apparatus. It is expected that the proposed rules will be a large step in that direction.

Medical Center ● 701 Park Ave. So., ●neapolis, Minnesota 55415

RECEIVED
JAN 12 1977
OFFICE OF HEARING EXAMINERS

HENNEPIN COUNTY

January 10, 1977

Mr. Steve Mihalchick, Hearing Examiner,
Office of Hearing Examiners, Room 300
1745 University Avenue
St. Paul, Minnesota 55104

Re: Rules as Proposed, Chapter 28 MHD 471 through 520

Dear Mr. Mihalchick:

MHD 487, A., 1., a., (5), (a), (ii), defines "charity allowances" which may be included in the current operating needs related to patient care which should be covered by an institution's rates. The definition restricts charity care to those institutions which have a committment under 42 CFR 53.111 (f) and (g), more commonly known as the Hill-Burton requirement. Defining charity allowances which will be allowed for rate purposes in this manner is not only severely restrictive but places the Minnesota Health Department in a position of usurping some of the authority of hospital governing boards and the communities which they serve.

There are a number of institutions in the State of Minnesota which do not have Hill-Burton requirements for free care. The definition of charity care proposed above will force these institutions to either fund this charity care from sources other than patient charges or to curtail the level of charity care which they have traditionally given to their community. I am sure that this was certainly not the intent of the Legislature when they passed Minnesota Statutes 10A .01 sub-dividion 11 (1974), and I would also be disappointed if this was the intention of the Minnesota Health Department.

Defining charity allowances as proposed might by implication be construed to limit the amount of charity care an institution could provide to its community to that obligation in terms of total dollars which it has because of its Hill-Burton committment. The effect of this would be the same, in other words charity care could be seriously curtailed or limited in certain situations.

Hennepin County Medical Center has an obligation under State Law and a moral obligation to provide charity care to needy persons who reside within Hennepin County and others in case of emergency. A large portion of the cost of this charity care is of course, funded through local property taxes. Our requirement for providing free care under the Hill-Burton Act for the next

Public's Exhibit No. D
File No. ...

twenty years is approximately $370,000 per year while we in fact will provide charity care this year worth approximately 4½ million dollars. If the regulations as proposed by you are interpreted to mean that only $370,000 of the charity care provided by us will be allowed for rate setting purposes, we are obligated to rely upon the regressive and repressive property tax to meet our statutory and moral obligations. While it is true that we would not propose to pass this entire obligation along to patients and third parties in the form of rates, we do not feel it is in the interest of the tax payers of Hennepin County or the patients this institution serves to force County government to levy a tax for the entire amount of charity care rendered in excess of those Hill-Burton requirements.

MHD 481 sets forth the general provisions for filing of reports under the proposed rules. The only comment that can honestly be made about this particular section is that the individuals who proposed the time filing dead-lines have absolutely no appreciation for the time frames required by health care institutions for gathering the extensive data required by these rules. I am sure that if these rules are allowed to stand with the filing dates as required, your department will spend much more time in processing requests for exceptions to the filing dead-lines than they will in actually processing the data filed.

Sincerely,

Mark S. Tidgewell

Mark S. Tidgewell
Fiscal Services Administrator
Hennepin County Medical Center

FOUNDATION FOR
HEALTH CARE EVALUATION
Suite 400 20 Washington Ave. So.
Mpls., Minn. 55401 612/339-6871

RECEIVED
JAN 14 1978
OFFICE OF HEARING
EXAMINERS

January 12, 1977

Steve Mihalchick
Hearing Examiner
Office of Hearing Examiners
Room 300
1745 University Avenue
St. Paul, Minnesota

Dear Mr. Mihalchick:

The Foundation for Health Care Evaluation is a private non-profit organization of physicians which has been working since 1971 with other health care providers and consumers in peer review of health care. Because of its involvement in peer review, the Foundation also serves as the Professional Standards Review Organization (PSRO) for the seven-county Twin Cities metropolitan area. PSROs are physician organizations established to fulfill Public Law 92-603 which mandated review of health care provided to patients under Medicare, Medicaid and Maternal and Child Health and Crippled Children's Services.

To comply with this law the Foundation has implemented the Health Care Evaluation Program in all 38 metropolitan area hospitals. Although the law only requires review of federally financed patients 35 of the 38 hospitals use our Health Care Evaluation Program to review all patients both federal and private. I have enclosed a brief description of our Health Care Evaluation Program.

Let me first begin my comments by quoting the "declaration of purpose" as stated in Public Law 92-603 sec. 249F.

> "In order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this Act and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under the Social Security Act will conform to appropriate professional standards for the provision of health care and that payment for such services will be made -
>
> "(1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and

Public's Exhibit No. E
File [illegible]

"(2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion."

The intent of the law is to assure that quality care is delivered in the most economical setting consistent of professionally recognized standards of care. As review programs such as the Foundation's Health Care Evaluation Program are implemented in hospitals there will be a change in the type of patient in the hospital. As more patients are treated in outpatient clinics, physician's offices, and long term care facilities, this will leave only the most acutely ill patients in the hospital. These acutely ill patients will require highly specialized treatment. As a hospital's patient population consists of a higher and higher percentage of these acutely ill patients a hospital's overall costs for patient care will increase proportionally. These costs for treating the increasing proportion of acutely ill patients will be reflected in higher hospital rates.

Another result of the Foundation's Health Care Evaluation program may be to lower occupancy, in certain hospitals, to the point where they may be considered to have "excess capacity". These factors will affect health systems agencies as well as rate review systems.

For instance suppose two similar hospitals are considered to have "excess capacity". However, one hospital performs utilization review on all patients while the other reviews only federal patients. Although both hospitals may have identical occupancy rates, the reasons for those rates may differ. The hospital performing all patient review may have "excess capacity" because they are utilizing their facility in a very efficient and appropriate manner. That is, all the patients not requiring acute level of care have been screened out and treated in more appropraite settings such as outpatient clinics or long term care facilities. The hospital reviewing only federal patients may have many private patients utilizing the facility who could be treated more appropriately in oupatient clinics or long term care facilities.

As you can see, on the surface two facilities may appear the same, in that they both have "excess capacity". However, one may be doing a more effective job of utilizing resources and controlling health care costs. I would encourage state planning agencies, HSA's and the Minnesota Hospital Rate Review System to consider these factors in their deliberations.

I offer these comments in a spirit of cooperation and coordination. As allocation of health care resources becomes increasingly difficult, cost/quality will become an even more crucial and complex issue. Therefore, it is important that the various health related agencies communicate regularly. The Foundation has no desire to become involved in the mechanics of the rate

review system as I'm sure the rate review system does not wish to become involved in the mechanics of quality assurance. However, it is important to be aware of how each organizations actions may impact on hospitals. This will prevent hospitals from being placed in the position of being asked to comply with conflicting regulations from different agencies.

Health Systems Agencies and Professional Standards Review Organizations are required by law to enter into a memorandum of understanding. The Metropolitan Health Board and the Foundation are working on such an agreement which will provide for; data and information sharing, notification of proposed activities, sharing of technical assistance, coordination of effort through regular communication and cross representation on committees. A similar agreement between the Minnesota Hospital Rate Review System and the Foundation for Health Care Evaluation may be one method of facilitating coordination and communciation.

On the following page I have included four specific suggestions for change in the rate review regulations. If I can be of any assistance or answer any questions please contact me.

Thank you for your consideration.

Sincerely,

Carl G. Gustafson

Carl G. Gustafson
Administrative Director

CGG:wlo

Enclosure

cc: Allin Karls, Minnesota Hospital Association
Fred Sattler, Minnesota Department of Health
Malcolm Mitchell, Metropolitan Health Board

Jan. 12, 1977

SUGGESTED CHANGES IN THE MINNESOTA HOSPITAL RATE REVIEW SYSTEM PROPOSED REGULATIONS

Page 21, B-2, Line 5 be changed to read "...appropriate health systems agency and professional standards review organization to this effect."

Page 21, C-2a, Line 6 be changed to read "...appropriate health systems agency and professional standards review organization to this effect."

Page 44, 4a, Line 2 be changed to read "...shall submit its preliminary determination to the appropriate professional standards review organization which is identified according to Public Law 92-603, Sec. 249F, and to the appropriate health systems agency and to the State Health Planning and Development Agency both of which are identified according to Public Law 93-641, Sec. 155 and Sec. 1521. The professional standards review organization may comment to the system regarding the consistency of this preliminary determination with professionally recognized health care standards regarding occupancy rates and whether this low occupancy rate may be (in whole or in part) the result of professional standards review as mandated by Public Law 92-603 Sec. 249F. The appropriate health systems agency and the State Health Planning and Development Agency may comment to the system regarding the consistency of this preliminary determination with health planning standards regarding occupancy rates.

Page 45, 4b, Line 2 be changed to read "...is consistent with health planning and professionally recognized health care standards and, if applicable, the declarations..."

RECEIVED
JAN 14 1978
OFFICE OF HEARING EXAMINERS

HEALTH INSURANCE ASSOCIATION OF AMERICA
CHICAGO NEW YORK WASHINGTON

CONSUMER and PROFESSIONAL RELATIONS DIVISION
Thomas O'Hare, *Associate Director*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0801

January 11, 1977.

Mr. Steve Mihalchick
Hearing Examiner
Office of Hearing Examiners
Room 300, 1745 University Avenue
St. Paul, Minnesota 55104

Dear Mr. Mihalchick:

My written statement submitted at the hearing in the matter of the proposed rules of the Board of Health governing the hospital rate review system inadvertently omitted a page of testimony. Enclosed with this letter is the material omitted which I am now submitting for consideration.

At this time, I would like to submit further comment on the definition of rate contained in the proposed rules MHD 472 U. In that section, rate is defined as meaning the average revenue for each inpatient admission. I believe that the definition of rate must satisfy at least two basic criteria. The first is that the definition be reasonable and second that it is capable of appropriately interpreting the language contained in S.F. 60 relative to the rate review system.

Relative to the first criterion, as I've indicated in my previously written statement, "rate" is generally understood to mean a rate of payment or basis for payment for hospital services. The only situation in which rate is defined in a manner similar to the proposed regulations is in the State of Washington. However, the definition, as used in the Washington rate setting situation, is challengeable as a violation of the intention of their enabling legislation. In summary on this point, then, "rate" is generally understood to be a charge and is so utilized throughout the country with the only exception being the State of Washington where we believe it is subject to challenge.

However, let us assume for the moment that the proposed definition is reasonable. Granting such an assumption, however, does not allow for an appropriate interpretation of the word "rate" as used in Article II, Section 7, of S.F. 60. In Subdivision 1 of that Section, the legislative requirement is made that the Board

Public's Exhibit No. F
File No.
Date

shall prohibit hospitals from discriminating among insurers in its rates. We would argue that the proposed definition of rate does not allow a determination of discrimination among insurers.

A review of the proposed definition of rate indicates that rate, so defined, is a single figure for the entire institution which does not regard in any way whatsoever the sources of hospital revenue which would be necessary to make a determination on the issue of discrimination. As can be seen from the proposed definition, rate is a monolithic figure calculated by dividing the number of admissions into total revenue. Therefore, substituting this definition in the Section quoted above, it would read: "The Board shall prohibit hospitals from discriminating among insurers as determined by $\frac{\text{total revenue}}{\text{number of inpatient admissions}}$". Clearly, this is an impossible situation in which differences between payment sources are being determined by a single overall hospital average revenue figure.

An alternative position might be identified by dividing total revenue from each insurer by the number of admissions of that insurer. However, such a definition is equally unworkable. This is true, because the program would then have to separately identify each individual insurance company payment which may run up to as many as 100 or more in the State of Minnesota in any one hospital. I do not believe the program is capable of making such extensive investigations. Even granting that such an investigation would be possible, it would be severely hampered by the differences in the modes of treatment rendered to each individual patient so that even if there were no discrimination among the average revenue from an insurer per admission and another insurer, the difference in the types of treatment of the insured patients would render such figures meaningless.

Therefore, the only workable definition of rate is to make it equivalent with hospital charges as defined in MHD 472 G. I recognize that one of the justifications for the proposed definition is to avoid swamping the program with myriads of hospital charge schedules. However, such submissions are not necessary for the effectiveness of the program. All that has to be assured is that there is no discrimination in charges and the impact of charge increases can be measured by changes in average revenue per inpatient admission.

If my point on this matter is not sufficiently clear, I would be happy to attempt a further clarification. Thank you very much.

Sincerely,

Thomas P. O'Hare

Thomas P. O'Hare
Associate Director

TPO/mjh
Enclosures
cc: Mr. Fred Sattler
Mr. Caroll Callaway

RECEIVED
JAN 14 1978
OFFICE OF HEARING
EXAMINERS

TESTIMONY OF PROPOSED RULES OF THE BOARD OF HEALTH GOVERNING THE HOSPITAL RATE REVIEW SYSTEM

St. Paul, Minnesota
January 5, 1977

Submitted by:

Thomas P. O'Hare
Associate Director
Consumer and Professional Relations Division
Health Insurance Association of America

MHD 487 A.2. (page 41)

This entire section on the use of income from other than patients is too permissive. Therefore, all the statements about "should be used (or not used)" ought to be changed to "will be used (or not used)".

These funds are derived from the community for the purpose of providing a resource to institutions and are to be used for this purpose. In addition, it should be clearly stated that such funds will not be used to pay for requirements previously included in financial requirement in patient rates so that a subsidy of ineffectiveness or double payment is realized.

Also, hospitals should not only disclose the extent to which such funds are used to offset costs, but also the extent they are available to offset costs so that the program can raise the question about the appropriateness of non-utilization of such funds.

MHD 487 A.4.c. (page 45)

This section is mistated. As indicated previously, price level factors are inappropriate. However, if the hospital has incurred debt with violating any certification of need procedures, that debt must be retired. At the same time, depreciation payments relating to the excess capacity should they exceed principal payments related to those beds should not be paid.

MHD 487 C.(2) (page 49)

General comments are in order here.

-The system should be given positive direction to establish comparative and normative cost and revenue standards among service centers. Norms for working capital, bad debts and charity must also be established.

-S.F. 60 calls for equity in rates. Such equity should not only be construed to include patients based on third party sponsorship but also patients categorized by the services they receive in the hospital. Therefore, it is inequitable for a patient who receives a certain service to be subsidizing patients who receive other services. Therefore, the patient who uses the pharmacy should not, in effect, pay for the patient using the obstetrical or intensive care units. The program should establish limitations to such subsidies and require justification for any deviations.

-The system must be required to render its findings prior to the implementation of a new budget year or implementation of an interim increase.

MHD 504 (pages 55 and 56)

The allowable increase limits should not be uniform across-the-board for all hospitals, but should be tailored to meet the needs of individual hospitals or at least categories of similar institutions. Hospitals differ in case mix, wage and non-wage costs, etc. All these factors have to be taken into account. The allowable increase limit should also be used as the mechanism for adjusting for revenue deficiencies or excess from prior periods.

MHD 504 H.3. (page 57)

Salaries, wages and fringe benefits to employees constitute approximately 55% of a hospital's annual expense. Therefore, so significant an element of cost should not be allowed to be passed through without scrutiny by the program. What is suggested, at the very least, is that the program develop labor indicators to serve as the basis for comment on negotiated settlements.

Certainly nothing in this section will militate against the program's ability to render judgment on staffing patterns and practices in various hospital departments.

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT HEALTH

Office Memorandum

TO : Mr. Steven Mihalchick
Office of Hearing Examiners

DATE: 1/11/77

FROM : Kent E. Peterson, Chief
Planning & Resources Control Kent E. Peterson PHONE: 296-5365

SUBJECT: DRAFTING OF PROPOSED RULES
FOR HOSPITAL RATE REVIEW

RECEIVED
JAN 18 1977
OFFICE OF HEARING EXAMINERS

During the opening remarks of the January 5, 1977 public hearing on proposed rules for the Minnesota Hospital Rate Review System, Mr. Thomas O'Hare alleged that his organization had not been provided sufficient opportunity to provide input into the proposed rate review rules. At the time, I disagreed with his allegation and I offered to submit evidence to show that the Department of Health repeatedly requested input from the Health Insurance Association of America.

There has been correspondence regarding proposed rules between the Department of Health and the Health Insurance Association of America since May 6, 1976. Additionally, we have met personally with Mr. O'Hare and his colleagues. We made no attempt to exclude Mr. O'Hare from any other meetings regarding these rules. However, due to the lack of his response to the first draft of rules (July 27, 1976) and also due to his location in Chicago, he did not receive notice of all of the meetings of our technical advisory group. Nevertheless, Mr. O'Hare had ample opportunity during other occasions, to make suggestions for the proposed rules.

Besides the official "Notice of Intent to Obtain Information from Non-Agency Sources," following is a list of communications with Health Insurance Association of America regarding drafting of our proposed rules:

1. Attached is a May 6, 1976 letter from Caroll Callaway, Assistant General Counsel, Health Insurance Association of America to Warren R. Lawson, Commissioner, Minnesota Department of Health. (Attachment #1)

2. Attached is a June 1, 1976 letter of reply from Kent E. Peterson, to Mr. Caroll Callaway. (Attachment #2)

Depts Exhibit No. 16

File No.

Date

3. There was a telephone conversation during June between Mr. Thomas O'Hare, Associate Director, Health Insurance Association of America, and Kent E. Peterson regarding concepts to be included in the rate review rules and the retention of Stephen M. Jackson to develop a draft of proposed rules.

4. Attached is a June 30, 1976 letter from Mr. Thomas O'Hare to Mr. Stephen Jackson. (Attachment #3)

5. Also attached is a July 13, 1976 letter from Mr. Caroll Callaway to Kent E. Peterson. (Attachment #4)

6. An additional attachment is a July 27, 1976 memo to Mr. Thomas O'Hare from Mr. Stephen Jackson which included the "discussion draft" of proposed rules. (Attachment #5)

7. On August 3, 1976, Mr. O'Hare and various representatives of commercial insurance companies met with Mr. Jackson and Mr. Peterson at the Department of Health regarding the status of rate review drafts. The insurance representatives were strongly urged to provide input and were invited to the August 6, 1976 meeting of the voluntary, technical advisory group. (No HIAA representatives attended the August 6th meeting.)

8. On September 21, 1976, a copy of the most recent draft of the rate review proposal was sent to Mr. Terry Klas, the local representative for Health Insurance Association of America.

9. We have also attached an October 6, 1976 letter from Mr. Thomas O'Hare to Mr. Stephen Jackson in which Mr. O'Hare makes some comments on proposed rules and apologizes for not making comments on previous drafts. (Attachment #6)

10. Mr. Caroll Callaway wrote to Kent Peterson on November 15, 1976 to submit additional comments regarding the proposed rules. (Attachment #7)

11. On November 30, 1976, Mr. Peterson replied to Mr. Callaway and invited HIAA to submit comments to the January 5, 1977 public hearing. (Attachment #8)

Finally, I believe that the documents previously submitted to the Hearing Examiner show that the State Board of Health complied fully with legal requirements for public notification. The evidence presented in this memo shows that the Health Insurance Association of America was given more than minimum, legal opportunity to make suggestions during the drafting process.

KEP:kmt
Enclosure

ATTACHMENT #1

MAY 10 1976

Executive Officer
Dept. of Health

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO · NEW YORK · WASHINGTON

LESLIE P. HEMRY, *President*

LEGAL DEPARTMENT
John P. Hanna, *Senior Vice President and General Counsel*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0301

May 6, 1976

RECEIVED
JAN 18 1977
OFFICE OF HEARING EXAMINERS

RECEIVED
MAY 12 1976
HMO Unit
Minn. Dept. of Health

Warren R. Lawson
Commissioner
State Board of Health
717 Delaware S. E.
Minneapolis, Minnesota 55440

Dear Commissioner Lawson:

The Minnesota Legislature recently enacted into law S. F. 60. Article II of this law establishes various mechanisms under the jurisdiction of the Board of Health for hospital and other health care facility rate review, uniform accounting procedures and financial reporting.

Our Association is a voluntary one representing the majority of insurance companies transacting health insurance in this country. The health insurance business is vitally concerned about the escalation of health provider costs and is, therefore, very much interested in legislation such as Article II of S. F. 60.

The purpose of this letter is to inform you of the interests of our business and to offer whatever assistance that would be appropriate to the Board in implementing the provisions of this new law. We would certainly appreciate being included in your mailing list for notices of any hearings that might be held in developing regulations under this law.

Yours truly,

Caroll Callaway

Caroll Callaway
Assistant General Counsel

CC/me

ATTACHMENT #2

June 1, 1976

Mr. Caroll Callaway
Assistant General Counsel
Health Insurance Association
of America
332 South Michigan Avenue
Chicago, Illinois 60604

Dear Mr. Callaway:

Your letter to Doctor Warren R. Lawson of May 6, 1976, regarding Hospital Rate Review in Minnesota was forwarded to my attention. Our office is developing the mechanisms under which the Minnesota rate review program will operate and is willing to receive any suggestions for its operation.

We will include your name and address on the mailing list to receive drafts of the rules to be proposed regarding hospital rate review; however, as additional assistance, we invite you to submit your views and recommendations even before the rules are proposed.

It is my understanding that the Health Insurance Association of America has been extremely active in support of hospital rate review programs around the nation and, your suggestions on this program would be greatly appreciated.

Sincerely,

Kent E. Peterson

KEP:kmt

ATTACHMENT #3

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO · NEW YORK · WASHINGTON

LESLIE P. HEMRY, *President*

CONSUMER and PROFESSIONAL RELATIONS DIVISION
Louis A. Orsini, *Vice President and Director*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0801

June 30, 1976

RECEIVED
JUL 6 1976
HMO Unit
Minn. Dept. of Health

Mr. Steve Jackson, Consultant
Minnesota State Health Department
717 Delaware Street, Southeast
Minneapolis, Minnesota 55440

Dear Mr. Jackson:

I am writing this letter as a follow up to our phone conversation in which I indicated our interest in the regulations which you will be issuing from your office relative to the hospital rate review program in Minnesota.

One of the items which we discussed was the issue of depreciation. I am enclosing with this letter a copy of testimony by the Maryland Commission staff which goes into this matter. Please note the position paper which is attached to that testimony. I believe this material presents a fairly good summary argument as to why alternative to historical cost depreciation should be considered.

Sincerely,

Thomas P. O'Hare/mjh

Thomas P. O'Hare
Associate Director

TPO/mjh

Enclosure

MATERIAL FILED IN
IV-3

ATTACHMENT #4

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO · NEW YORK · WASHINGTON

LESLIE P. HEMRY, *President*

LEGAL DEPARTMENT
John P. Hanna, *Senior Vice President and General Counsel*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0801

July 13, 1976

Mr. Kent E. Peterson
Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, Minnesota 55440

Dear Mr. Peterson:

Thank you for your letter of June 1, 1976 regarding the interest of the health insurance business in hospital cost containment mechanisms.

The HIAA does actively support hospital rate review programs, and we have developed model legislation that we recommend in states where such controls are needed. Since Minnesota now has a law implementing formal financial and other reporting requirements hospitals and other health facilities as an alternative to the existing voluntary system, a model bill would not appear to be needed in Minnesota.

Beyond this we have no specific materials to offer, except that we would like to offer constructive comment and suggestions that we may have to any proposed implementing regulations. To the extent to which we may be of assistance in this regard we would appreciate being on your mailing list for proposed regulations or guidelines.

Yours truly,

Caroll Callaway

Caroll Callaway
Assistant General Counsel

CC:rt

HEALTH ATTACHMENT #5

July 27, 1976

Stephen M. Jackson
Consultant

296-5366

ENCLOSED DRAFT - RATE REVIEW RULES

The enclosed represents a formulation of draft rules intended for discussion purposes only. I would appreciate it if you would take the time to read through this draft and note any problems you may have with any part of it.

At this point, the draft does not address itself to the fees to be charged, nor does it attempt to finalize any terms in need of further definition. I have enclosed a list of some of the terms which we will need to define according to the draft rules as they presently stand.

Your most critical appraisal is especially valued now in these early stages of rule development. I will call you shortly to ascertain a time convenient for discussing this draft. Thanks for your help.

SMJ:kmt
Enclosure

Sent to: Dr. Fifer
Kent E. Peterson
Janet G. Brodahl
John Dilley
Fred Sattler
Steve Mosow
James Dean
Dick Oszustowicz
Malcolm Mitchell
Tom O'Hare

ATTACHMENT #6

HEALTH INSURANCE ASSOCIATION OF AMERICA
CHICAGO NEW YORK WASHINGTON

RECEIVED
OCT 12 1976
HMO Unit
Minn. Dept. of Health

CONSUMER and PROFESSIONAL RELATIONS DIVISION
Thomas O'Hare, *Associate Director*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0801

October 6, 1976

Mr. Steve Jackson, Consultant
Minnesota State Health Department
717 Delaware Street, Southeast
Minneapolis, Minnesota 55440

Dear Steve:

I have to apologize for not making comments on your previous draft of the regulations implementing the rate review sections of S.F. 60. I understand that a new draft of the regulations has been completed, and I will be receiving a copy from Terry Klas of North American Life & Casualty. I will comment on that draft as soon as I receive it.

However, I believe I should make some general comments which reflect my own thinking based on HIAA policy and my reading of the voluntary rate review program and your previous regulations. My comments do not necessarily reflect the attitudes of our industry people in Minnesota.

Voluntary hospital rate review, in my opinion, is minimally effective at best and self-serving at the worst. However, we have become involved in the voluntary program because in fact it was the only ball game in town which has any promise of impacting on hospital cost increases. For whatever else we say as an industry regarding S.F. 60, I, for one, regret the fact that the program of hospital rate review is voluntary and not mandatory.

The only consolation I take in the current legislated situation on this matter is that your department will in fact set the standard for the voluntary hospital review committee. This is the only leverage which will assure the effectiveness of the program. As I said, I have read your previous draft regulations, and because I am not an accountant in the strict sense of the word, I am not sure exactly what they mean. However, I would like to register my specific comments in a few areas:

Price Level Depreciation

Price level depreciation for plant assets in the hospital setting does not serve the public interest. This is true, because it hampers the effectiveness of the new planning law by providing a substantial source of revenue to hospitals to expand facilities, and in fact, it makes today's patient who is already paying for the facilities he is utilizing pay also for tomorrow's patient through the price level system on plant assets.

Price level depreciation on plant assets is especially inappropriate in Minnesota in light of the fact that according to AHA figures published in 1975, Minnesota had the second largest ratio of beds per 1,000 population in the United States (5.9 beds per thousand in Minnesota vs. 4.4 beds per thousand in the U.S.).

After reading the guidelines in this area, I am not sure exactly what you are driving at, but I would hope it would be something along the lines of the Maryland system which allows the greater of cash requirements (interest and debt amortization) or accumulation of up to 20% of the replacement value of plant assets based on average utilization.

Year End Reconciliation with Budget

Rate review based on applications by hospitals requesting rate increases in and of itself will prove to be a very ineffective means of impacting on hospital cost increases. What is required is that all rate increases be based on hospitals budgets with a reconciliation at year end with those prospective budgets. In the absence of such budget review, hospitals will merely have an incentive to increase their utilization in order to maximize revenue.

Plus Factor

I am under the impression that the current voluntary program utilizes some sort of a plus factor for hospitals over and above their usual financial requirements. I believe this is completely unjustified unless it is placed in the context of an allowance for variance in the budget which will have to be accounted for at year end. After all, the review process should assure the hospitals of their financial requirements which to my mind obviates the need for any inclusion of an unidentified plus factor.

Uniform Accounting

Without some form of uniform accounting system, the basis for evaluating a hospital's request for a price increase becomes a charade. At minimum, there should be some form of uniform system of reclassifying revenues and

expenses for reporting purposes by patient care or revenue centers in order to allow for adequate comparisons between institutions. Any sharp hospital controller has a great deal of latitude in the accounting system he utilizes to fill out his Medicare cost report and will generate an apples and oranges comparison situation.

Differentials for Patients

Without having the text of S. F. 60 right in front of me, I believe that there is a provision that there should be a single charge structure for all patients under the program. Obviously, we support the basic thrust of that position. Relative to differentials, we believe they should be allowed only upon a demonstrated impact on hospital costs and should be available to all patients who satisfy the criteria for such differentials. In addition, it seems to me that the patient who pays his bill fully upon discharge should be entitled to the maximum differential allowable.

As mentioned, I will return comments to you on your latest draft and look forward to discussing some of the issues as listed above.

Sincerely,

Tom O'Hare

Thomas P. O'Hare
Associate Director

TPO/mjh
cc: Mr. Kent Peterson
Mr. Terry Klas
Mr. Mike Richdorf

Attachment #7

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO NEW YORK WASHINGTON

LEGAL DEPARTMENT
Caroll Callaway, *Assistant General Counsel*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0801

RECEIVED
Hospital Rate
Review System
NOV 17 1976

November 15, 1976

Mr. Kent E. Peterson
Minnesota Department of Health
717 S. E. Deleware Street
Minneapolis, Minnesota 55440

Dear Mr. Peterson:

This is with further reference to our earlier correspondence regarding the Department of Health's proposed regulations implementing the Hospital Cost Review Provisions in Article II of Minnesota S. F. 60. As I indicated in our July 13 letter, we were interested in reviewing the proposed regulation when drafts were available and we offer the following comment with regard to the proposed regulation:

1. Delete paragraph (iv), page 26. This paragraph, titled "Contract Allowances" talks in terms of "requirements may be required" of a hospital to establish "differentials in rates" which are to be allowed certain governmental programs, other insurers and HMOs. Restriction on such "differentials" are to be defined by "MHD_____", which appears to be a reference to some regulation to be written in the future.

   There are several problems with this paragraph, the most important is that S. F. 60 does not permit "differentials", or "contract allowances" at all. The provisions would appear to allow hospital discounts simply established under another name. Further, the language "governmental programs", other insurers and HMOs does not appear correct since S. F. 60 does not define a governmental program as an insurer.

2. Delete paragraph 5, page 34. This paragraph, titled, "Allowance for Differentials" begins by stating the law that hospitals shall not discriminate among insurers in their rates, but goes on to say that certain differentials, the difference between a hospital's rate and the amount paid by an insurer, may be made. The paragraph closes by stating "Under these conditions discrimination does not exist."

   The law does not define "rates", however, it is clear that "rates" means that amount of money charged by a hospital to a patient for the services rendered. The regulations cannot, without some statutory basis, attempt to define "rates" and "charges" as something totally different for the purposes of allowing hospital discounts when the law states there shall be no discrimination in rates.

In addition to the above comments which reflect concerns of the legal department, the following non-legal concerns have been expressed by our Council staff.

3. No specification is made in the regulations on the composition of rate review panels which will investigate and comment on hospital financial requests under the voluntary nonprofit rate review organization. Such panels should be made up of a balanced input of providers, consumers and third parties (including insurers) in order to render objective decisions. HIAA policy would imply that in this situation the review body composition should be delineated. Under the current voluntary program, hospital representatives whose budgets are reviewed one day are allowed to sit on review panels on the next day. Such a system makes the program less than credible.

4. The regulations in paragraphs 6 through 13 do not call for any meaningful uniform revenue and expense accounting and reporting which is necessary to compare hospitals. The use of Medicare cost reports is not sufficient because they do not produce accurate comparisons. HIAA policy supports a uniform system of cost accounting which would permit comparisons with institutions of comparable size and character.

5. On page 27 under (ii) price level or replacement level depreciation is granted for buildings. Such depreciation is inappropriate for the following reasons:

   A. The historical cost of the facility may be unreasonable.

B. Price level depreciation requires this generation's patients to pay for the facilities they use as well as those to be used in the next generation.

C. Philanthropy is discouraged.

D. Since Medicare and Medicaid will include only standard depreciation in their reimbursement, any allowance exceeding depreciation will have to be unfairly subsidized by private sector patients. Even though S. F. 60 in this area has no direct control over government programs, the obvious intent is to eliminate discrimination in rates. The payment of price level depreciation will increase the discrimination in rates between government and private patients.

6. Page 26 (b) "Plant Capital Needs" does not require approval of capital expenditures for new facilities and services by the appropriate planning authority as a condition for recognition of capital costs by the system. Such planning approval is necessary if the system is to financially support only those facilities and services which the community has judged to be necessary. HIAA guidelines require close cooperation and coordination between the rate review and planning functions.

7. Also, it would be appropriate to establish an ongoing advisory council to the Minnesota State Board of Health which would report on the effectiveness of the program, suggest modifications and serve as a sounding board for the Department on various issues. The advisory council should be made up of an equal number of representatives of consumers, government, third party payors (i.e., private insurance companies and Blue Cross Plans) and providers. HIAA policy supports the establishment of an adivsory council.

We feel these above comments are very significant, particularly the questions of law indicated in the first two numbered paragraphs. It is with regard to these two specific comments that we feel the proposed regulations to not reflect the statutory requirements. Please let us know if we can be of any further assistance.

Yours truly,

Caroll Callaway

Caroll Callaway
Assistant General Counsel

CC:dms

Attachment #8

minnesota department of health
717 s.e. delaware st. minneapolis 55440

November 30, 1976

Mr. Carell Callaway
Assistant General Counsel
Health Insurance Association
of America
332 South Michigan Avenue
Chicago, Illinois 60604

Re: Minnesota Hospital Rate Review System

Dear Mr. Callaway:

Thank you for your letter of November 15, 1976 regarding a recent draft of rules for the Minnesota Hospital Rate Review System. We have finished the draft rules for public hearing. I am enclosing a copy of that proposal along with a Notice of Hearing.

We have carefully reviewed your comments and I will be discussing these matters, as well as others, with Mr. Thomas O'Hare on November 30, 1976. We invite you to present the suggestions to the Hearing Examiner at the public hearing.

Some of your suggestions, including uniform accounting and reporting, will require statutory change to authorize. Unless a federally mandated, uniform procedure is adopted soon, we will support such a state procedure.

Your continued assistance will be appreciated.

Sincerely,

Kent E. Peterson, Chief
Planning and Resources Control

KEP:jh
Enclosure

an equal opportunity employer

NORTH AMERICAN Life and Casualty Company
1750 HENNEPIN AVENUE • MINNEAPOLIS, MINNESOTA 55403

TERRY C. KLAS, C.L.U.
SECOND VICE PRESIDENT
DIRECTOR OF CLAIMS

RECEIVED
JAN 10 1977
OFFICE OF HEARING EXAMINERS

January 10, 1977

Mr. Steve M. Mihalchick
Office of Hearing Examiners
1745 University Avenue, Room 300
St. Paul, Minnesota 55104

Dear Mr. Mihalchick:

During my testimony concerning the proposed rules of the Board of Health governing hospital rate review, a question arose by Mr. Fred Sattler concerning cost justified discounts or differentials under MHD 487 A 1a (5) (iii) and related provisions.

Mr. Sattler questioned whether prominence should be given to the last sentence contained in Subdivision 1 of Section 7 of the law, as he felt my testimony was recommending. Prominence is an inappropriate consideration. The directive is that in following the general considerations set forth in the first sentence, the system cannot do so in such a way as to allow discrimination in rates among insurers.

I think also if you look at the paragraph in its entirety, there is a method to the sequence in which the phrasing is set forth which supports the idea that a specific mandate was being given by the legislature in that last sentence wherein they use the mandatory word "shall". If you look at the first sentence, it appears to me the legislature first starts with the proposition that total costs have to be related to total services. Then, the direction is that aggregate revenues have to be related to the aggregate costs. When those two considerations have been made, (and, in fact, are normally made in just that sequence), the next thing to do is to set rates which have become dictated in trying to meet those considerations; and, the provision then follows with the statement that such rates are to be set equitably. However, in setting those rates equitably, the legislature then gives a specific directive as I testified. I feel the last sentence cannot and should not be broadened as the department has attempted to do in their proposed regulations if they intend to abide by the law as enacted. If they wish to change the law, the proper forum is the legislature.

I would also comment that to permit such discounts can have the effect of distorting working capital requirements because working capital is intended to provide the capital necessary to fund daily operations. Since discounts are an unknown variable, it seems to me that to permit them would

Public's Exhibit No. G
File No.
Date

likely result in distortion of the working capital, depending on the estimate of the discount activity to be expected. I do not think the legislature intended this, and for that reason I feel, after rereading Section 7, there may be a serious question whether the hospital can be permitted to offer any type of discount, including one for rapid payment. But if they can, the mechanism permitted is through gross cost and revenue considerations, not through differential charges, i.e. through working capital, bad debt and interest on borrowed funds, not through variable rates between insurers.

Clearly, the language proposed in the rules goes far beyond time value of money. In my judgment, it is at variance with the legislative intent, and with specific legislative mandate.

Sincerely,

Terry C. Klas, C.L.U.
Second Vice President
Director of Claims

TCK:cm

cc: Mr. Thomas P. O'Hare, Associate Director, Consumer and Professional Relations Division, Health Insurance of America

minnesota hospital association

serving nonprofit hospitals and nursing homes

RECEIVED
JAN 25 1977
OFFICE OF HEARING EXAMINERS

January 25, 1977

Steve Mihalchick
Hearing Examiner
Office of Hearing Examiners
1745 University Avenue
St. Paul, Minnesota 55104

Dear Mr. Mihalchick:

Enclosed are the written positions of the Minnesota Hospital Association regarding the proposed rules for Minnesota Law 1976, Ch. 296, Art. III.

Each section we support or wish to comment on is presented in numerical order with precise rewordings offered and specific comments or explanations following. We have modified several positions since the oral testimony and also offer more clarification in writing than we gave orally. Where in conflict, this written testimony should take precedence over the earlier verbal presentation.

Sincerely,

Gary Appel

Gary Appel
Director of Finance

GA:ds
Encl.

Public's Exhibit No. H
File No. _____
Date _____

2333 UNIVERSITY AVENUE SOUTHEAST • MINNEAPOLIS, MINNESOTA 55414 • PHONE (612) 331-5571

POSITION OF THE MINNESOTA HOSPITAL ASSOCIATION
regarding the proposed rules for Minnesota Laws 1976, Ch. 296, Art. II

RECEIVED
JAN 25 1977
OFFICE OF HEARING
EXAMINERS

General Comments Regarding the Rules:

The Minnesota Hospital Association generally supports the regulations as a positive step toward cost containment, together with continued hospital viability. We recognize and support the regulations' efforts to generate and disseminate critical hospital cost information toward the end of a better informed public, health providers, and the government.

The objectives of the written testimony are:

A) To support key provisions which are consistent with our current program which are crucial to its continued viability.

B) To recommend certain changes in the proposed rules which will improve their eventual effect on the rate review program, and

C) To offer some suggestions to clarify and define the precise meaning of the language of the rules.

The written format of the testimony will be section by section following the sequence of the rules.

We support all the amendments offered by Fred Sattler during the Hearings of January 5 and 6, 1977, except as specifically noted in our verbal or written testimony. For purposes of this written testimony we presume the amendments will be adopted and offer specific changes where necessary.

Each of the proposed changes is supported by an explanation of the change and our position regarding its desirability. These written positions are extensions of the verbal testimony given on January 5 and 6, 1977, but significant new testimony is also provided.

MHD 471 Scope B.

We support the amendment removing the word step-down.

Explanation:

The purpose of this change is to permit the broader use of the term "allocation of costs" without limiting it to a "step down" procedure.

MHD 472.I. (page 3)

MHA recommends adding the words *and treatment* as follows:

I. "Emergency services" are those inpatient hospital services and outpatient hospital diagnostic *and treatment* services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to life or health of the individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.

Explanation:

Outpatient services are about equally split between diagnostic and treatment; therefore, both should be included in the definition.

MHD 472.O. (page 4)

MHA recommends the words *cost or* be deleted and replaced with *net book value of* as follows:

O. "Loss" means the excess of all expenses over revenues for an accounting period or the excess of all or the appropriate portion of the ~~cost or~~ *net book value of* assets over related proceeds, if any, when items are sold, abandoned, or either wholly or partially destroyed by casualty or otherwise written off.

Explanation:

Loss on the sale of assets is determined by subtracting the proceeds from the sale from the depreciated value of the asset. The term *net book value* clarifies the point that depreciation should be taken into consideration.

MHD 472 U (page 5)

MHA suggests deleting the first two sentences in Section U in their entirety, replacing them with the following:

U. "Rate" means the average revenue per adjusted admission

$$\frac{\textit{Total Revenue}}{\textit{Number of adjusted admissions}}$$

for a full accounting period.

Adjusted admissions are determined by:

$$\textit{Number of Outpatient and Emergency Visits} \times \frac{\textit{Total Outpatient and Emergency Revenue}}{\textit{Number of Outpatient and Emergency Visits}} \times \frac{1}{\textit{Inpatient Revenue Per Admission}} \quad \textit{PLUS} \quad \textit{The number of Inpatient Admissions}$$

Explanation:

The term "Rate" is used consistently throughout the regulations to mean average revenue per adjusted admission. Defining rate in these terms adds clarity to the regulations. Also, since a significant portion of a hospital's outpatient activity involves emergency services, these should be expressly included in the calculation of adjusted admissions.

MHD 472.U. (page 6)

In the third sentence of the Section, add the word *adjusted* between projected and admission as follows:

projected *adjusted* admissions as stated in the rate revenue and expense report.

Explanation:

Both revenue and admissions should be used in the adjusted form according to the formulas on page 5.

MHD 473 (page 8)

In the third sentence from the top of the page, the word *or* should be changed to *and* as follows:

MHD 473. The Minnesota Hospital Rate Review System. The Minnesota Hospital Rate Review System is established. This system shall be operated by the board ~~or~~ *and* any voluntary nonprofit rate review organization whose reporting and review procedures have been approved by the board, pursuant to MHD 496. The system shall consist of reports, administrative procedures, and standards.

Explanation:

The change in wording allows the system to be operated by the board and a nonprofit rate review organization.

MHD 474 A.2.a.(6)(d) and (g) (page 12)

MHA suggests deleting item (iv) of (g) and moving item (v) of (g) to become item (iv) of (d) as follows:

(d) Other professional fees, including:

(i) Consulting and management services;

(ii) Legal services;

(iii) Auditing services; and

(iv) Collection services

(e) Special departmental supplies and materials.

(f) General supplies, including:

(i) Office and administrative supplies;

(ii) Employee wearing apparel;

(iii) Instruments and minor medical equipment which are non-depreciable;

(iv) Minor equipment which is non-depreciable; and

(v) Other supplies and materials.

(g) Purchased services, including:

(i) Medical - purchased services;

(ii) Repairs and maintenance - purchased services;

(iii) Medical school contracts - purchased services;

~~(iv)--Management-services;~~

~~-(v)--Collection-services;-and-~~

(iv) Other purchased services.

(h) Other direct expenses, including:

(i) Depreciation, amortization, and rental or

Explanation:

This eliminates the redundancy in the use of the term "Management services" and recognizes that collection services may be classified as professional fees.

MHD 474.A.5. (page 14)

MHA suggests the deletion of the words beginning with "are true and conform..." through the end of the section and the insertion of the words *have been audited* as follows:

5. Attestation by a qualified, independent public accountant that the contents of the balance sheet and statement of income and expense ~~are-true-and-conform-to-the-bases-for-judging-the-reasonable-use-of finances-in-a-hospital,-as-established-by-MHD-487-A.~~ *have been audited.*

Explanation:

Public accountants are not in a position to attest to the "reasonable use of finances in a hospital" as established by MHD 487 A.

MHD 47~~4~~ B.1.b.(1) and (2) (page 14)

MHA suggests the following changes in Section b.:

b. The hospital's full accounting period during which a hospital files this report with the system. This period shall be known as the current year. Information for the current year shall be actual and estimated according to the following:

(1) Information for at least the first ~~eight~~ *six* months shall be actual;

(2) Information for ~~the-last-four~~ *any remaining* months may be estimated.

Explanation:

A serious timing problem would result from requiring the use of eight months actual data for the rate revenue and expense report. If a hospital wishes to institute a rate increase at the beginning of its accounting period, the report must be filed 60 days prior to the increase. Only 60 days would remain after the eight month period of actual information to complete the complicated and time-consuming budgeting and reporting process. This 60 day period becomes even more constraining if it is difficult to compile the current year experience into a form useable for the budgeting and reporting process. Since the minimum period for compiling the actual financial data in the most sophisticated hospitals is approximately 15 days, only 45 days are left for these hospitals to prepare an accurate departmental budget. Forty-five days is unreasonably short for hospital managers to have sufficient time to thoroughly analyze and prepare their budgets.

We suggest that the period of actual information needed for the interim financial statement, six months (Item 474.B.3.a. page 16), is more reasonable to complete the complicated budgeting and reporting process.

MHD 474 B.2.d. (page 15)

Delete the word "routine" as follows:

d. The number of beds available for the hospital and for each appropriate ~~routine~~ service center.

Explanation:

This is the only place where the word "routine" is used to modify service center. To be consistent and to avoid confusion, "routine" should be deleted.

MHD 474 B.3.e. (page 17)

Replace the words "patient days" with *days' charges* as follows:

e. A statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of ~~patient-days~~ *days' charges* outstanding at the end of each period.

Explanation:

This change is consistent with common usage and also the definition found in Item MHD 487 A.1.(c)(2), page 39.

MHD 474 B.4.a. (page 17)

MHA supports the following addition to Item 4.a.:

a. The pricing policy of the hospital which incorporates the overall pricing policy and financial objectives of the institution. *This will be supplemented by a statement of budgeted increases in charges, revenues and rates for the budget year including these items:*

(1) Date(s) on which charges, revenues, and rates will be adjusted.

(2) For each such date, the resulting aggregate dollar amount and weighted average percent of increase in Budget Year gross charges for each revenue center.

(3) For each such date, the resulting aggregate dollar amount and weighted average percent of increase in Budget Year total hospital revenues.

(4) For each such date, the resulting aggregate dollar amount and percent of increase in the Budget Year rate.

Explanation:

MHD 474 B.4.a. is silent on any requirement that the hospital disclose in advance its plan for adjusting charges (and thereby revenues and rates) in the budget year. The system needs such information in order to analyze and comment on the Rate Revenue and Expense Report. The proposed change eliminates the ambiguity and confirms the statement by Mr. Sattler during the Hearing that

the hospital plan for such adjustments would be incorporated in the budget and would constitute part of the required information, and that hospitals would not be required to furnish schedules of detailed charges (i.e., price lists) each revenue center.

MHD 481 A.1. (page 19)

MHA proposes the addition of a sentence as follows:

A. General Provisions for Filing of Reports.

1. Forms to be Specified. The system shall design and issue forms as necessary for meeting the requirements of reports established by these rules. *The hospitals under the system will be allowed to comment on the forms prior to their adoption.* These forms shall contain clear instructions for their completion.

Explanation:

The present form set used by MHA was developed by trial and error to be compatible with usage by hospitals and relevant to hospital accounting systems. Any proposed change may already have been discarded as unworkable.

MHD 481 B.2. (page 21)

MHA is concerned over the severity of the penalty for failure to file the annual financial information report. License revocation is reasonable for violations of board rules protecting the personal well being and safety of the patients, but not for noncompliance with administrative procedures.

MHD 481 C.1. (page 21)

MHA suggests the following change:

C. Filing of Report of Rate Revenue and Expense.

1. Each year, each hospital shall file a report of rate revenue and expense ~~sixty-days-prior-to-the~~ *on or before the* commencement of any accounting period of the hospital. *No change in rates shall be made until 60 days have elapsed from date of filing.*

Explanation:

Hospitals normally complete development of the annual budget just before the start of the next fiscal year. This timing permits the use of maximum actual operating cost data and makes estimates for the coming year most current. The budget is an essential part of the rate review process. If rate review documents have to be filed 60 days before the "commencement" of the fiscal year, the budget would be much less reliable. Actually, hospitals would re-do the budget to update it, duplicating a lot of work. The intent of this section is to provide a 60 day lapse of time to permit the system to review the rates before they are changed. MHA's amendment will provide the hospital greater flexibility, still allowing the system 60 days for review.

MHD 481 D.1. (page 22)

MHA suggests the following modifications of Sections 1.a. and 1.b.:

1. A hospital shall file an interim increase report sixty days prior to the effective date of any amendments or modifications ~~to-rates~~ *in charges* then on file with the system for the budget year if:
   a. the proposed ~~rate-change-exceeds~~ *adjustment in charges causes the change in the rate to exceed* the allowable increase limit established according to MHD 504, *and if;*
   b. *Such* amendments or modifications to ~~rates~~ *charges* which are to become effective *on or* after the first day of the budget year and prior to the end of the last day of the budget year were not included

in the report of rate revenue and expense then on file with the system.

Explanation:

As pointed out by Mr. Ego in the hearing, hospitals do not set "rates." There is only one "rate" for each hospital for any accounting period. This "rate" is the dividend of total hospital revenue divided by total adjusted admissions. Consequently,the rate is a by-product of the interplay of many elements:

1. The number of inpatient admissions (controlled basically by the medical staff).
2. The number of outpatient admissions (controlled basically by the medical staff).
3. Determination of the choice between inpatient and outpatient admission for a given patient condition (controlled basically by the medical staff).
4. The mix of patients (i.e., surgery (higher cost) or no surgery (lower cost), condition to be treated, extent of testing (radiology, etc.)). All these elements are commonly referred to as intensity of service.
5. The length of stay (controlled basically by the medical staff in response to diagnosis).
6. The charge structure assigned by the hospital to each specific service it renders (controlled primarily by the hospital management).

Of these six elements, the hospital has direct control over only the last, namely, how much to "charge" for specific services. Consequently, hospitals do not, and in fact cannot, amend or modify "rates" as contemplated by MHD 481.D.1. Hospitals can, and do, adjust the "charge" for specific services and this is one element in the complex formula of the "rate". Prospectively, one can postulate that under certain assumed admission patterns, intensity of service patterns, etc., a given "charge" structure will yield a given "rate". Retrospectively,

one cannot conclude that a given "rate" increase was or was not due solely to hospital pricing policy with respect to "charges" because undoubtedly the assumed admission patterns did not materialize. It would be impossible for a hospital to have filed an interim increase report sixty days prior to the date upon which the "rate" exceeded certain defined limits if the hospital had made no modifications or amendments in its "charge" structure. The proposed change limits the filing requirement to the one condition over which the hospital has any control, namely, a change in the level of "charges" in the hospital.

MHD 481 D.1.e. (page 22)

MHA suggests that Section 481 D.1.e. be renumbered as *481 D.2.* and that Section 481 D.2. and 481 D.3. become *D.3. and D.4.* respectively.

Explanation:

This section does not properly follow the heading of D.1., for this section refers to the waiving of any provision of D, not just those provisions of D.1.

MHD 481 D.2.d. (page 23)

MHA suggests the following additions and deletions:

d. In making any retrospective assessment of a hospital's compliance with requirements to file interim increase reports, the system shall recognize that actual rates for the budget year may exceed projected rates for that budget year ~~by a reasonable amount~~ due to ~~slight~~ variations from projected information contained in the rate revenue and expense report then on file with the system. *The punitive action contemplated in MHD 481.D.2.c above will be implemented only in instances where a hospital failed to file an interim increase report as required by MHD 481.D.1. above.* ~~A reasonable amount may vary with the financial and statistical composition of each hospital but, it should never exceed one and one tenth times the allowable increase limit for the accounting period in question.~~

Explanation:

As explained under suggested changes to MHD 481.D.1. above, hospitals do control "charges" but do not control "rates". Punitive action cannot be taken retroactively for variations from budget over which the hospital has no control. Punitive action can be taken retroactively where the hospital failed to report amendments or modifications in "charges" as required by MHD 481 D.1.

MHD 487 A.1.a.(2)(d)(ii) (pages 28 and 29)

MHA presumes that this section will be amended as suggested by Mr. Fred Sattler during the January 5 and 6, 1977 Hearing. We suggest the addition of the words *bed capacity in* as follows:

Incurred on a loan made for a purpose reasonably related to patient care. ~~Loans-made-to-finance-that-portion-of-the-cost-of-acquisition-of-a-facility that-exceeds-historical-cost-and-which-has-been-determined-to-have-excess capacity,-pursuant-to-MHD-487-A.4.,-or-whose-services-have-been-determined to-be-inappropriate,-pursuant-to-Public-Law-93-641,-§-1523-(a)(6)-(National Health-Planning-and-Resources-Development-Act-of-1974),-are-not-considered to-be-for-a-purpose-reasonably-related-to-patient-care.~~ Loans made for the following are not to be considered to be for a purpose reasonably related to patient care: to expand *bed capacity in* facilities that have been determined to have excess capacity, pursuant to MHD 487 A.4.

Explanation:

The determination of excess capacity (on page 44) is based upon the criteria of beds only and efforts to reduce such excesses should be stated in such terms. The term "facilities" may be defined more broadly than beds precluding legitimate efforts of hospitals to convert excess space into productive use by adding needed new services or equipment, hence it should be modified.

MHD 487 A.1.a.(3)(e) (pages 30 and 31)

MHA recommends the deletion of the entire last sentence of the provision as follows:

(e) The extent of costs incurred for the provision of educational activities contributing to the preventive health education of the population of the hospital's areas of patient origin should not exceed that amount necessary to provide activities recommended appropriate for hospitals by the State Health Planning and Development Agency, pursuant to Public Law 93-641, §1523 (a)(6). ~~In any instance, these costs should not include any payments in excess of the normal salary or remuneration to professional employees of the hospital or health professionals who maintain consultative, contractual, or patient relationships with that hospital.~~

Explanation:

1. Many small hospitals may not have professional employees on staff who can provide these educational activities. We assume the costs for retaining such professional employees will be allowed in financial requirements for these hospitals.

2. Unless a hospital remunerates staff for the additional time required to provide the educational activities, they will not, as a rule, work the added hours. If the hospital is forced to hire new staff for this purpose the costs may well be greater than simply supplementing the earnings of present staff. The hospitals should be given the flexibility to provide such services for the community at the lowest possible cost.

3. The fact that the deleted sentence begins with the words "In any instance" could make it in conflict with the preceding sentence. This conflict would occur if those costs excluded by the deleted sentence had been deemed to be appropriate by the State Health Planning and Development Agency.

MHD 487 A.1.a.(5)(a)(ii) (page 32)

The Association, during verbal testimony, offered pertinent comment on this section but wishes to indicate their preference to support the regulation as written.

MHD 487 A.1.a.(5)(a)(iii) (pages 32, 33 and 34)

MHA strongly recommends that Sections (aa), (bb) and (cc) and the proposed amendment to Section (aa) should be deleted in their entirety.

Also, Section (iii) should be changed as follows:

(iii) "Contractual allowances" ~~and "courtesy discounts" are those governmental contract adjustments to or other cost justified discounts or differentials from the established charges of a hospital.~~ *and "discounts" are those discounts required by law. These include Title V, Title XVIII, and Title XIX of the United States Social Security Act. Only those discounts specifically required by law may be included as part of hospital financial requirements.*

Explanation:

Providing cost related discounts was not the intent of the Legislature. The law -- Minn. 1976 Ch. 296 Art. II. Paragraph 7, Subd. 1 -- specifically states: "The Board shall prohibit hospitals from discriminating among insurers in its rates".

The Attorney General's informal opinion states that he "believes that the Board may properly interpret this statute as permitting rate differentials which are demonstrated to be cost-justified".

May we point out that there is nothing in the earlier drafts of the bills which preceded this law that indicates the authors of the bills intended to permit differentials at all, much less that the Board should be empowered to write such a rule. Had the Legislature intended this, it would have appeared,

at least in some earlier draft, but it did not. We submit that this is an unwarranted extension of administrative power in rule making.

The Attorney General cites Minn. Stat. §325.03 as permitting "price differentials based on grade, quality and quantity". We would point out that hospital care does not vary in grade, quality or quantity according to whom the purchaser may be. Further, the Attorney General quotes the Robinson-Patman Act which is a law, "generally prohibiting price discrimination". He goes on to say that a particular discount "must be based upon the cost savings to the seller of a particular sale". It is difficult to perceive how the hospital, the "seller", benefits by whom the purchaser may be as long as the charges are paid.

From a practical point of view, this proviso will create an intolerable administrative burden both upon the hospitals of the state and upon the rate review system. It would require, for instance, that every hospital receiving payment from Blue Cross, and that is virtually every hospital in the state, would have to attempt to "cost justify" the discounts taken by Blue Cross. These vary from one hospital to another in any year, and they vary from year to year within each hospital. If the hospitals are unable to justify the full amount of the discount taken by Blue Cross, then they will lose those discount dollars from their rate base.

If one private third party payor, such as Blue Cross, is permitted to claim and take a discount, this is an open invitation to all insurance companies and all HMOs to likewise claim and take discounts. The result would be complete chaos.

It should be kept in mind that hospitals are under tremendous pressure to contain operating costs and to express them in lower rates. To permit any discounts and to require that the hospital "cost justify" such discounts will add significantly to hospital operating costs.

In summary, all discounts should be outlawed, as the Legislature clearly intended. Whether state law can prevail against Federal impositions remains to be fought out. There is no more reason to grant Federal discounts than there is to grant private ones. MHA strongly recommends that paragraphs 487 A.1.a.(5) (iii) (bb) and (cc) be withdrawn.

MHD 487 A.1.b.(1) (page 34)

This section requires two modifications, each of which will be explained separately. One modification is an additional sentence restricting the use of the fund. The other involves the insertion of the words *land* and *land improvements*, and the substitution of the term *price level depreciation*. MHA recommends the following wording:

(1) Finances which relate to *land, land improvements*, building and building equipment and movable equipment shall be placed in an identifiable fund. *The use of the fund shall be restricted to debt principal retirement, new plant and equipment (with certificate of need approval if necessary), major repairs, and replacement of capital equipment (with certificate of need approval if necessary).* The annual increment to this fund should be:

(a) The greater of:

(i) The annual debt principal repayment on *land, land improvements*, buildings, building equipment and movable equipment. This principal payment should be computed as though it were a level payment over the life of the debt instrument. Or,

(ii) The annual straight-line depreciation expense on *land improvements*, buildings, building equipment and movable equipment.

(b) Plus ~~inflation-factors~~ *price level depreciation*, annually determined and consistent with the established useful lives of

land improvements, buildings, building equipment, and movable equipment. ~~These inflation factors~~ *The price level depreciation* shall be determined by the system ~~on the basis of~~ *based on a* price level adjustment index recognized by independent public appraisers as expressing the annual price level adjustment from historical cost of hospital *land improvements*, buildings, hospital building equipment and movable equipment. The system shall derive these factors from any of the most current indices then available to the system which give specific recognition to the following factors:

(i) The effect of inflation upon the replacement cost of existing *land improvements*, buildings, building equipment, and movable equipment, based upon their historical cost; and

(ii) The effect of inflation upon funds necessary for the modification of or addition to hospital buildings, *land improvements*, building equipment, and movable equipment.

Explanation for restricting the use of the fund:

MHA supports the Blue Cross position that it is desirable to set limits on the uses to which the fund is put, and to require disbursement from the fund for items of long term benefit. Such disbursement will prevent an unnecessary accumulation of funds.

Explanation for adding *land* and *land improvements* and *price level depreciation:*

MHA generally supports Section 487 A.1.b.(1) as stated in the regulations. The addition of *land* and *land improvements* in the places cited above gives explicit recognition to the fact that these are often financed with debt and, in the case of land improvements, subject to depreciation. There is no practical way to separate these items for reporting purposes.

MHA particularly supports the price level depreciation provision in Section 487 A.1.b.(1)(b) since the price level depreciation allowance adjusts the annual historical depreciation expense by a current replacement factor. The annual increment to be included in rates should be based upon the current replacement cost of the assets. Due to inflation, historical depreciation amounts are insufficient measures of asset values being consumed each year, and hence, price level must be added. These amounts are placed in a depreciation fund where they can earn income which also stays in the fund. The fund balance will never yield full replacement value when assets need to be replaced, because:

1. Debt principal payments are taken from this fund every year.
2. The cost of new equipment for new services comes from this fund.
3. The cost of additional equipment to handle increased volume of service comes from this fund.
4. The added cost of technological improvement in replacement assets comes from this fund (e.g., a 1966 x-ray machine would cost twice as much in 1976 if an exact replacement could be found. However, the 1976 models are technically superior and will cost three times the amount of the 1966 model).
5. Major renovations, government-mandated improvements, etc., come this fund. Buildings must be improved and updated periodically during their usual 40 year lives.
6. The fund investment rate is always less than the rate of inflation in hospital building and equipment costs.

MHD 487 A.1.b.(2) (page 36)

In the seventh line from the top, strike the word "inflation factor" and insert *price level depreciation*. Hereafter, *price level depreciation* should be substituted for the words "inflation factor".

Explanation:

This change is for clarity, using a commonly understood term.

MHD 487 A.1.b.(4) (page 36)

This section should be modified as follows:

(4) The annual interest income earned from an investment of this fund annually should ~~be used to~~ *remain within the fund until the fund balance equals 100% of the replacement cost of equipment and 50% of the replacement cost of land improvements and buildings. Once the fund reaches these percentages, the interest income should be used to* reduce the ~~inflation factor requirements~~ *price level depreciation* for plant capital needs which are included in rates.

Explanation:

Building life is typically 40 years, long term debt is 25 years. 2-1/2% straight-line depreciation goes into the fund (related to building life) plus (in the early years) minimum additional amounts for price level depreciation. At the same time, 4% is coming out for debt amortization. By retaining interest earned by the fund, total depletion of the fund in early years can be avoided. Keeping in mind that average equipment life is less than 10 years -- usually 5 to 7 years -- the fund will be constantly reduced by equipment replacement. See explanation for MHA-suggested changes to Section 487 A.1.b.(1).

MHD 487 A.1.c.(2) (page 39)

Add the words *should be supplemented with* as follows:

(2) The amount of working capital is dependent upon the number of days' charges in accounts receivable for the hospital. These days' charges should be stated in aggregate for an accounting period and *should be supplemented with* a statement of accounts receivable by payor.

Explanation:

This clarification is necessary to ensure that accounts receivable are broken down by third party payor categories.

MHD 487 A.2.b. (page 42)

MHA proposes the following change:

b. Unrestricted Funds from Non-patient Sources. Unrestricted funds from non-patient sources ~~should~~ *may* be used to reduce the total financial requirements of a hospital.

Explanation:

The reasons for the change are:

1. Such a proviso pre-empts the authority of the hospital governing board from best determining both the intent of the donor and the needs of the community.
2. If such funds are kept for long range plant additions and improvements (which have to be cleared through the certificate of need process), the amount of borrowing and related interest expense will be reduced.
3. Patients in any one year should not experience artificially reduced charges just because a windfall legacy materialized in that year.
4. Such a proviso will adversely affect future philanthropic giving by limiting the conditions under which a gift may be accepted.
5. Unrestricted funds always benefit patients eventually -- there is no other place for such funds to go.

MHD 487 A.2.c. (page 42)

Several additions and deletions are proposed as follows:

c. Auxiliary Enterprises. ~~Profits~~ *Gains or losses* from such enterprises operated by hospitals should *not* be ~~used primarily to offset~~ *considered in* the financial requirements of a hospital. ~~Such enterprises should be self-sufficient and profitable.~~ Any losses incurred by the hospital due to such an enterprise which can be demonstrated to be a fringe benefit to hospital employees or of direct economic benefit to patients receiving care during the period of incurred loss may be included in rates.

Explanation:

By the definition of Auxiliary Enterprises in MHD 472 D, such activities have nothing to do with direct patient care. Therefore, neither the gains nor the losses should be used in calculating financial requirements. Patients should neither gain from nor be asked to support those activities not directly related to patient care.

MHD 487 A.3. (pages 43 and 44)

MHA recommends that Section 487 A.3. be changed as follows:

3. Variations From Budgeted Volumes of Activity and Service, *and from Budgeted Financial Requirements.* changes in ~~rates~~ *charges, revenues and rates* may be necessary due to variations from budgeted volumes of activity and service *and from budgeted financial requirements. In order to recognize such variations, the* financial requirements of a hospital for a budget year should reflect ~~adjustments in volumes of activity and service~~ *the impact of gains and losses* realized during the prior and current years.

a. If a hospital ~~over-projects-its-volume-in-a-service-center~~ *incurs a loss in either the prior or current year (financial requirements in excess of revenue),* ~~in-the-next-year-its~~ *its next year's* financial requirements should be increased by an amount equal to ~~the percentage-of-(fixed)-costs-for-that-service center-and-multiplied-by-the-income-less-due-to-unrealized-activity~~ *loss, provided that:*

1) The loss carry-forward is reduced by the amount of any loss which had been previously budgeted.

2) The amount of loss carry-forward is reviewed for reasonableness by the system.

b. If a hospital ~~under-projects-its-volume-in-a-service-center~~ *achieves a gain in either the prior or current year (revenues in excess of financial requirements),* ~~in-the-next-year-its~~ *its next year's* financial requirements should be reduced by the ~~percentage-of-(fixed)-costs-of-that-service-center-and-multiplied by-the-budgeted-income-of-that-service-center~~ *amount of the gain.*

Explanation:

The proposed changes clarify certain ambiguities and provide for a more comprehensive inclusion of those budget elements which are subject to variation.

1. As drafted, Section 487 A.3. together with MHD 481.D. were not clear. A possible interpretation was that hospitals must monitor the "rate" during a budget year and file an interim increase report sixty days prior to the date on which the "rate" was to be amended or modified. Some variances would be impossible to predict and could place hospitals in a position of noncompliance (subject to penalties) because of circumstances they do not control. Hospitals do not set "rates". Hospitals establish charges for specific services. Depending upon

the interrelationship of such factors as occupancy, patient mix, and hospital charges, an average "rate" develops. (See definition of rate in MHD 472 U.)

2. The regulations as drafted encompassed only one element of many which cause revenues and financial requirements to vary from amounts projected in the budget. The regulations considered the impact of revenue increases and decreases, but did not consider:
   a. Variations in staffing patterns and in the consumption (or usage) of supplies and other expenses caused by changes in intensity of service or by changes in the average length of stay. (The regulations did provide for an arbitrary and/or complex set of calculations which attempted to adjust for those elements.)
   b. Variations in the actual rates of inflation as compared to those projected in the budget. The budget is projected assuming specific rates of inflation in salaries, food costs, supply costs, insurance, etc. The actual rates of inflation can be significantly different. The regulations completely ignore this contingent possibility.
3. MHD 487 A, page 26 states that "...the system shall recognize that rates must supply the financial resources necessary to meet the financial requirements of a hospital". If hospitals are to achieve this objective, then it becomes necessary to carry forward from one year to another the amounts by which hospitals exceed or fall below this goal, thus adjusting the financial requirements in the succeeding year.
4. The regulations attempt to make adjustments between years through the use of calculations based upon fixed costs. There are significant

and honest differences of opinion among accountants as to which elements of cost are fixed and which are variable. Theoretically, fixed costs do not increase or decrease with changes in the volume of services or revenues, whereas variable costs increase or decrease in direct proportion to increases and decreases in the volume of services or revenues. Unfortunately, many "fixed" costs contain variable elements and many "variable" costs do not fluctuate to the same degree that volume of services and revenues do. For example, salaries cannot be neatly categorized as fixed or variable. Salaries tend to be fixed over a narrow range of activity, but become somewhat variable over wider ranges of activity. Also, medical supplies are more "variable" than are housekeeping, maintenance, and office supplies. Such fixed costs as utilities can vary widely from the budget due to weather conditions and/or the price of fuel; their variance can be in the opposite direction of that seen in levels of activity and revenues.

5. The justification for these regulations submitted by the Board openly admitted the difficulties with the proposed calculations and widespread lack of general agreement on the methods for determining fixed/variable cost percentages. Considerable additional study and review of hospital costs and statistics will be required in order to adopt their theoretical concepts to a method which will adequately deal with the difficulties discussed above.

MHD 487 A.4. (page 44)

MHA suggests adding the words *more than 20%* as follows:

4. Excess capacity. For hospitals with occupancy rates based upon staffed and set up beds *more than 20%* below the average occupancy rate of other hospitals determined by the system to share common

characteristics, rates set on the basis of costs may produce unreasonable charges to patients. The system may assess the rates of such hospitals where the criteria of need for beds shall be consistent with the demand for beds as indicated on a hospital or a service center level by occupancy rates. In cases where low occupancy appears to affect hospital rates, the hospital shall be considered to have excess capacity.

Explanation:

"Average" means that half the hospitals will be above a given figure and half will be below. This stipulation would require the system to annually assess the rates of half the hospitals in the state. This large number of assessments will burden the system. Minor deviations would not be significant, but those hospitals more than 20% below the mean occupancy may be subject to assessment. Large fluctuations in occupancy due to natural occurences (e.g., hospitals in vacation areas) should be taken into consideration in reviewing the hospital's position relative to its peer group.

MHD 487 C.1.e.(1)(a) (page 47)

Change the word "and" to *or* as follows:

(a) The hospital informs the system of any errors within thirty calendar days of the initial filing of a report; ~~and~~ *or*

(b) The amendment to the report is submitted to ...

Explanation:

This change allows the hospital the flexibility of informing the system of errors within 30 days or sending in an amended report by an acceptable time without affecting the filing date.

MHD 487 C.1.f. (page 48)

Section F should be changed as follows:

f. If the system discovers an error in the statements or calculations in a report filed with it which the system determines will have a noticeable impact upon its ability to render a fair comment on the report, it may:

~~(1) If the discovery occurs within thirty calendar days after the date of filing of the report,~~ require the hospital to amend and resubmit the report by a date determined by the system and the hospital to be acceptable. The initial filing date is not affected in this instance.

~~(2) If the discovery occurs thirty calendar days or more after the date of filing of the report, require that the hospital resubmit a new report. The date of filing shall then be the date when the new report is submitted to the system, pending the determination by the system that the new report is complete.~~

Explanation:

The system has an obligation to be timely and the hospitals should not be penalized for the system's lack of timeliness. Section f.2. should be deleted to eliminate unfair punishment of the hospitals for the untimely audit and processing by the system.

MHD 487 G (page 51)

MHA suggests the additional Section G as follows:

G. Appeal. There will be provided within the system a mechanism for appealing the findings of the system pursuant to rate review as described

in Sections MHD 471-472-474-481 and 487. The mechanism shall set time limits for filing, hearing and ruling on appeals. Fees for filing shall be prescribed. Rulings of the appeal mechanism will be subject only to judicial review.

Explanation:

The regulations specify no appeal procedure. Some appeal mechanism within the system should be established.

MHD 509 (page 57)

MHA suggests the addition of a sentence immediately after the word "Fees." as follows:

MHD 509 Fees. *Hospitals whose rates are reviewed by a voluntary, non-profit rate review organization shall submit such fees as are specified by that organization and at such times as the organization may stipulate.*

Explanation:

The voluntary non profit rate review organization will have cash flow requirements that may indicate a different payment timetable from the one specified in MHD 509 A. The organization will have a steady level of staff salaries to carry, and cannot depend on an erratic flow of funds related to the random filing dates of 180 hospitals. Also, the rates contained in MHD 509 A probably cannot be changed except by formal public hearing, a cumbersome and time consuming process.

HEALTH INSURANCE ASSOCIATION OF AMERICA
CHICAGO NEW YORK WASHINGTON

RECEIVED
JAN 27 1977
OFFICE OF HEARING EXAMINERS

CONSUMER and PROFESSIONAL RELATIONS DIVISION
Thomas O'Hare, *Associate Director*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 939-0801

January 25, 1977

Mr. Steve Mihalchick
Hearing Examiner
Office of the Hearing Examiner
1745 University Avenue, Room 300
St. Paul, Minnesota 55104

Dear Mr. Mihalchick:

The purpose of this letter is to submit additional comment on the proposed rules of the Board of Health governing the hospital rate review system.

Overall, the proposed regulations are so extremely broad in their definition of hospital financial requirements and are so loosely stated that the effectiveness of the program is seriously threatened. The extreme lattitude of these regulations is seen not only in the broad definition of financial requirements but also in the lack of directives in the regulations to establish criteria for reasonableness of costs and the requirement of some uniform system of reclassifying hospital revenues and expenses, which is the foundation of any effective program if it is to render consistent and non-arbitrary decisions based on hospital comparisons.

I would like to conclude my comments on the single most questionable financial requirement included in the proposed regulations, price level depreciation on buildings and fixed and major movable equipment. It is alleged that price level depreciation of facilities and equipment is required in order to provide sufficient capital for maintenance, replacement and expansion of the facility. There is no question that health care facilities should be in a position to meet the needs of their community through improved services and facilities as required. However, to provide capital through price level depreciation is a completely arbitrary approach to the problem. Price level depreciation will provide funds to hospitals regardless of the need of the particular hospital in question and will result in underfunding some hospitals and grossly overfunding the needs of other hospitals. In addition, it should be recognized that the funding of price level depreciation would not be necessarily restricted to replenishment or maintenance of the facility but, in fact, could be used for expansion or at least create the pressure for expansion by the availability of such resources.

Public's Exhibit No. I
File No. _____
Date _____

The notion was also advanced that failure to provide price level depreciation would, in fact, be making a planning decision, which is outside the scope of the rate review authority. However, it should be clear that to provide so substantial an amount of funds through price level depreciation is, in effect, making a planning decision by allowing the accumulation of funds for replacement and expansion, which, in fact, may never be necessary to the extent funded under the proposed system.

Also, an extraordinary burden would be placed on the nongovernmental patient because of the fact that government programs, both under Medicare and Medicaid, do not recognize the price level depreciation. Therefore, nongovernment financed patients would not only be required to pay the price level increment for costs related to their care, but also would have to pay the increment for governmental patients. Such a situation also exists relative to bad debts and charity. However, such subsidy payments are justified in that case, because they are tied directly to the expense of rendering care to those who don't pay their bills. But this is not true relative to price level depreciation, which is to be given without regard to a specific need of the institution.

It is often cited that the Maryland Rate Setting Commission allows price level depreciation. This is true but only partially so. The Maryland Commission does allow price level depreciation on equipment. However, in the area of building, depreciation is not allowed, and the maximum of only 20% of replacement costs can be accumulated in the fund. But more importantly, the replacement fund for buildings is offset by the entire amount the hospital may have in its restricted funds for capital improvement and all other unrestricted funds. This includes both the corpus of the funds as well as the income. Such is not the case in the proposed rules.

One must also ask why, if price level depreciation is so necessary as a financial requirement, some hospitals currently under the voluntary program have not requested price level depreciation. In all likelihood, they have not done so because they recognize that the price level depreciation is an unnecessary drain on community resources for no specific purpose and that no capital projects are under consideration by the institution.

I have contacted representatives of the Wisconsin and Indiana Hospital Associations (Robert Taylor, Vice President-Finance, Wisconsin and Corky Morris, Vice President-Finance, Indiana). Both states have voluntary rate review programs. In both programs, across-the-board price level depreciation is not allowed as a financial requirement; and, in fact, the Associations' representatives do not believe such price level payments are necessary to preserve the financial integrity of their institutions. In addition, they agreed that across-the-board price level depreciation would be an inappropriate method of allocating community resources to meet an institution's capital requirements.

I have also contacted Maurice Click, Deputy Director of the Washington State Hospital Commission, and Harold Cohen, Executive Director of the Maryland Health Services Cost Review Commission. Both of these individuals, representing hospital regulators, did not believe across-the-board price level depreciation was appropriate.

While acknowledging the need of hospitals to generate sufficient revenues to meet a future community health care needs, an alternative solution, which is more reasonable, should be explored. Serious consideration should be given to the way in which this situation is handled in the State of Washington. The Washington Hospital Cost Commission gives separate consideration to the hospital capital requirements, which include:

1. The principal payment on debt;
2. Needed additional capital expenditures; and
3. Working capital needs.

These requirements are delineated annually in the hospital budget submission. The Commission, in reviewing these financial needs, looks then to sources of funds available to cover these requirements. Such sources include funded historical costs depreciation as well as other nonpatient revenue sources. If the sources of funds available are not sufficient to meet the capital requirements of the institution, then the Commission will allow a growth and development factor to be included in the rates. We believe such an approach is entirely reasonable in that it ties the growth and development factor to specific purpose projects and, therefore, eliminates the danger created by arbitrarily assigning price level depreciation, which will allow some institutions to obtain greater payments than necessary and others not enough. In addition, the danger of perpetuating an institution or part of an institution, which is not needed, is also eliminated. Therefore, we would suggest this as a more reasonable alternative than price level depreciation.

Thank you very much for this opportunity to submit further comments on this important area.

Sincerely,

Thomas P O'Hare

Thomas P. O'Hare
Associate Director

TPO/mjh
cc: Mr. Caroll Callaway
Mr. Terry Klas
Mr. Fred Sattler

HEALTH INSURANCE ASSOCIATION OF AMERICA - 332 SOUTH MICHIGAN AVENUE, CHICAGO, ILLINOIS 60604

RECEIVED
FEB 7 1977
OFFICE OF HEARING
EXAMINERS

COPY

February 3, 1977

Mr. Steve Jackson
House Research Staff--Health
State Office Building
St. Paul, Minn. 55155

Dear Mr. Jackson:

This letter is with reference to the January 5 & 6, 1977 Hearing regarding the Hospital Rate Regulations proposed by the Minnesota Board of Health.

At the opening of these Hearings, I made several oral statements, not contained in my written testimony, preliminary to presenting comments on the substance of the regulations. I understand that these comments have caused personal offense to be taken by you, Fred Sattler, and the Staff of the Board of Health.

Upon reflection I realize that these remarks were hastily considered by me and inappropriately expressed. I do apologize for any personal embarrassment they may have caused or any implied or expressed reflection upon anyone's personal integrity. These statements were not an expression of HIAA policy or views.

By copy of this letter to Mr. Mihalchick, I am asking that my apology be included in the record of the Hearings. In addition, I will be sedding a similar letter to Mr. Sattler, Mr. Breviu of the Attorney General's Office, the Staff of the Minnesota Board of Health and the Staff of the Minnesota Hospital Association.

Sincerely,

Thomas O'Hare

Thomas O'Hare
Associate Director

TO/mmg

cc: Steve Mihalchick

Public's Exhibit No. J
File No. HLTH-77-035
Date 2-7-77

RECEIVED
FEB 15 1977
OFFICE OF HEARING EXAMINERS

Fairview Hospital
2312 South Sixth Street, Minneapolis, Minnesota 55454
Telephone (612) 332-0282

John G. King ■ Administrator

RECEIVED
Hospital Rate
Review System
FEB 9 1977

January 25, 1977

Mr. Fredric L. Sattler, Consultant
Rate Review
State Board of Health
717 Delaware S.E.
Minneapolis, MN 55440

Dear Mr. Sattler:

I wish to provide testimony on the regulation for the Health Care-Administration and Protection Act (Rate Review) passed by the Minnesota Legislature.

Specifically, I support the opinion of the Attorney General of the State of Minnesota that this act was intended to allow contracts between hospitals and health maintenance organizations that would enable hospitals to provide services to said organizations by contracts other than full fee for service reimbursement so long as the contract is cost justified.

Our experience with Group Health would indicate that it may be within the interest of the public to allow hospital service contracts with H.M.O.'s based on per diem rates, capitation, or other formulas. It is our experience that organizations that are able to direct patients to specified hospitals can reduce unit costs of the hospital. It is also our experience that added volumes of patients in low utilized services such as Pediatrics and Obstetrics will help in maintaining high quality service for the patient.

The volume of a large HMO spread around five or ten hospitals does little to affect costs. The volume concentrated in one or two institutions can have beneficial results in improved utilization and cost containment of those hospitals.

I urge you to establish the criteria for determining how the said hospital contracts might be "cost justified" and to allow hospitals and HMO's to determine their contracts according to their own interest consistent with public policy.

Sincerely,

John G. King
Administrator
Fairview Hospital

Public Exhibit No. K
File No. HLTH-77-035
Date

STATEMENT OF COMPLIANCE WITH

MANUAL OF RULE MAKING PROCEDURES

I, Special Assistant Attorney General John A. Breviu, do hereby declare that I have examined the proposed rules relating to the Hospital Rate Review System and all related documents and that, based on them and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed.

Dated: April 21, 1977

JOHN A. BREVIU
Special Assistant
Attorney General

ORIGINAL COPY

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

Docket No. HLTH-77-035-SM

VOLUME I

The above-entitled matter, came on for hearing before Steve M. Mihalchick of the State Hearing Examiners Office, on the 5th day of January, 1977, at the Minnesota Department of Health Building, 717 Delaware Street, Southeast, Minneapolis, Minnesota 55440, commencing at approximately 9:00 o'clock a.m.

* * *

APPEARANCES:

Frederic L. Sattler, Consulting Director, Minnesota Hospital Rate Review System, Minnesota Department of Health.

John Breviu, Special Assistant Attorney General, representing the Minnesota Department of Health.

Kent Peterson, Chief of Planning & Resources Control, Minnesota Department of Health.

Stephen M. Jackson, Legislative Analyst/ Health, Minnesota House of Representatives, Former Consultant to Minnesota State Board of Health.

* * *

WHEREUPON, the following proceedings were duly had:

* * *

EXAMINER MIHALCHICK: This hearing will come to order. This is Office of Hearing Examiners Docket No. HLTH-77-035-SM. It is entitled In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System.

My name is Steve M. Mihalchick, and I am a Hearing

Examiner from the Office of Hearing Examiners.

Out on the front desk there was a register which everybody should have signed whether they are going to testify or not, and there was also a Rules Hearing Agenda and Guidelines, which I will just briefly summarize at this point.

Shortly I will ask the panel to introduce themselves. They will make some opening statements. Mr. Jackson is going to make a general statement first, and then it is my intention, if I can, to get some general statements from interested groups in the audience so that I know where you are coming from. I understand the major interested groups will be the hospitals, the hospital association, third party payors, and perhaps consumers. If it is possible I would just like to get a general statement, maybe from a representative of each of those groups, as to your general position on the proposed rules. Also inter-agencies too, Mr. Sattler tells me.

At that point then Mr. Sattler will begin the formal agency presentation. He indicates that he wishes to go generally section by section, taking comments and questions at the end of each section, but slightly out of order, taking Rules 471 and 472 first; that is Scope and Definitions, and then skipping down to 487, Investigations, Analysis and Review Standards, which should be most of the meat of the rule, and then going back and taking the remainder of the rules section by section.

If you do wish to make a question or comment please

come up to the front, state your name and spell it for the reporter, and state whom you represent, if anyone.

I am also required to remind you of the rule on lobbyists. It is also on the front desk, a handout from the Ethical Practices Board, summarizing the lobbyists law. I refer you to that, and anybody that does qualify as a lobbyist is required to register within five days. If you have any questions on your status, contact the Ethical Practices Board. Their number is on that handout.

I have also been asked to recognize that there are -- looks like fifteen to twenty students from the University, who will be working on the rate review project during the coming year, I understand.

Mr. Sattler, would you introduce yourself, and then the other members of the panel?

MR. SATTLER: Fred Sattler. I am Consulting Director of the Rate Review System, with the Health Department.

MR. BREVIU: I am John Breviu, a Special Assistant Attorney General. I represent the Department of Health.

MR. PETERSON: I am Kent Peterson, on the staff of the Minnesota Department of Health.

EXAMINER MIHALCHICK: There are some procedural matters to complete before we get into the comments.

The purpose of this hearing is to meet the requirements of Minnesota Statutes Chapter 15, that the Agency when attempting to adopt rules make a presentation at a hearing, documenting its authority to do so,

showing that it has fulfilled procedural requirements, and showing the need for and reasonableness of the proposed rules.

The second purpose, probably more important, is to receive public comments that hasn't been received already in the drafting of the rules, and to consider those comments.

After the hearing the record remains open for twenty days. Anyone may submit written comments to me. My address is shown on the back of the agenda sheet. After the twenty-day period I will submit a report back to the Board of Health, stating my findings and conclusions as to how well I felt they did show their authority, follow procedure, and demonstrate need and reasonableness.

The Agency, the Board of Health, then makes a final determination on whether to adopt a rule either as it was proposed or perhaps as modified by suggestions at this hearing.

One procedural requirement is the filing of a number of documents. I am going to list those now. I have marked them previously as Exhibits.

Board Exhibit No. 1 is a letter estimating that 150 people will attend this hearing, and that it will take six hours. That was filed on November 9, 1976, and is required by Office of Hearing Examiners Rule 102.

On the same date they filed a proposed Notice of Hearing. That is Exhibit No. 2.

The Order for Hearing and authorizing resolution of the Board of Health, that is Exhibit No. 3.

Exhibit No. 4 is a copy of the proposed rules.

On December 10th the Board filed the following documents required under Hearing Examiners Rule 103; a copy of the Order for Hearing and the Board's authorizing resolution. That is Exhibit No. 5.

Exhibit No. 6 is the Notice of Hearing as it was mailed, and it included the summary of the proposed rules.

Exhibit No. 7 is a Affidavit of Receipt of the Secretary of State's mailing list.

Exhibit No. 8 is the Secretary of State's list and certificate that it was complete as of that date.

Exhibit No. 9 is the Affidavit of Mailing that the Board of Health on November 23rd mailed a Notice to all the people on the list.

Exhibit No. 10 is a Notice of Intent to obtain information that was mailed in June, soliciting comments and proposals on this rule.

Exhibit No. 11 are copies of the materials that were received in response to that Notice.

Exhibit No. 12 is a 97-page document which is a combined Statement of Need and Evidence.

Exhibit No. 13 is the name of the Agency personnel that will be appearing today.

Exhibit No. 14 is a copy of one State Register, 832, showing that the Notice of Hearing and a copy of the rules were published therein on November 30th.

That completes the procedural documents.

I also received one public comment prior to this hearing. That was from Blue Cross-Blue Shield of

Minnesota. I have marked that Public's Exhibit A.

This morning the Department submitted what I have marked as Department's Exhibit No. 15. It is Amendments to the Proposed Rules.

All those Exhibits are received now, and that completes the procedural part of this hearing.

(Whereupon, Board's Exhibit Nos. 1 through 15, inclusive; and Public Exhibit A, were received in evidence.)

Mr. Jackson, I believe you are going to make the opening statement.

MR. JACKSON: Mr. Examiner, my name is Stephen M. Jackson.

From the first of June, 1976, until the 15th of October, 1976, I was a consultant under contract with the Minnesota Department of Health for purposes of drafting these rules which are now before you.

Since the 15th of October, I have been a legislative analyst for health policy with the Minnesota House of Representatives. As a result of this appointment I am unable to be present during the entire course of these hearings, but if so required by you to be present at any time in the future I will provide you with my telephone number and hop right over.

To continue my presentation it is my intention here to provide you with a broad overview of the law as the basis for the rules as we saw it in the process, a brief description of the process we used in terms of developing the rules, and a brief overview of the pro-

pose rules themselves.

Sections 1 through 9 of Chapter 296 of Minnesota Laws 1976 provide the basis for our rulemaking, for the rules you have before you. The law contains three basic legislative mandates. First of all, it requires the disclosure of hospital budgets; second of all, it requires the review of hospital rates and changes in those rates, and, third of all, it requires the monitoring of institutional solvency.

It was the specific intent of the Legislature that the emphasis be placed not on regulation but more on the disclosure in these early stages of rate reivew in Minnesota.

This fact is evidenced by the Legislative decision in the course of the evolution of Chapter 296 to remove provisions reguiring uniform accounting and reporting. That is why you will find no provision in that law governing the uniform accounting and reporting.

I will draw your attention to the fact that some offering testimony before you today on these rules would have the law be more than a disclosure provision. I would remind some of those persons that the Legislature is the proper avenue to seek strengthening of the law. Rules must not go beyond the authority prescribed by the law.

In my effort to draft a comprehensive set of rules, with the broadest possible input, I began by circulating a 75-page draft of rules to numerous people four days after beginning my contract on June 1st. I asked for input and constant leads for persons with an

interest in helping develop the rules. Some of these persons' input was sporadic but was very helpful. Others, who I assume you will hear from, were able and willing to assist on a more continuing basis. It is this latter group which suffered through the tedium at least six complete times of reviewing draft rules line by line. The rules you have before you are a product of their labor.

It is with my extreme confidence that I assure you, Mr. Examiner, that these rules have the complete and sought-after input of providers, insurors, consumers and planners of health care in this state and indeed some across the nation.

The rules as the Department has presented them to you represent an aggregation of the hospital rate review processes in the States of Washington, Maryland and Arizona.

Generally speaking, the rules create a system of rate review which must be used as a minimum standard by the state and by the voluntary non-profit rate review organization; in other words, the Minnesota Hospital Association in our instance here.

This system consists of reporting requirements, administrative procedures, and assessment standards. We take a brief look at the reporting requirements. They seek to encourage hospitals to follow accounting and reporting procedures recommended by the American Hospital Association, their parent body, and the American Institute of Certified Public Accountants.

Since we cannot require uniform accounting or re-

porting in these rules, the specificity of these requirements is merely suggestive. Three types of reports are required by these rules. The first type of report we require is a report of annual financial information. It is an annual report due 120 days after the expiration of the fiscal year of the hospital, and it is a report required specifically by statute. The second report we require is a report of rate, revenue and expense. That also is an annual report. It is due sixty days before the commencement of any fiscal year of the hospital, and while the language is not specific in the law it is basically the intent of the law that that be a separate and distinct report. The third type of report required by the rules is an interim increase report, which is in reality an amendatory report to that second report, the rate, revenue and expense report. It is really not a completely separate third report.

We tried to construct these reports in a way to minimize the administrative hassle and red tape that any hospital or anyone reading the rules, as a matter of fact, is going to have to go through in the implementing of these rules.

The second part of the rules is the administrative procedures detail, such administrative provisions as those pertaining to the filing of reports, the determination of the completeness of certain reports, the starting point of the sixty-day time clock for the rate, revenue and expense report, and the development of forms which may be used by hospitals to meet the requirements of these rules.

The third part of the system is the assessment standards, perhaps the most controversial area of the rules. These standards prescribe the broad basis upon which the judgments of reasonableness of rates will be made. This judgment of reasonableness is an explicit requirement of the law. Some will object to the recognition of certain elements of hospital costs contained in these standards. I would first emphasize that the recognition of the existence of costs in certain areas is not necessarily an endorsement of the existence or the scope of these costs. This recognition of areas of existing costs is, to my mind, one of the necessary distinctions between a rate review disclosure system, as our law permits, and a rate setting system such as the Maryland law prescribes.

The fact that we recognize certain categories of costs, in exactly the same manner, by the way, as Medicare regulations recognize those areas of costs, is in itself really not prima facie evidence that the recognition will give rise to massive health care cost increases.

The increases which some will allude to here are, if anything, redistribution of health care costs among several purchasers of services. Non-cost-justified differentials granted to some insurors in the past have forced other purchasers of care to bear an unduly heavy portion of health care expense. If these rules do assist the leveling of the health care cost burden then I would assert that the rules help the law achieve a major legislative mandate, the equitable setting of

rate.

You will find in your review of the rules that some of these standards are fairly flexible. I would note, however, that they are all sufficiently explicit to meet the requirements of the Administrative Procedures Act.

I would caution you in recommending anymore stringent provisions. The concept of rate review is fairly new, and we honestly do not know its true impact upon costs. A rigid system can only cement imperfections in an experimental program.

The final section of the rules addresses itself to the supervisory functions of the State Board of Health. This section provides for, first, the approval, reapproval and continuous monitoring of the voluntary rate review organization by the Board; the second provision for the Board establishment of administrative thresholds governing which hospital rate increases will be assessed during the interim of each year; and the third thing that section does is simply provide other administrative procedures which must by law be reserved for the Board. You will probably be covering those in detail.

I would like to thank you for the opportunity to make this brief comment. I am sorry I can't be here for the full course of events. I know Mr. Sattler will be able to completely explain each rule and the questions you have. If there are problems I would be glad to reappear.

I would only urge you that in evaluating the input

of others you recall these rules are for disclosure and not a control system of rate regulation. Many of the concerns that come before you, as you will recognize, are more properly legislative questions.

Thank you very much.

EXAMINER MIHALCHICK: Thank you.

Let's go off the record a minute.

(At this time a discussion was had off the record.)

Back on the record.

Would you state your name and whom you represent, please?

MR. VAN HAUER: Mr. Examiner, members of the panel, my name is Robert Van Hauer. I am a member of the Board of Trustees of the Minnesota Hospital Association, and my purpose in appearing here today is to present the position of the Minnesota Hospital Association with respect to the proposed rules.

The Association represents virtually all of the 180 hospitals in the state. I wish to make it clear, however, that there are many hospitals represented individually here this morning, and they may well want to speak to a given point in furtherance or in difference with the position of the Association.

In addition to the Minnesota Hospital Association there is the organization of the Hospital Financial Managers Association. This is a group of men and women engaged in the accounting services in hospitals generally throughout the state. They have addressed

the earlier drafts of the proposed rules. They have furnished to the Association advice and comment. To a certain extent then I will be conveying ideas which have originated with this group of financial experts.

In a general sense may I say that the Association can support these regulations as being a very positive step towards cost containment, together with some assurance of continuance of the private hospital system as we have all come to know it.

We recognize and support the efforts of these regulations to generate and make available to the public critical hospital cost information for the benefit of a better informed public, for health providers and for governmental agencies.

Mr. Examiner, I trust you are aware that the Minnesota Hospital Association has been engaged in operating a rate review program very similar to the one being proposed in this regulation, and this endeavor has been under way for some two years or more.

Out of this experience we have learned many things. We have the feeling that the system which we have developed is working with a fairly high degree of efficiency and is providing the participation in the rate process, participation by the consumers as well as by the providers, as well as by the third party payors.

The operation of the system has already brought about significant cost reductions in the operation of hospitals in the State of Minnesota. It has become a very positive force in making hospital administrators

and managers aware of the need for more careful planning and budgeting, and we feel that this improvement will continue over the time to come.

In presenting our testimony from time to time during the course of the hearing we will be supporting certain key provisions which we feel are vital to continuance of the rate review program which we have initiated. We will be recommending certain changes in the proposed rules, with the hope that it will improve their effect upon the rate review program. We will be offering minor suggestions to improve the clarity and to define the precise meaning of the language of these rules. Lastly, after these rules are adopted the Minnesota Hospital Association intends to apply to the Minnesota Department of Health to become the non-profit corporate entity authorized to operate the system.

With that, Mr. Examiner, and gentlemen, I conclude my remarks for the moment. The Hospital Association appreciates this opportunity to be present and to convey to you our further concerns in a timely manner. Thank you.

EXAMINER MIHALCHICK: Mr. Van Hauer, I just have one question. Would you expect any other organization to attempt to receive certification also as a review organization?

MR. VAN HAUER: I don't know of any at this time, Mr. Examiner.

EXAMINER MIHALCHICK: Would your organization cover all the hospitals in the state or virtually all of them?

MR. VAN HAUER: Virtually all of them. It now does.

EXAMINER MIHALCHICK: Thank you.

Yes, sir.

MR. ANDERSON: Mr. Chairman, I would appreciate it if I could remain standing because of the brevity of my remarks.

My name is John T. Anderson. I am a registered lobbyist with the Minnesota Ethics Commission, and I am here representing Blue Cross and Blue Shield of Minnesota, and I wish to make the following statement:

Blue Cross and Blue Shield of Minnesota has already extended to the Hearing Examiner a list of our proposed changes that we would like to see taken into consideration, and in general we would like to say that we are in agreement with the proposed rules and the hospital financial requirements which are a part of the rules.

There are certain items that we do take a difference in, have already been presented to you in writing, and we are sure that there are some changes that we feel would be to the benefit of the consumers and to tha hospitals alike.

That would end my presentation.

EXAMINER MIHALCHICK: Thank you. Your comment was what I previously referred to as Exhibit A.

Yes, sir.

MR. O'HARE: Mr. Mihalchick, members of the panel, I am Thomas O'Hare, Associate Director of the Consumer and Professional Relations Division of the Health Insurance Association of America.

The HIA, for the record, is an association of over 300 private insurance companies throughout the country,

involved in the payment of health care benefits on behalf of its insureds, and HIA represents more than 85% of the health insurance benefit payments made by all private insurance companies in the country. In the State of Minnesota, according to our figures, over $241,000,000 was paid for health benefits in this state.

I have an exhibit here which I would, I guess, submit, which contains the essence of my general comments as well as specific comments, which I think I would like to do with your permission if that is all right.

In terms of overall comment on the regulation I think maybe a starting point is perhaps taking a difference with Mr. Jackson. He seemed to emphasize that Senate File 60, Section 7, really was only a disclosure kind of document, kind of a legislative mandate, and I would just submit that it says in Senate File 60 that, "The Board may initiate reviews or investigations as necessary to assure all purchasers of care that the total costs of the hospital are reasonably related to the total services offered, that the hospital's aggregate revenues are expressed by rates reasonably related to aggregate costs, and that rates are set equitably." That sounds to me to be a good deal more than disclosure.

The health care expenditures have been increasing at multiples of the gross national product, and to save you all the figures, they have doubled in Minnesota in the last five years, and they will double again by 1980. Therefore, the cost of health care, and hospital care in particular being the largest component, is an area that I think needs particular attention, and I

don't say that in an adversary way with hospitals, but rather that all sectors must cooperate together, both payor and provider, to bring about an accountable system for the increases in expenditures, and Senate File 60, I think, in its provisions and these regulations that we have before us offer a unique perspective and ability for an experimentation of the cooperation between a voluntary and mandatory kind of system; voluntary in the sense that the program will operate presumably under the direction of the providers themselves with input from all other parties, and mandatory in the sense that the state has the obligation to lay down the rules under which that system will operate, so it is mandatory as well as voluntary, as I see it, and, in fact, these regulations provide the public accountability necessary for the voluntary program. In other words, a voluntary program operated by providers is suspect from the outside; therefore, the state has the obligation of providing what I would call the public accountability for the operation of the program through these regulations and the effectiveness of the program through these regulations.

I find these regulations in many respects are very forward looking and very appropriate in their delineation, especially in the areas of sharing of bad debts and charity care as a financial requirement among all patients who pay. Traditionally, throughout the country, the greatest burden on hospitals has been the disturbing of their capital base by payment of charity and bad debts out of that base for the payment of ser-

vic[redacted] for patients who cannot p[redacted].

The government, both in Title XIX and Title XVIII, have across the board denied any obligation for payment for such care, and the private sector in many cases through non-profit prepayment plans has also done the same; consequently, the hospitals have been put in a financial bind.

I think all patients who pay should pay for those services that are not paid for by people who are medically indigent, so that is very forward looking.

The equity section on rates I think is also appropriate, and there are many, many other things. However, I do have some severe reservations about many sections of the document that I think do not properly take into account the financial resources available to meet the aspirations in the financial area set forth in many of the sections of the document.

Secondly, and I am somewhat hesitant to say this but I will, I think the accountability is an absolute necessity; therefore, these regulations should operate and be implemented and come to culmination without a cloud and without any possible self-interest motivation, and with the broadest possible input.

I find that in the development of these regulations at critical points in the development and through these hearings to finalization there is certainly, in my perspective, a lack of input from third parties in an effective manner such that these regulations would be accountable.

In other words, there is no -- well, there seems to

be lacking a good deal of a balanced input that balances hospital needs and aspirations with the resources available, and I will, with some hesitancy, point out two particulars, if I could, and conclude my remarks.

The first, as I understand it -- again, I am with the Health Insurance Association of Chicago; I am an outsider to the State of Minnesota, and, therefore, my information may not be accurate. If it is not, I apologize to all concerned, but, as I understand it, the Health Board in putting forth these regulations for the hearing operated through a task force or an ad hoc committee of the Board itself. Three members, I believe, were involved. One was the Chairman of the Minnesota Health Board, but all three individuals, as I understand it, are providers; a hospital administrator, a physician, and, I believe, a gentleman representing the administration of nursing homes. I may be mistaken in that, but I believe that is correct based on the information I have obtained.

I find that somewhat strange, and I find that in terms of the accountability and public credibility we are looking for this program, because we want this program to succeed; it is an interesting and timely experiment in the constant fight between government takeover and voluntary operations, so I see this critical. We want it to operate in an accountable fashion. I don't see having three individuals representing providers solely without input from the economic interests that are available to finance the resources required in these regulations present at that level. That is one element.

The second element I am even more hesitant to bring to the attention of the group, but I will. I see a potential conflict of interest, and I will leave it up to the panel to decide if that is the appropriate terminology, in the sense that Mr. Fred Sattler, whom I know personally and have the utmost respect for professionally, and is also well respected by members of our industry who have been involved with the voluntary program operated by the Hospital Association, is now under contract to the state to in effect perform many functions as a consultant relative to this program on the regulations.

The reason I find difficulty and a possible irreconcilable difference there is that Mr. Sattler now is operating on behalf of the state, whose functions, I believe, are such things as bringing these regulations through the hearing, assisting in writing of the final report to the Health Board as the recommendations to be made, and I understand to be involved in the on-going operation of the program and maintenance through the Health Board as the program is implemented.

The reason I find that difficult is that Fred's capacity in the Hospital Association has been to implement and staff the on-going operation of the voluntary program, which in effect these regulations are to be demanding an accountability of, and also has been the chief spokesman for the input of the hospitals to these regulations in the various discussions that were heard.

Therefore, I find that somewhat disconcerting, and if I could make a rather crude analogy, which is not

entirely applicable, the analogy is it is somewhat like having James Sinclair, whom you may recall was President Nixon's special defense counsel, having served President Nixon now replacing Archibald Cox as special prosecutor, and then involved in reporting to the Senate and House investigating committees on Watergate the results of his findings.

Now, you can be assured that Mr. Sinclair is a person of great integrity, great renown, and would just work very hard to do the best he could, but I ask you what would the cloud be associated with his efforts in that regard?

Again, I am not calling into question anyone's integrity, their capacity, their intelligence, their desire to do a good job. What I am calling into question is the arms length relationship that has to be here in order that these regulations be accountable. What I am calling into question is the objectivity of judgment. What I am calling into question is the ability to have a balanced perspective, not only from the provider needs but also from the financial resources available to the community, to the patients and to third party payors.

With that I will end my general comments.

MR. BREVIU: Excuse me. I wonder if I can ask one or two questions of Mr. O'Hare?

EXAMINER MIHALCHICK: Yes.

MR. BREVIU: I believe you made some allegations regarding accountability. Has your organization been in any way denied the opportunity to provide input in

the development of these rules?

MR. O'HARE: Not generally, but in one respect I would say so. I understand there were approximately -- and maybe you could correct me -- nine hearings or meetings of some sort which considered the various stages of the draft regulations which Mr. Jackson had been developing.

We had been provided with copies, various copies; we didn't get the nine copies or -- I don't know -- I am not sure we got all the various drafts. We got several drafts, so we knew the regulations were going on.

We did reply to those drafts in three different ways. One was a meeting of our industry representatives with Mr. Jackson in the offices of the Health Board here. The second response was a letter that I sent to Stephen Jackson commenting on a particular draft, and the third was a letter sent to Mr. Peterson, I believe, by Mr. Calloway, who is our legal counsel for our Association, with staff responsibility for Minnesota, so we did have opportunity to comment back, but what I am saying is I was aware of one of those nine meetings that were held, but we never received any formal notification or invitation to those nine meetings, nor was I aware that there were even as many as nine meetings.

I was aware of one which had occurred, I believe, shortly after the meeting we held in the Fall with Kent Peterson and Steve Jackson, but we were not aware of these on-going meetings, so that I would say we have had opportunity for input, but in terms of the on-going

meetings we have not been there and I was informed later that these meetings were held so I don't know if that answers your question.

MR. BREVIU: You have participated in any drafting of the rules at least in regard to commenting on the rules?

MR. O'HARE: Yes.

MR. BREVIU: Since when? Last Summer?

MR. O'HARE: Yes, I would say so, since the initial draft came out, I believe.

MR. BREVIU: Okay.

EXAMINER MIHALCHICK: Mr. Peterson.

MR. PETERSON: I would differ on your being invited to those review sessions. I believe you were sent the invitation to at least four to six sessions. Several of those sessions were scheduled as continuing sessions, so you could not have received an invitation had you not been at the meeting, but I feel that the invitations were quite complete and if you wish to receive some type of affidavits or records of how we proceeded to draft these rules we will present those.

MR. O'HARE: If I may respond, if you have that, that may be entirely possible. I was not personally aware of those, and I did check with several of our industry people here in Minnesota. They said that they were not aware of any invitations.

MR. PETERSON: There is some problem always being out of state.

MR. O'HARE: Right.

EXAMINER MIHALCHICK: Well, perhaps the Board could

submit an affidavit of those.

There is on Exhibit No. 12 a list of all the meetings that were held, but it doesn't show who was invited or anything like that.

One question, Mr. O'Hare. What is the interest of the third party payors, especially insurors, in this sort of rule?

MR. O'HARE: The interest is primarily a community interest. Insurance companies, despite what people might think, don't have money machines in the basement to pay benefits. These benefits come out of the pockets of the insured, the individual person, the large corporations; the Honeywells, the General Mills, the Cargills. These are the people who are paying premiums to insurance companies for these benefits, and we are placed in the position of being a steward and having a fiduciary responsibility to those insureds for the millions and billions of dollars throughout the country that we receive and they in effect are asking ever so loudly every day, "What are you doing with the financial resources which we are giving you to disburse on behalf of ourselves and our employees and so on? Are you exercising any way whatsoever of using those funds in a manner that would be most cost-effective? What are you doing to minimize the increases?"

Well, the increases, of course, are coming from escalating costs of health care, so what is needed is an accountability for that increase, and our policyholders and insureds are having to pay for the increasing cost of health care, and are asking that there be

some activity performed that will produce an accountability for those costs, so we are faced with rising costs of health care benefits which produce an increase in premiums, and are, in effect, requiring additional amounts of corporate revenue to pay insurance health care benefit premiums.

EXAMINER MIHALCHICK: Thank you. Okay.

MR. O'HARE: May I submit this (indicating)?

EXAMINER MIHALCHICK: Oh, sure. I will mark that Public Exhibit B and receive it.

(Whereupon, Public Exhibit B was marked for identification and received in evidence.)

Yes, sir.

MR. ANDERSON: Could I just add an addenda to what has been said?

My name is John Anderson, Blue Cross-Blue Shield of Minnesota. I would just like to say for the record that Blue Cross and Blue Shield of Minnesota is not a member of the Health Insurance Institute of America, so that when you talk about those third party payors you will know we are not a part of their industry.

EXAMINER MIHALCHICK: Yes, sir.

MR. KARLS: I am Allan Karls. I am Associate Executive Director of the Minnesota Hospital Association.

At some point we would like to take strong exception to the comparison that was drawn, whether you wish it done now or later.

EXAMINER MIHALCHICK: No, not now.

s, ma'am.

MS. CARANICAS: I am Doris Caranicas. I am Chairman of the Metropolitan Health Board. I am here representing their position.

We have submitted written comments. I have a copy of them here, with a letter to Dr. Warren Lawson. I would like to leave that with you as our written comments on the proposed rules.

The Metropolitan Health Board, which is the metropolitan health systems agency, is made up of a majority of consumers, and we have appreciated the opportunity to be involved in the drafting of the rules and regulations on the rate review system.

We also support the efforts of the Minnesota State Board of Health to implement this law, and we also support the efforts of the Minnesota Hospital Association to aid in implementation of this legislation.

Our position is one of support and general cooperation, and I won't go into any of the particular comments that we have included in our written documentation as I feel that would become part of the record anyway.

I just wanted to call attention to the fact that we have submitted them, and we are in full support of the concept of the rate review.

EXAMINER MIHALCHICK: Thank you. Let me mark that Exhibit C, and it is received.

(Whereupon, Public Exhibit C was marked for identification and received in evidence.)

. Peterson.

MR. PETERSON: May I make another comment regarding Mr. O'Hare's statement?

EXAMINER MIHALCHICK: Let's save them. I just wanted a general feeling of where people were coming from.

MR. PETERSON: We may not get back to that one allegation of process.

EXAMINER MIHALCHICK: Okay.

MR. PETERSON: I feel that it is appropriate to also comment on the other point of process which Mr. O'Hare objected to, and that is the hiring of Mr. Fred Sattler as the Consulting Director of the program.

The Department of Health went through a thorough process of trying to find people who were qualified in the rate review process. There are very few people nationwide who have the experience that Mr. Sattler has in the field.

We looked nationwide, and we found the most capable person in Minnesota. The person was employed at that time by the Minnesota Hospital Association. He is no longer employed by the Minnesota Hospital Association. He is the full time rate review director at the Department of Health, and we feel there is nothing improper about that process.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: Yes. I think for the record maybe the documentation of that search might be appropriate as to how that was done, the nationwide search mentioned.

Secondly, if I understand correctly, I believe Fred still has responsibility with the Hospital Association.

MR. BREVIU: Mr. Examiner, I guess I'd better respond. These comments are getting irrelevant in regard to rule setting.

EXAMINER MIHALCHICK: I agree with that.

MR. BREVIU: I don't think the process of hiring of Mr. Sattler relates to the rules.

EXAMINER MIHALCHICK: All right. Mr. Sattler, why don't you give us the rules?

MR. SATTLER: Maybe I should pull myself together before we get to the rules.

I think we will start with the first section, Scope, Section 471, and let me just begin by pointing out that we do have a number of amendments which we are proposing in conjunction with the original rules.

I will be pointing those amendments out to you as we move through each section so you will know exactly where we are, and would, of course, invite your comments regarding these amendments.

Generally speaking, I think these amendments are for the most part, you know, for clarity purposes and do not change the essence of the rule as initially proposed, but if you find they do change the essence we would certainly like to hear about it.

Initially also let me point out that these particular rules come out of legislation which sets up a rate review and comment procedure. It is really not a rate setting process as in many other states, and in

the drafting of these proposed rules we have been quite cognizant of the fact that this is not a rate setting procedure but one of review and comment.

The hospital has the opportunity under all circumstances to either take heed of the comments made by the Department or the voluntary peer review organizations, or discard those comments and proceed as it will, so as a result we felt in many cases it was really not appropriate to set up a system which would be overly taxing of the reviewing and comment legislation.

I think if the Legislature would at some point move to rate setting, of course, those changes might well be considered in the rule making process, but to arbitrarily set up a system which would mirror some in other states in which there are rate setting systems I think would be inappropriate at this time for this state.

Also it should be recognized that this particular state, I think, has a much more stringent Administrative Procedures Act than many states and, therefore, given the nature of rate review and rate setting, and the lack of experience that we generally have in this field, and the requirements of our Administrative Procedures Act, which would require a substantial detailed rule, would necessarily make the system inflexible and we would like to keep as much flexibility in the system as possible in the formative stage of this program.

Let me also point out that the Department has prepared a Statement of Justification, which can be reviewed at the Hearing Examiners Office, and it can be purchased from the Department. I don't know the price.

MR. PETERSON: $5.05, I believe it is.

MR. SATTLER: $5.05, I am told. It runs about 90 pages.

During the course of these hearings I will hopefully just summarize part of this justification and not read it to you. I will try to comment on every section and will provide additional detail, I think, when you feel it appropriate, or when we feel it appropriate, but I will not go into every single section and every single line in great detail.

First let me point out in Section 471, that is page 1, Paragraphs A., B., and C., we do have one amendment, and that is in Paragraph B., so when we get to that we will pick up on it.

Okay. Generally, Section Rule 471 defines the scope of the system, and quite generally comes out of the legislation. We are dealing with acute care hospitals and, therefore, will rate review and comment upon rates for acute care beds in hospitals only.

The only amendment is in B., the second to the last line, where you see we are talking about removing the cost associated with long-term care beds that may be in a hospital, and the words, "normal step-down requirements for allocation of costs," is in the initial proposal, and we are proposing to strike the words "step-down." The reasons become apparent later on in these rules, but essentially "step-down" I think is a very specific accounting term, implying a certain specific allocation process, and we did not have in mind that that specific process be followed, but that

oth[redacted] allocation methodology m[redacted] be used, so that is the reason for striking the words "step-down." Okay.

EXAMINER MIHALCHICK: Any questions on that?

(No response.)

MR. SATTLER: Any questions on 471?

(No response.)

EXAMINER MIHALCHICK: I see none.

MR. SATTLER: Then we move on to the Definitions.

Please note that we are amending on page 2, Definition E., of "beds."

Let me read to you the change. The change is we are moving to strike the definition as it stands in the proposed rules and amend it to the following:

"'Beds' means the number of acute care beds licensed by the Minnesota Department of Health, pursuant to Minnesota Statutes, Sections 144.50 to 144.58."

The reason for the amendment is to establish, I think, what would generally be accepted as the normal definition of a hospital bed complement, consistent with planning agencies' views, and with what the Board uses. Where in fact we will use something other than this definition it is so qualified in the rule.

Rather than setting up a different definition and then qualifying it back to licensed beds, we established licensed beds as the criterion. Then we will

qualify it to something other.

Rather than going through each specific definition let me just say that generally we have to set forth definitions. We hoped in most cases to use those that are standard definitions and that could be readily acceptable by the accounting industry, the insurance industry and the hospital industry, so that was our basic parameter when establishing these definitions, and rather than go through each specific one; I hope you have had an opportunity to review them, and if there are any difficulties with the definitions that are set forth I invite comments.

EXAMINER MIHALCHICK: Are there any questions or comments on the definitions?

MR. VAN HAUER: Mr. Examiner, members of the panel, my name is Robert Van Hauer.

Generally we find the definitions, including the amendments by the Hospital Board, satisfactory.

We do have certain language suggestions we would like to offer. Beginning on page 3, under Paragraph I., the second line, it reads "out-patient hospital diagnostic services -- " we would like to interpolate the words "and treatment," between "diagnostic services," so it would read, "out-patient hospital diagnostic and treatment services," the reason being, of course, that these out-patient services are about equally divided between provision of diagnostic service and provision of treatment.

On page 4, under Definition O., for "Loss" we were concerned about the application of depreciation to

assets since it does not appear to be included, and we would suggest the following language change: We would replace the word "Cost" with the words "Net book value," which is an accounting term meaning the book value of the asset minus the accrued depreciation; and the next word "or" we think grammatically should have been "of."

On page 5, under Definition R., we again suggest the inclusion of "treatment" in the out-patient diagnostic service, so it would read, "out-patient diagnostic and treatment service center," for the reason advanced earlier.

At the bottom of the page, under Section U., we find the term "adjusted rate." This appears in the line below the first fraction.

We would suggest that that term "adjusted rate" be used wherever the word "rate" appears later in this document as, for instance, in the bottom line on page 5, which begins, "The rate for the budget year -- " we would submit this might be better, "The adjusted rate," and similarly at the top of page 6, where we have the matter of admissions. Here we would suggest, "projected adjusted admissions," since adjusted admissions and adjusted rates are the foundation of this plan.

That concludes our comments on Section 472. Thank you.

EXAMINER MIHALCHICK: Thank you. Any comments, Mr. Sattler?

MR. SATTLER: Let me start with the last one on rate. It was the intent to have "rate" and "adjusted

rate, be used throughout wherever "rate" is used. That was our intent. I think it was an oversight on our part.

I think that's all.

MR. VAN HAUER: Thank you.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: Is it necessary to identify myself each time?

EXAMINER MIHALCHICK: No, not if I remember your name and call it out, just so the record shows who is talking.

MR. O'HARE: We have just three more or less editorial changes to clarify in this Section 472.

Going to 472 G., on page 2 at the bottom, the word "insurers" here is misused in the context inasmuch as insurers do not receive services. The patients are the recipients of services.

Therefore, we suggest that it be changed to read, "'Charges' means the regular amounts charged to patients and/or insurers' prepayment plans and self-insured groups on the patient's behalf."

Also in this section, a more substantial issue, services relative to the indication here of discounts. It is our position that Senate File 60 in its language prohibits any discrimination in rates between insurers and, therefore, discounts have no foundation in Senate File 60, and, therefore, should have no foundation in these regulations, so we would also then move to delete the last portion of this paragraph G., to eliminate the word "discounts" the reason being the proposed regula-

tion establish discounts which go beyond the provisions of the law.

Moving on to 472 U., on page 5, this is a definitional change in that the rate, the word "rate" in this section is really erroneously defined both as to its commonly accepted meaning and as to the implications in the Senate File 60.

The ordinary meaning of the word "rate" in the context of hosptial financial matters is as a payment rate or the basis of payment for hospital services. If that is so used in this section it would mean that hospitals wish to be paid by patients and third parties on the basis of average revenue per admission or per case, and that doesn't seem to be the intention of the regulation.

Then in Senate File 60 rate is also assumed to be the basis of payment. For example, Subdivision 1 under Section 7, says, "The Board shall prohibit hospitals from discriminating among insurers in its rates."

Can rate mean average revenue per admission or does it expect that the insurers will be paying on a rate per admission? That is not so. Okay.

There just is no foundation in the section of the law to define rate in this manner, and you can see by the way it is indicated here in the regulation with quotation marks. It should be used as it is meant. In other words, rate should mean really average charges. That is what it should mean.

In other words, it is a way of measuring a rate but it is not a rate in itself. The average revenue for

each in-patient admission might be a way of measuring charge increase, but it is certainly not a rate; therefore, we have indicated in our written testimony the subsequent changes that will take place in these algebraic expressions here. I won't go through that.

Okay. 472 AA, page 7, we would move that the definition of "third party payors" should be revised to read as follows:

"'Third party payors' means insurers, non-profit service plan corporations, health maintenance organizations, self-insured or self-funded plans, and governmental programs, whether it is state or federal, including Title V, Title XVIII and XIX."

This would be a clarification of what should be included in third party payors. Insurers there is too broad a category, and it should be further defined as including non-profit prepayment service plans as well as self-insureds, self-insured groups, and it is the intent of Senate File 60.

That concludes my comments on this section.

EXAMINER MIHALCHICK: Mr. Sattler?

MR. SATTLER: Just generally on the rate, without getting into the legal implications which we will deal with in writing, generally we feel that, number one, when we are looking at rates we are looking at the relationship between cost of the hospital and revenue, so that it would be appropriate then to look at revenue generally and relate revenue and costs.

Also, I would like to ask a question as to what specifically should we be using?

MR. O'HARE: Instead of rat[redacted]in that section?

MR. SATTLER: Yes.

MR. O'HARE: Well, all I am saying is really it is a definitional problem, a definitional question in my mind.

What I am merely suggesting is that the average rate for each patient -- well, what I am saying is that rates are equivalent to charges; in other words, charges are rates -- period.

Therefore, in this Section U., you should merely state that average revenue for each in-patient admission will be -- and so on down the line, the idea being that average revenue for each in-patient admission is a way of measuring charges or rates, and the impact of charges or rates. It is merely definitional, but I think it has other implications which I won't go into here necessarily, but, in other words, you have got to keep the definitions consistent.

We are talking about rates. If you want to measure rates by average revenue per admission, that's fine, but rates are not average revenue per admission. Rates are the charges of the hospital for each specific service as the basis for their receiving payment.

MR. SATTLER: Are you suggesting that we review individual rates and individual charges let's say?

MR. O'HARE: No. I am just saying call it charges -- charges and rates are the same. Those are the same by definition. Average revenue per admission is average revenue per admission. It is a tool for measuring what impact any charge increases, or revenue increases,

might have taken place into a variety of charge increases which we are not necessarily looking at individually.

MR. SATTLER: Okay.

EXAMINER MIHALCHICK: Anybody else on definitions?

MR. BREVIU: Mr. Hearing Examiner, --

EXAMINER MIHALCHICK: Mr. Breviu.

MR. BREVIU: -- one quick comment in regard to the definition of third party payors on page 7. The statement was made by Mr. O'Hare that the definition is not sufficiently broad.

You will note that the definition includes insurers, and insurers is defined by term in the Statute, and it includes non-profit prepay organizations, and so on. Those organizations are included in the definition on page 7, AA.

MR. O'HARE: Yes, I was aware of that. I was merely asking for a further explicitation of that.

EXAMINER MIHALCHICK: This might be an appropriate place for a break before we get into 487.

MR. SATTLER: Okay.

EXAMINER MIHALCHICK: Let's recess until 10:45.

(Whereupon, a recess was taken.)

EXAMINER MIHALCHICK: The hearing will come to order, please. Mr. Sattler.

MR. SATTLER: Before we pick up with the next section, I would like to make one comment about the definition of rate, and let me begin by quoting from Section

7 of Senate File 60, which says that "The Board may initiate reviews or investigations as necessary to assure all purchasers of hospital health care services that the total costs of the hospital are reasonably related to the total services offered, and that the hospital's aggregate revenue -- " Let me emphasize the words "aggregate revenue," -- " -- as expressed by rates are reasonably related to the hospital's aggregate costs and that rates are set equitably."

I would like to point out that there is significant confusion, I think, in the industry between the words "charges" and "rates," and they constantly have to be defined everywhere they are used so that the exact definition would be known, and there are numbers of units of payment which can be used. The units of payment can vary from individual charges or individual prices for each service offered by the hospital, or it can go all the way up to a total budget for an institution. It can also be acceptable units of payment and, therefore, defined as the rate or charges for the hospital.

Rate setting systems or rate review systems around the country use these various units of payment.

The State of Washington uses actually three, two of them being the total budget for the hospital as one unit of payment, which they can define as a rate, or individual charges or prices for each service offered.

I would like to quote from a report written by Catherine Bower for the Social Security Administration, Department of Health, Education and Welfare. Mrs.

Bowe[redacted]is of Harvard University [redacted]d she participated in a uniform reporting and accounting seminar that was held in 1975, and I quote from page 37 of this report, which is the proceedings of the 1975 Conference on Uniform Reporting and Accounting for Hospital Rate Reviews, Criteria to Guide Development, and I quote where she is discussing some comments that Frank Baker of the Washington Hospital Commission made concerning units of payment.

Mr. Baker observed that, "The Washington Rate Commission has concluded that it is administratively impossible to set prices for each hospital item. Their method allows management to set the price for charges within the Commission's definition of rate," so that the Commission does set individual definitions for rates, and which is consistent with our approach here, that for rate review purposes it is perfectly permissible for the rate reviewers to set the definition of rate that they will be applying during the rate review process, and we think that our definition is consistent with the legislative language, talking about aggregate costs relating to aggregate revenue as expressed by averages.

EXAMINER MIHALCHICK: Okay.

MR. SATTLER: Let's move on then to page 26.

I think this section, as we indicated earlier, is the most significant section, I think, from the standpoint of rate review purposes in determining reasonable costs and charges. We know that there are many interested parties in the room so we will get to this

section and probably I would estimate it will take the rest of the day. We will see how quickly we can go through it.

In this section generally we are addressing really the reasonableness of rates as they relate to costs, and the reasonableness of costs put forth by hospitals. We in doing that first had to establish the financial requirements of institutions so that we could have a uniform basis of judging hospital budgets and their reasonableness.

In putting these rules together we went to various sources, among those, as Steve Jackson mentioned earlier, rate review programs in other states, among those specifically the States of Maryland, Washington and Arizona.

We also discussed financial requirements with the American Hospital Association, their statement on financial requirements for hospitals. We have looked into literature for public utilities and determined what would be reasonable for any public utility who has its rates or prices set, and what are reasonable elements of their rate base or expenses.

We have talked with people at the Social Security Administration, and finally come back and looked at what the Minnesota Hospital Association has been doing for the last two years in its financial requirements, and talked to the accounting profession; also consulted with Blue Cross of Minnesota to see how they handle financial requirements in their inter-agency agreement.

Given that as background to the general area I would

like how to move into the broad categories of financial requirements, and I think in this case what I will do is move through each financial requirement and ask if there are any comments, because I think we will get into a very technical area and I would like everybody to have the opportunity to comment on each particular requirement if they have one, so we don't lose the thrust of the arguments from various individuals.

The first area generally are those things that relate to direct patient care, and here we talk about the general areas of expenses; salaries, wages, fringe benefits, services, supplies, maintenance, building repair, and any taxes. We talk about the monetary value of voluntary work, particularly of religious affiliated institutions; also any work that is done by governmental units where there might not be a direct monetary charge.

There are parameters put around these particular charges and the enumerations really are similar to those that would be found in the normal employment sector of the economy of what would be paid for these types of voluntary services if they were not volunteered.

Are there any comments on the salaries, wages, fringe benefits, things of that nature?

(No response.)

Okay. No indication. We will move on.

I have been asked to indicate the section numbers, so that would be MHD 487 A.1.a.(1)(a) and (b).

Let's move then to 2. on page 28, Interest Expense.

It is generally accepted that interest is a reasonable expense to be included in financial requirements assuming that interest is not exorbitant to what would be really paid in an arms length agreement from a borrower.

We do have an amendment on page 28, and it is to (ii), and we are proposing that we strike the section starting with the second sentence and include in its place the following, "Loans made for the following are not to be considered to be for a purpose reasonably related to patient care: to expand facilities that have been determined to have excess capacity, pursuant to MHD 487 A.4."

EXAMINER MIHALCHICK: Is that written in that form so that you can add things later to it?

MR. SATTLER: No, it is not. We have a period.

EXAMINER MIHALCHICK: I think that could be reworded.

Mr. Van Hauer.

MR. VAN HAUER: Mr. Examiner, may I speak to the proposed amendment and suggest a further amendment dealing with the word "facilities"? This is related to excess capacity. Excess capacity elsewhere in these rules is dealt with on page 44 under that heading and as such deals with beds.

I would suggest that the word "facilities," be supplanted by the term "bed capacity." "Facilities" is a broader term, embracing bed capacity and ancillary facilities of all sorts.

ain then because we are d ling with bed capacity, excess capacity deals with bed capacity, I would suggest that further change. Thank you.

EXAMINER MIHALCHICK: How would that be worded? Just replace the word "facilities" with "bed capacity"?

MR. VAU HAUER: Yes.

EXAMINER MIHALCHICK: Okay.

MR. SATTLER: To expand facilities, meaning to expand hospitals, okay.

EXAMINER MIHALCHICK: What is your reaction to that, Mr. Sattler?

MR. SATTLER: I think what we are really talking about is facilities generically, meaning in the hospital context, to expand those hospitals that have been determined to have excess capacity.

MR. VAN HAUER: Mr. Examiner, I apparently did not state myself correctly. May I correct my statement?

I have suggested replacing the word "facilities." That is in error. The language should read, "to expand bed capacity in facilities that have been determined to have excess capacity."

EXAMINER MIHALCHICK: The reason for that being that even though a hospital may have excess capacity they may reasonably want to expand in some other department other than just beds?

MR. VAN HAUER: Correct.

EXAMINER MIHALCHICK: Some other service?

MR. VAN HAUER: That's correct.

EXAMINER MIHALCHICK: Mr. Sattler.

MR. SATTLER: I see a potential problem with "bed

capacity." In areas where a certificate of need is required I don't see the problem. I don't think any expansion can be undertaken without a certificate of need when required regardless of the capacity.

I do though see problems with areas that do not reach the certificate of need threshold, but where expansions can take place in departments for less than a hundred thousand dollars, or where it is not considered to change the scope of services, which may not necessarily be in the best interest of a hospital or communities where there is excess capacity, so, in other words, an expansion in an area can be made underneath the certificate of need threshold even when the institution is determined to have excess capacity.

EXAMINER MIHALCHICK: So your reaction right now is you would not like this change?

MR. SATTLER: Correct.

EXAMINER MIHALCHICK: Any other comments on page 28, Interest Expense? Mr. O'Hare.

MR. O'HARE: Yes. I would just like to ask a question here as well as make a suggestion.

The necessary and proper interest on funds, is that going to be defined by further methodology of the program? In other words, what you get into is a situation -- this is at the top of the page, (2)(a). We talk about interest. You also have to talk about interest offsets through, let's say, investment of operating income and so on if that should occur. In other words, you have interest offsets through other income; let's say, invested operating funds, for in-

statute, which I don't think is covered anywhere else.

We talk later on about unrestricted income and restricted funds, and I think somewhere in the definition we left out operating income; it is not to be considered unrestricted income. I am not sure of that, but what I am getting at is that when you get to necessary and proper interest on funds you have to make a determination at some point as to what is necessary and proper, and what to do about possible interest offsets, and so I raise the question as to if it needs to be something done here, because I don't think it is addressed anywhere else.

Secondly, the MHA statement on, I believe, financial requirements does not address the issue of offsetting interest expense by interest income.

MR. SATTLER: I think possibly you might have a point, but can we hold that until we get to the offset section --

MR. O'HARE: All right.

MR. SATTLER: -- because I think we handle offsets generally against financial requirements, but why don't we wait and see if we cover that point when we get there?

EXAMINER MIHAICHICK: Anyone else?

(No response.)

Okay.

MR. SATTLER: Okay. We move on to page 29, (3) Educational Program Expenses, and we have an amendment

in [redacted](a)(i). We would like to [redacted]trike the word "and" and replace it with the word "or".

The reason for that is we set up two criteria, and we do not mean that in order to qualify as financial requirements they have to meet both criteria simultaneously, but one or the other, so we are suggesting the word "or" rather than "and."

Okay. Here generally we talk about educational program expenses. We say that they should be includable if they directly relate to patient care, or they do provide preventive education to the population in general and will, therefore, reduce total hospital costs in the long run.

We say that these educational activities must be approved in a similar manner to Medicare. We talk about the net cost of education meaning not necessarily the full cost, but if there are other income to meet the costs of these educational programs that they should be used to offset the cost first.

We say that job orientation or on-the-job training is a reasonable inclusion.

We then get into, on page 30, (e), where we would also like to amend, and the amendment takes place down toward the bottom of the page, and as it reads it is for hospitals -- let me see -- "provide activities recommended appropriate for hospitals by the State Health Planning and Development Agency," and I would like to include "and appropriate health systems agency, pursuant to Public Law 93-641, Section 1523," striking "(a) (6)" and add "and Section 1513, respectively."

r rationale here is not o[illegible]y should we check into the recommendations from the State Health Planning and Development Agency, but also comments from the local health systems agency, and it is consistent with the way we handle these types of things in other sections.

Okay. We also point out in (e) that there should be no additional payment to hospital employees, particularly physicians who might run some of these particular programs. We feel if they are employed by the hospital giving a program in the institution that that should be covered by the normal remuneration rather than charge extra and, therefore, pass on the cost of that to the patient. Okay.

EXAMINER MIHALCHICK: How are you able to separate educational costs which don't relate to the allowable purposes?

MR. SATTLER: Generally speaking -- well, from the first, the direct patient care, we go back to Medicare, and Medicare has the same requirement and if they are approved programs for Medicare purposes then they will be approved programs for this particular program for direct patient care purposes.

EXAMINER MIHALCHICK: But mechanically will the hospital have to have these approvals first?

MR. SATTLER: Yes, they have to get approval first, and we do get the Medicare Cost Report and can consult with the Medicare intermediary if the system has any questions concerning allowable educational programs of this nature.

EXAMINER MIHALCHICK: Mr. Anderson.

MR. ANDERSON: I just wonder if this is the forum now to bring into focus for you, Mr. Hearing Examiner, when you read the record of our objection at this point.

It is proposed by us, Blue Cross-Blue Shield of Minnesota, that Paragraph (a)(ii), Page 29; Paragraph (e), Pages 30 and 31, be deleted.

While Blue Cross-Blue Shield of Minnesota endorses the concept of community preventive health education and the proper benefits they may provide to that part of the population that choose to participate, we believe that the required funding should come from sources other than the current hospital patient.

It is our position that patient charges should include only the net cost of educational acticities of the hospital which directly contribute to the care of patients who are in the hospital during the time the cost is incurred.

We believe that the cost of those educational programs conducted for the benefit of non-patients should be paid by those participating in the program or from funds the hospital may have available for such a purpose.

EXAMINER MIHALCHICK: I would note I appreciate your pointing that out. Even though there are written comments if you bring them out now at least the Agency will have a chance to respond better at this point too.

Do you wish to do that?

MR. SATTLER: Yes. I think we generally agree. I think we say other funds that are available should be utilized first, and that is where we get the net cost,

utilizing grants, and these others.

I think that part of the intent of the program is to encourage long range cost containment. To the extent that we can get people out of the hospital I think it is working to the benefit of the entire community, and one way to get them out is to not get them in in the first place, and if we can provide programs in the preventative area that will accomplish this end, I think it behooves the system to undertake reasonable costs in this area.

Secondly, we are under, I think, pressure from health systems agencies or are becoming under pressure from health systems agencies and the State Health Planning and Development Agency to make changes in the current delivery system.

They may suggest the -- well, I think they may even require hospitals to undertake programs in this area which have to be funded some way. I think the important thing is to keep a dialog open between the health systems agencies, the State Health Planning and Development Agency, and the rate review system to let the planning people know what the costs of these programs are if they become excessive or burdensome.

By the same token I think we need to keep the avenue open and available financially to provide these programs if required, so that is, I think, the state's rationale for including this as a financial requirement, yet all -- by the way, just let me comment that all of these financial requirements are subject to reasonableness criteria, so that none of them, we hope, will get out of

hand

EXAMINER MIHALCHICK: Mr. Van Hauer.

MR. VAN HAUER: Mr. Examiner, the Hospital Association has some concern with the latter part of Paragraph (e), which begins at the bottom of page 30 and extends to page 31, the sentence, "In any instance, these costs should not include any payments in excess of the normal salary or remuneration to professional employees of the hospital or health professionals who maintain consultative, contractual, or patient relationships with that hospital."

Our concerns are two: The first is that we want to be assured that those hospitals -- and there are many small hospitals that fall in this category -- who have no professional employees nor any health professionals under contractual arrangement who can provide these instructions, who do have to go outside of those frameworks to get them, we would hope that those costs might be included.

Then, secondly, speaking directly to the impact of this, the impact as we perceive it is that anyone on the payroll shouldn't receive anything extra for providing any of these educational programs.

Let me point out what regularly happens, and I'm speaking from an actual instance in a hospital which conducts a course of training for prospective patients in the maternity department. These courses are usually conducted in the evening for the convenience of the public. They are conducted by nurses and other technical people from the hospital who come back to the

hospital from their homes, having already worked a full shift.

If these people are not to receive any compensation for this extra work they will refuse to come at all, and then the hospital will have to go out and hire a still more expensive person to come in, so that the provision becomes a bit self-defeating in that instance, so those again are two concerns.

We want to be assured that the small hospital who has no employee, has no health professional under contract, can receive its costs, and we would point out that to refuse allowing extra costs for qualified hospital people who come in outside of the normal hours to conduct training will be self-defeating. Thank you.

MR. SATTLER: Our only hope here was to really encourage hospitals to, wherever possible, collect funds from the people taking the courses to cover those kinds of expenses rather than establishing an open avenue, so to speak, through financial requirements in all cases and, you know, to build this into in-patient rates, and really set up a system to encourage, wherever possible, and we recognize it is not always possible to do this, but to charge, or to recover costs from the people actually taking the courses.

EXAMINER MIHALCHICK: Any other questions? Mr. O'Hare.

MR. O'HARE: Yes. Relative to this section I am in the happy situation of siding with Blue Cross relative to the impropriety of inclusion of what you might call community-related or solely community-related preventive

health education programs.

I think it is completely unfair to burden the patient in the bed with any part of those programs whatsoever. They are not recognized by Medicare and Medicaid anywhere in the country; they are not recognized, as far as I know, by any rate review program, either voluntary or mandatory, and we have got several in the adjacent area; we have got Wisconsin, Kentucky and Indiana -- not adjacent exactly, but in the same general area. None of those in looking at their financial requirements, none of those three voluntary programs, recognize such expenses although they certainly would approve any educational programs that deal with patient education programs for the patients themselves, pertaining to the actual people using the hospital to improving the capabilities of the staff and so on -- no problem -- but when you get to these community kind of activities, although the hospital may be the focal point for the conduct of those, I think the funding for that should be coming from other sources rather than from the patient in the bed, and I just don't see the propriety of including this here.

It would be the first time that it was ever included, as far as I know, in any program, either voluntary or mandatory. Thank you.

MR. SATTLER: My comment about it being the first time, it may well be. I think that this is one case where the State of Minnesota is not being myopic in approach.

I think we recognize that it is really in the long

run ● we believe that it will ● in the long run in the best interests of the insurers to participate in this program as we find subscribers to plans and purchasers of insurance who actually experience a long run decrease in premiums as a result of less hospital utilization. This is one case where possibly short run minor increases in expenses, may well result in long run decreases, and we would hope that the industry would really go along with this in this regard, and as long as the system keeps these particular kinds of costs under control we don't foresee a great burden at this point, and the possible long run benefits we think will be substantial.

EXAMINER MIHALCHICK: Anyone else?

(No response.)

Proceed, Mr. Sattler.

MR. SATTLER: Okay. Research Program Expenses, on page 31.

Here we take a rather narrow approach to the research and say that costs must directly relate to the patient care and the patients in the hospital.

We do not anticipate financial requirements that would relate to research programs that do not benefit current patients.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: Well, then I think to be consistent we ought to include research expenses in there as well for the same rationale that was developed on patient educa-

tion because obviously research produces the wherewithal by which to bring about, you know, the long term benefits you are talking about, and I think insurance companies ought to participate in that. I am being facetious, of course.

MR. SATTLER: We might take you up on that.

MR. O'HARA: At least there should be consistency.

MR. SATTLER: We feel also that there are -- well, as a matter of fact in discussion with some of the larger hospitals that participate, have very large research programs, that there is a rather clear cut delineation in funding.

Research programs are usually funded through other sources. In other words, in these types of programs there are grants, funds available, the Federal government is involved in funding these programs, while in preventative health care programs there appears to be difficulty in all cases with receiving funds.

We do not necessarily have, I think, a clear cut Federal or State policy to provide funding for these kinds of preventative programs which we see on the horizon, particularly with the requirements and changing of the delivery system that we foresee under the new Planning Act, so what we are trying to do is not preclude funding through the hospital system for preventative programs while we are saying that we do have some rather straightforward policy on the funding of research programs, and that these funds are available and can be sought out so that we don't see the need to fund those kinds of programs through patient sources.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: I don't want to delay the hearing. I guess I have made my point so I hesitate to go over it the second time, but I think the question is why aren't these funds forthcoming for community education programs? It is probably because some of these funds are tight. You know, there is no money available; the government is being strained, the private sector is being strained and so on, and here you are unilaterally lumping another burden on top of in fact the private sector patients because the government, the state is not going to recognize this, the State of Minnesota; Medicare is not going to recognize this. What you are doing is heaping another burden on top of the private sector patients and in fact, you know, Senate File 60 says that the rate shall be equitable. You are causing a situation which I think can fairly be interpreted as inequity between what patients are paying because one patient is a Title patient and one is not.

I think that this is inappropriate and that -- one last point -- I think it ought to go through the State Health Planning and Development Agency, just like a project review goes through the State Health Planning and Development Agency, referring back to the point about HSA programs, programs sanctioned by the HSA, but I think it ought to go back to the State Health Planning and Development Agency just like a project review would go through the State Health Planning and Development Agency. In other words, there should be more accountability than just the local agency.

MR. SATTLER: I believe it says in the amendment -- I believe it says both have to go through the State Health Planning and Development Agency and the HSA.

MR. O'HARE: "And"?

MR. SATTLER: Yes, and, secondly, it would not, I don't believe, heap any more costs upon the private sector than are already there.

Also, the system sets up a review mechanism which will comment upon the reasonableness of the particular costs of programs that hospitals would like to undertake of this nature, so that there are constraints on the amounts, the number of programs and the costs of programs in any given individual institution that will be undertaken in this regard.

Once again, we foresee this as really an investment in the future rather than a quota, "cost" but to the extent that we can keep people out of the hospital we are really doing the insurance companies and the community a service.

EXAMINER MIHALCHICK: Any other comments on the research programs?

(No response.)

Proceed.

MR. SATTLER: Next we come to page 31, Bad Debts, and we have a few amendments.

We would like to essentially just strike the words "courtesy discount allowances," and the word "expenses," and make "contractual allowances" plural so it reads

"contractual allowances."

Number (5)(a) we would also like to strike the words "courtesy discount allowances," and before we move on to the next page I would point out that the reason we would like to strike the words "courtesy discount allowances" is that as we move into the rules you will find that courtesy discount allowances don't really exist.

We get into it definitionally and we say that you either have cost justified discounts or non cost justified discounts. Courtesy discounts may well be cost justified or they may well be not cost justified, so to set them out as a separate type of discount we think inappropriate.

Let me move through the rest of the amendments on this section. Under (i), Bad Debts, we go over to page 32 and again remove "courtesy discount allowances."

Under (iii) we have additional language we would like to remove, and then replace.

It reads now, "Contractual allowances," and we would like to add a comma and then strike everything from "and" all the way through "hospital," and insert "cost justified discounts" and "non cost justified discounts."

It has come to my attention since we published these amendments that there is also another reference to cost justified discounts on page 34, (b) line 2, and although we don't have it printed here I would just for consistency sake suggest that we strike "courtesy discount allowances" in that section also.

at takes care of the amendments on this particular section, and let me go back then and talk about what we are attempting to do and the rationale behind this.

The legislation specifically asks that we have equity in rates. It states there shall be no discrimination among insurers. It defines insurers as commercial insurance carriers, I believe. Let me read it.

"Insurer means a person selling policies of accident -- "

Is this it?

MR. BREVIU: That's it.

MR. SATTLER: " -- of accident and health insurance pursuant to Minnesota Statutes Chapter 62(a) or non-profit health insurance plans subscribed by contract pursuant to Minnesota Statutes Chapter 62(c)," which I believe completely exempts governmental insurance programs such as Title XVIII, XIX, V and others.

So here we are, you know, trying to establish what equity will be, who will be covered by this particular section and what, quote, "discount" really is, and what the discrimination really is.

In the first instance we are saying that rates should cover bad debts, charity and government contractual allowances. We then define bad debts. I am taking some time to go through this because I know this will be a section that will cause some problems for people.

Bad debts mean any amounts to be considered uncollectible from accounts, and that quite generally bad debts will be includable.

It says that charity allowances may be includable,

but [redacted] defines very narrowly w[redacted] charity allowances are and really limits those to Hill-Burton liabilities that hospitals may have.

We talk about contractual allowances and specifically say that contractual allowances are those governmental allowances that may exist between a hospital's rates and what a governmental reimburser will reimburse.

EXAMINER MIHALCHICK: Wasn't that amended?

MR. SATTLER: Not in that part.

EXAMINER MIHALCHICK: Not that part?

MR. SATTLER: Right.

We talk about cost justified discounts, and we say that a discount is not necessarily discriminatory if there is some economic reason for offering or granting one particular payor, as defined by the insurer section, or self-pay patients a lower, quote "price" if there is an economic reason for doing so, if it can be cost justified, and we think that there are rationale in this in Federal legislation and common practice in the industry.

We also believe that it offers an incentive for payors to attempt to achieve discounts or to pay lower prices for undertaking positive economic action, for instance, to pay hospitals sooner.

As an example, if individuals or insurers will pay within the first ten days after discharge they may well deserve some percentage discount, or what is commonly called in industry a cash discount, and it might well be some other types of discounts that can be established that payors can take advantage of.

also say that discounts that are not cost justified or economically justified are not allowable as a financial requirement.

An institution may grant discounts to payors but it cannot include the difference between the normal rate and that lesser rate in its financial requirements so that other payors will pay them, will pick up that burden, so here we are giving every payor an opportunity to achieve a discount equitably. They all have the same opportunity to achieve the discount, and we think it will generally work to the best interest of all paying patients, meaning insurers and paying patients, to reduce the cost of care by taking advantage of these discount opportunities.

I think that that is about as far as I can go. We finally have the last section on page 34, (b). We state that bad debts, charity allowances, should be offset by other income where appropriate; where income is set up or endowments or funds are set up to specifically handle these, that those sources should be utilized first, and we also recognize the difficulties that this particular arrangement can set up with some of the Medicare requirements, Public Law 93-603, Section 223, which specify the lower of cost or charges limitation on Medicare reimbursement, and subject any hospitals to receiving less reimbursement from Medicare than would normally be applicable.

Okay. We will start with comments on page 31 (5).

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: I would just like to make a point on

this section on discounts. I agree with the rationale that was developed relative to the appropriate differentials based on cost-saving factors. This is something I think which is intelligent and supportable; however, I think we have to look at the wording of Senate File 60, which in the opinion you are expressing here would not allow such discounts.

It is our position that the Senate File 60 when it says that rates shall be set without discrimination among insurers means in fact that discrimination will be taken at its face or first value, which is no distinction, no delineation, no deviation between those rates, and that to do otherwise would go beyond the limitation of the Statute.

Now, as this pops up I don't need to repeat the citations of every instance where that comes up and is mentioned here, but that is the general point. I do have them delineated in my written document that I have submitted.

EXAMINER MIHALCHICK: Mr. Breviu.

MR. BREVIU: Mr. Hearing Officer, it is our view of the statute that cost differentials, price differentials which are cost justified are not discriminatory, that by its very nature to refer to price discrimination it means unfair discrimination as opposed to cost justified differences in rates.

We have expressed that view in our Statement of Justification. That expands upon the comment I have just made.

We think this is consistent with the interpretation

of various state and Federal Unfair Trade Practice Acts, and we think it is a reasonable interpretation of this law.

EXAMINER MIHALCHICK: Mr. O'Hare, you are saying the strict language says the Board shall prohibit hospitals from discriminating among insurers in its rates?

MR. O'HARE: That's right. Essentially, you know, it doesn't say fair discrimination or unfair discrimination; in other words, no discrimination between the rates based on any cost factors, just as you are interviewing somebody for a job under equal employment, you don't discriminate between people although you might have a basis for discriminating between them based on their background and so on. You must give equal opportunity on that point, but I recognize the value of the argument.

I just want to be looking at it -- what you are addressing is the legislative intent here, and I guess it is not clearly defined and we would take the position we have to fall back on the basic definition of no distinction.

EXAMINER MIHALCHICK: Any other questions or comments? Mr. Anderson.

MR. ANDERSON: I would like to present Mr. Ernest Lamson with Blue Cross-Blue Shield of Minnesota, who has the technical background in this area.

EXAMINER MIHALCHICK: Why don't you come up close for the reporter?

MR. LAMSON: My name is Ernest Lamson. I am the

Director of Provider Reimbursement, Blue Cross-Blue Shield of Minnesota.

In response actually I could respond to the comments that were just made regarding the differential in cost justified, we feel that there is ample reason for justification. We have developed a study and there have been studies developed across the country in various different locations to substantiate a cost justified differential.

Some of the reasons, of course, would be the time value of cash, credit and collection costs, billing costs, admitting costs, bad debt expenses and accounting and audit costs. Different values would be attributable to each one of these items.

Some of the items that we have reviewed, for example, in the bad debt area, specifically I would like to propose that in Paragraph 487(5)(a)(i), bad debts, and the top of page 32, following the sentence ending "in the near future," "Bad debts may be included in patient charges in the amount up to the median of its peer group, but this amount shall not exceed 1-1/2% of the gross billing to patients as recorded by the hospital."

Now, we suggest that this system should set a limit on the amount of loss due to bad debts a hospital may include in patient charges.

As stated in the rules, expenses resulting from the provision of charity care should not be reclassified as bad debts. The purpose of this statement is an effort to assure that patient charges do not include charity

care expenses other than as defined in MHD 487 A.1.a(5)(a)(ii), on page 32. A fair and reasonable limitation on the amount of bad debts permitted for rate setting purposes would be helpful for those responsible for administration of the system and the rate review process.

Now, as far as charity allowances on page 32, we propose that paragraph (ii) on page 32 be deleted, and the costs of charity care not be allowed as an element in patient charges.

Hill-Burton grants have been received by certain hospitals at various times and in varying amounts. The purpose of the grant was to provide financial assistance to selected hospitals for the development of facilities and services. This relieved the hospital of the need to borrow this amount of the funds required to accomplish the construction program and the debt service requirements that would have resulted if a loan had been necessary.

It is Blue Cross' position that current patients should not be required to pay for charity care requirements that Hill-Burton has imposed on hospitals.

Traditionally the hospitals have been allowed to include in patient charges depreciation expense related to the asset which was constructed from the grant amount. The hospital may now also include an adjustment in patient charges for price level changes for this asset.

If the cost of charity care related to the grant amount is included in hospital charges it could result in the patient paying for the grant at least four times.

MR. SATTLER: One question for clarification. The Hill-Burton requirement, if the hospital did get a Hill-Burton grant what is their liability? In other words, if a hospital borrowed a million dollars, or got a million dollars under a Hill-Burton grant, what would their liability be?

MR. LAMSON: Up to two times the amount, is my understanding.

MR. SATTLER: Okay.

MR. LAMSON: Ten percent a year for twenty years.

MR. SATTLER: In other words then the Hill-Burton requirement could be twice --

MR. LAMSON: Twice the grant, plus the regular depreciation, plus a price level on top of it so you have got four times -- possible four times.

MR. SATTLER: Just a question for clarification. Okay. That's fine.

MR. LAMSON: On pages 32 and 33, propose that Paragraph (aa) be deleted and that government contract adjustments resulting from Title V, Title XVIII and Title XIX be required to be cost justified and included in Paragraph (bb).

Whenever mention is made in Paragraph (bb) of "certain patient, groups of patient or third party payors," the words "government contract adjustments" should be added.

The government programs at the present time do not recognize in their hospital reimbursement programs certain elements of financial requirements included in the rules. The elements are: charity discounts and

allowances, adjustment for price level changes and working capital needs, non-patient related education costs and bad debts unless the loss is directly related to Medicare recipients, uncollectible amounts, and from services normally covered by the program.

Blue Cross suggests that it is unfair to include in patient charges the amount of governmental discounts which result from reimbursement policies of these programs.

EXAMINER MIRALCHICK: Any comments?

MR. SATTLER: Just one general comment about the government contract adjustments. I think there has generally been a move by states involved in these types of rate reviewing, rate setting, programs, to attempt to get waivers of the Medicare reimbursement principles for Medicare or Medicaid reimbursement, and to a degree a number of states have been successful; among those the States of Washington, Rhode Island, some hospitals in South Carolina. I believe New Jersey and a few others are attempting to get these waivers.

I think that Medicare, as we move into rate review and rate setting programs, does recognize that their principles of reimbursement are not adequate to cover all of the hospitals' true costs. Their attempts at containing costs because of the nature of the legislation and the mandate under which they are operating have been to pay, quote "full costs" in certain recognized areas without any regard -- well, with limited regard, and the State of Minnesota is almost no regard, to what the level of those costs are, so what we have

done is attempt to chip away at the base of the pyramid and say, "Well, certain types of costs are not real costs for Medicare purposes."

I think that we could not operate a hospital system if we truly adopted Medicare reimbursement principles for all hospitals. Would you agree to that?

MR. LAMSON: Yes.

MR. SATTLER: So to the extent that we can, I think, look at a reasonable basis of costs and hope that we can show, as other states have shown, and the Federal government, that we can really have some cost containment in a program of this type while keeping the base reasonably large, but keeping the lid on the level of those expenses, I think we can accomplish something.

I think that to cut those particular elements of this program out, as Medicare has done, I don't think we would really be doing justice to the public or the State of Minnesota, so until the time that Medicare and Medicaid do accept the program or the principles of this program, I think that we are stuck and we can't do anything with Medicare, with the Federal program.

We certainly will be making overtures to the Social Security Administration to get them to participate in the program, and that is our intent, but until that time I think we have to recognize that a broader base of cost is necessary to run the hospitals in this state.

EXAMINER MIHALCHICK: I have a question. In the report you refer to do they happen to say that Blue Cross cost differential is justified?

MR. LAMSON: There have been several studies made in the various different states that have justified a differential for Blue Cross, yes.

EXAMINER MIHALCHICK: And in this state?

MR. LAMSON: We have not yet been able to conduct a study of the hospitals. We are prepared to. We have presented a study to the Minnesota Hospital Association, and at the present time we are awaiting to get together with them. I think they are waiting for the results of this hearing before we do agree to work together on a cost justified differential study.

MR. SATTLER: Mr. Hearing Examiner, I might also point out that the system is very interested in this whole area and will be undertaking studies pursuant to Section 5 of Senate File 60, the continuing analysis section, to investigate this whole area of discounts, cost justified discounts and what would be reasonable, what might not be reasonable, and things of this nature so we can establish some uniform criteria for, you know, applying these discounts.

EXAMINER MIHALCHICK: One other question for you, Mr. Lamson. Is it true that Blue Cross at the present time enjoys a cost differential or discount in relation to other employers in most hospitals in the state?

MR. LAMSON: At the present time we have a contract with the hospitals which is an inter-hospital agency contract, which provides payment to the hospitals on the basis of costs as developed through a formula or charges, whichever is the lesser. As a result of that differential, last year the differential was just less

that [redacted]% on the average.

The hospitals we are talking about, what we consider controlled hospitals, that is the large hospitals in Minnesota, of 63 of them 33 of them, I think, were paid at 100% of charges; 30 of them were paid at a figure less than 100% of those charges, which developed this approximately 3% contractual adjustment.

EXAMINER MIHALCHICK: Mr. Thames.

MR. THAMES: Mr. Mihalchick, Mr. Sattler, Mr. Breviu, Mr. Peterson, ladies and gentlemen, my name is John Thames. I represent Group Health Plan, Inc., a health maintenance organization serving 93,000 patients.

I would like to address these remarks to the paragraph on page 33, beginning with the words "cost justified discounts." In order to get these remarks in focus I must give you some background. I would like to respect the positions that have been advanced so far in this testimony by Mr. O'Hare, Mr. Sattler, Mr. Lamson and Mr. Breviu.

The law that we are preparing rules for is part of a sort of a compendium law with three major sections, one section of which, the first, relates to standardized insurance programs.

It has a definition of insurer in it. That definition includes insurance companies governed by 62(a), service plans governed by 62(c), health maintenance organizations governed by 62(d) and self-insured.

It is no accident of fact or fancy that the definition of insurer in Article II of the law, which concerns this particular issue, defines insurers as organi-

zations covered by 62 -- it calls it persons, which, of course, includes corporations -- governed by 62(a) insurance companies, governed by 62(c) service plans and none other, not organizations governed by 62(d), not organizations governed -- not health maintenance organizations, not self-insureds.

All right. With that in mind in order to -- well, it should be said to further define this business about this statement that this is no action of fate that that definition was worked upon by Group Health, those definitions were worked upon by Group Health with the drawers of the statute and the authors of the statute, and the definition at issue, which is the one in section or Article II, was designed to further the development of HMOs, among other things, as there are other laws designed to further the development of HMOs.

This is the reason that Group Health had its input in the drafting of these proposed rules, that the definition of third party payors clearly says insurers. This means 62(a) and 62(c) people, health maintenance organizations, which means 62(d) people, and governmental insurance programs, so now with this in mind go to an admonition that was given here by Mr. O'Hare.

He said it says someplace in the law that there may be no discrimination of insurers. That is correct, so therefore, we shouldn't have this cost justified discounts.

Mr. Breviu said there is a definition of price discrimination as a matter of law. I have been privileged to read his memorandum on that topic, which talks

to f[illegible]r discrimination, and Mr. [illegible]'Hare says the law doesn't say anything about fair or unfair discrimination; it says discrimination only.

Okay. You settle that argument between you two and all the rest of you, but separately look at the paragraph "cost justified discounts" as it pertains to HMOs only, and to governmental organizations, Medicare, Medicaid, and all that sort of thing.

Now, what it says is "'cost justified discounts'" -- and I am picking words out -- let's say "'cost justified discounts' . . . mean . . . discounts . . . granted to certain patients, groups of patients or third party payors."

These certain third party payors are HMOs or governmental subdivisions whose laws and regulations preempt this law, Medicare, Medicaid.

We say then in effect that the proposed paragraph as it stands without a modification that Mr. Lamson suggests, that third party payors and governmental subdivisions or government people whose laws preempt this thing -- it is superfluous; it is a superfluous addition.

Third party payor is already defined, as I have said, to include insurance companies, service plans, HMOs and governmental subdivisions, so the words "third party payors" are used here consistent with the definition of the law.

With that I will close unless you have some questions.

EXAMINER MIHALCHICK: I intend to go until about

12:15 and then break for an hour or some convenient time.

Any retort?

MR. THAMES: Excuse me, if I may, Mr. Chairman. I did say that the legislature -- I said in effect that the legislature in its wisdom has done something to place HMOs at a certain position of advantage under the application of the provisions of this law, and I did say there are reasons for it.

One of them that has not been articulated, which I think should be -- I mean, Mr. Lamson, for instance, ticked off all kinds of advantages that an organization a typical third party payor would have, you know, no collection problems, cash discounts, and so forth.

The one unique thing that an HMO can address to a relationship with the hospital and should be considered as of some substantial advantage is a concentration. Our 93,000 people receive services from our positions at only those hospitals where our positions will go; in this case it is one hospital.

That hospital, I should think, which enjoys that concentration is enjoying a unique service.

EXAMINER MIHALCHICK: Is there any service plan to that?

MR. THAMES: No. A service plan is a plan such as the Blue, which theoretically provides the service of the appendectomy or the service of the hospitalization for a sum of money paid in advance. That is medical service, and it will pay for that appendectomy wherever it is performed if it is a contractual benefit. It will

pay [redacted]r that hospitalization al[redacted]st wherever it is extended, and that could be anywhere in the world as far as that goes, so that if Mihalchick decides that he and his family want to enjoy the benefits of a service plan, he goes into the fee for service arena and goes anywhere he wants to, and that appendectomy is paid for.

There is no prediction on the service plan's part, and it so states in their contract, that you will go to Dr. Jones or Dr. Smith. There is no prediction that you will go to Fairview Hospital or some place in Idaho.

In our case it is a predictable control, that the individual will come to a health maintenance organization, non-fee, for service paid in advance, prepaid; a salaried physician who will treat his patient at one bed only, and that is a bed located in one hospital only under the current arrangement that we have for 93,000 Twin Cities people.

Thank you.

MR. SATTLER: Just one comment about these two areas. I think Mr. Thames has brought up an excellent point.

There is one legal question here concerning insurers and discrimination among insurers, and there is another which talks about cost justified discounts generally. Let me give you an example of two patients who pay out of their own pocket and have no insurance. One pays within ten days of leaving the hospital and one pays in 180 days. There are a number of hospitals in this state that have a finance charge for that 180-day payer. Essentially then the payer that pays in ten days does

not [redacted] a finance charge, and t[redacted] one that might pay in 180 days would have a finance charge.

The cost justified discounts would allow that practice to continue while if we did not have that section we might not allow that practice to continue. What we are saying is that finance charge covers the cost of additional working capital for carrying that account for 180 days, and would be recognizable.

On the other hand, if we did not have a cost justified discount we may not allow finance charges necessarily for those payers who took longer periods of time.

We can look at it backwards and say for a hospital that does not have a finance charge that the someone who pays in ten days pays somewhat less than the bill. What we are saying there is essentially there is an implicit finance charge for those that pay in more than ten days, and we can allow that kind of situation to occur, forgetting about the legal implications of who is an insurer and who is not an insurer, but that is the intent. That is why I think it is necessary to keep those cost justified discounts in. We might have to decide if it is applicable to insurers in any other form.

MR. LAMSON: You indicated that you would be making a study or doing a study regarding Blue Cross Minnesota. We would be glad to work with you, provide manpower or financial support to the program, whatever if we can discuss it.

MR. SATTLER: All right. We feel that guidelines are necessary in this particular area and in spite of

the earlier comments we think the appropriate place would be here at the Department rather than necessarily coming completely from the industry or both sides. I think we might be able to put something in this particular area, but we would be happy to hear from anybody.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: On that issue I would just like to point out the Federal government has issued a request for a proposal for development of methodology to measure price differentials. I just want to bring that to your attention.

MR. SATTLER: I have been a consultant on one of the proposals.

MR. O'HARE: Oh, are you? All right. Has it been awarded?

MR. SATTLER: We are negotiating right now.

MR. O'HARE: I just wanted to mention that.

If I could just on this section -- we sort of went over it because there are a lot of elements in there, and I just want to say that I think the inclusion of unmet financial requirements from non-paying patients and from the government not recognizing those financial requirements in the short term as of now is entirely appropriate because if patients who can pay don't pay, then who is going to pay?

What I mean is you are going to leave the hospital coming up short and this is a continuing problem throughout the country on paying for these unmet financial requirements. The hospitals have nowhere to turn to meet payments for those financial requirements. The

government won't pay. The patient can't pay, and I think although the ideal solution would be to get all payors in there at the same rate, that is unworkable in the immediate future and, therefore, it has to be paid for then, I guess, by the people who are subject to the program. There is no other alternative even though it is inequitable, but that is the only way it can be met.

Unlike educational costs, these other educational costs, these are costs for the hospital to operate and I certainly support that.

However, before we get off this subject and break for lunch I would like to follow up on -- I guess it is appropriate here. I think there has to be some type of parameters developed for bad debts, you know. I don't like the percentage approach that was, if I understood correctly, proposed here by Mr. Lamson because it varies so much from hospital to hospital, depending on their location. The inner cities, of course, are going to have uncompensated care to a larger extent than the more affluent areas, and I don't think a uniform cap like that across would be appropriate.

I do think the program should develop parameters, should be given direction in these regulations to develop such parameters on the appropriateness of bad debts because what you have got on bad debts, you could have a poor practice in billing, credit and collection, and so on, and I don't think that it is appropriate that that should be considered reasonable when the program renders its decision, and that applies to really all the

areas but I guess we will get to those later as well as other costs involved.

I think the key issue is how you cover bad debts and charity, and I support the way it is handled here with the development of parameters.

MR. SATTLER: Under the continuing analysis section we plan to develop parameters. We don't think we have enough data at this time to put into the rules other than the mean for peer groups that we are using, that the Hospital Association has used, and we will be using during the first year, but we will be developing additional parameters as data permits and time, and once again other states have had a number of years to put their review process into operation after the passage of legislation, but we have to become operable within the first year so as a result we have to proceed somewhat differently than some of the other programs.

EXAMINER MIHALCHICK: How many more people want to comment on this section?

All right, Mr. Van Hauer, why don't we take you?

MR. VAN HAUER: Mr. Examiner, in view of the fact that you wish to recess at 12:15; it is now 12:14, and we do have a lengthy position to present, I would ask your indulgence that we might recess and present it beginning after lunch.

EXAMINER MIHALCHICK: All right. Let's recess until 1:15.

(Whereupon, at 12:15 p.m. the hearing was recessed until 1:15 p.m. this date.)

EXAMINER MIHALCHICK: The hearing will come to order, please. Mr. Van Hauer.

MR. VAN HAUER: My name is Van Hauer.

Mr. Examiner, members of the panel, in presenting the position of the Hospital Association I would like to range rather widely over those sections which were under discussion just before the noon recess, and these are contained chiefly on Pages 31, 32, 33 and possibly 34. I will not attempt to speak on a point by point basis to the various issues which were raised by Mr. Lamson, by Mr. O'Hare and by Mr. Thames, though I will be speaking to them as we go through the discussion. The record, after all, will disclose which of them made which statement so I will not attempt to identify on a point by point basis who said exactly what.

I think we are all indebted to Mr. Thames for his educational, enlightening, and always entertaining comments, and which drew our attention to the particular treatment which had been accorded Health Maintenance Organizations.

The staff of the Health Board apparently have been aware of this for some time. I find in the large 90-page document that they address this very specifically, and pointed out that health maintenance organizations are exempt from the prohibition against discrimination among insurers because they are not within the definition of insurer.

I think I would like to start with some comments that begin on Page 32 in the (ii) paragraph captioned,

"charity allowances," which in effect says that the only charity allowances which may be entered in the rate base are those which are required by Hill-Burton. I would like to make the following comments:

This is a very discriminatory requirement. One hospital may have Hill-Burton funds; the other may not. Those who do will have Hill-Burton funds in varying amounts.

The point was made by one of the earlier speakers when he gave an example quoting a Hill-Burton grant, and he went on to show how that would work out. It should be noted for the record that the Bill-Burton program is also a loan guaranty program as separate and entirely distinct from grants of funds.

Under the loan guaranty program the Federal government undertakes to pay a certain percentage of interest on a conventional loan which the hospital will otherwise negotiate. The effect of that is to reduce the interest cost to the hospital, to the obvious benefit of all patients concerned.

Hill-Burton, however, in exacting their pound of flesh for the provision of free care make that requirement applicable not only to the loan grant program but to the loan guaranty program.

The reason this becomes discriminatory is because you can have this sort of a situation: You can have two hospitals serving two communities that are more or less identical. One hospital has a large Hill-Burton grant or guaranty, as the case may be, and is empowered to provide extensive charity care and enter that in their

rat[redacted]ase. The other hospital [redacted]t having been the beneficiary of the Hill-Burton program, if they attempt to give the same identical type of charity to the same identical group of elderly citizens will not be permitted to include this in their rate base. This is obviously inequitable.

The fact that a hospital received a Hill-Burton grant or guaranty or didn't receive it is governed by a host of circumstances which have nothing to do really with the hospital and the community it serves. It is governed by allocations made by the Congress. It is governed by a priority list. It is governed by the availability of funds. It becomes a completely irrational, erratic set of circumstances, and to allow such irrational judgments to place a limitation on the charity which a hospital may provide does not make good sense.

I think that will conclude my remarks on that section, with this added observation: When the Hill-Burton program first started, this requirement for granting free care was not a condition to accepting a grant of Federal funds. This was a later added on proviso which was made retroactive. Some day some hospital is going to be sued by HEW for not providing charity care, and then this matter will go to court and perhaps once and for all we can be free of it.

In any event, I would strongly caution the State of Minnesota against adopting an inequitable and irrational proviso simply because the Federal government enunciated it and made it applicable in a program of

rather narrow limitations.

It is one thing for the Federal government to do this. It is something else entirely for the State of Minnesota to pick this up and make it a part of the rules and regulations which will have the force and effect of law in determining the rate structure of all the hospitals within the state. So much for charity allowances.

I should point out that we perforce will agree and go along with the Department in retaining its conclusion, but I wanted these comments to be of record nonetheless.

MR. SATTLER: My question is -- I think you might have answered it already -- but what would you have us do with this?

MR. VAN HAUER: Leave it in.

Now, speaking generally to the provisos on page 33, under Subparagraph (bb) "cost justified discounts," and other provisions elsewhere too, as a general statement the hospitals of the State of Minnesota are opposed to the granting of discounts to any group, any payor or any individual, including the Federal government.

We are familiar, Mr. Breviu, with the opinion you prepared for the Department, but I would like to make some comments about it, sir, if I may. We have read the law, Minnesota 1976, Chapter 296, Article II, Paragraph 7, Subdivision 1, which states flatly, and I quote, "The Board shall prohibit hospitals from discriminating among insurers in its rates." End of quote.

In your opinion you have gone on to say that you believe that the Board may properly interpret this statute as permitting rate differentials if they are demonstrated to be cost justified. I think that is an exact quote from your letter.

I would like to point out that we don't find anything in the legislative record of the bills which became parts of this law that would indicate that the authors of the bill intended to permit differentials at all, except perhaps to the HMOs, and much less that they intended to empower the State Board of Health to write such a rule. Had they intended it it should have appeared at least in some earlier draft, but to the best of our knowledge it does not.

Going on with your letter, Mr. Breviu, you cite Minnesota Statute 325.03 as permitting, quote, "price differentials based on grade, quality and quantity." End of quote. I would point out that hospital care does not vary in grade, quality or quantity according to who the purchaser may be.

Further, you have brought in the Robinson-Patman Act, which you say is, and I quote, "a law generally prohibiting price discrimination," and then you go on to say that a particular discount, and again I am quoting your letter, "a particular discount must be based upon the cost savings to the seller of a particular sale." End of that quotation.

It is difficult to perceive how the hospital; namely, the seller, benefits by who the purchaser may be as long as the hospital charges are paid.

From a practical point of view this proviso will create an intolerable administrative burden both upon the hospitals of the state and upon the rate review system itself. This would require, for instance, that each and every hospital receiving payment from Blue Cross, and that is virtually every hospital in this state, would have to attempt to cost justify the discounts taken by Blue Cross. These vary from one hospital to another and the year, and they vary from year to year within each hospital. If the hospital is unable to justify the full amount of the discount taken by Blue Cross, then they will lose those discount dollars from their rate base.

If one private third party payor, such as Blue Cross, is permitted to claim and take a discount this is an open invitation to all insurance companies, as well as HMOs, to likewise claim and take discounts. The result will be complete chaos.

It should be kept in mind that hospitals are under tremendous pressure to contain operating costs, and to express them in lower rates. To permit any discounts and to require that the hospital cost justify such discounts will add a significant and expensive burden to hospital management costs.

All discounts should be outlawed, as the legislature clearly intended. Whether state law can prevail against Federal impositions remains to be fought out. There is no more reason to grant a Federal discount than there is to grant a private one.

Minnesota Hospital Association strongly recommends

that paragraph 487 A.1.a(5)(a)(i)(bb) be withdrawn.

Mr. Thames in his dissertation alleged that the practice of his organization to direct the hospital care of all their subscribers into one hospital was of benefit because his organization was able to negotiate a discount from that hospital's regular prices. He felt that this was indeed a contribution to health care costs generally because by concentrating the volume of patients in that one hospital it would enable them to attain greater savings of scale that would otherwise be the case.

What wasn't said, and I will point it out now, is that by funneling all of those patients into one hospital, other surrounding hospitals are being deprived of their portions of that volume. While it might have been beneficial to the hospital which received this contract, it was certainly detrimental to all the other surrounding hospitals whose caseload was diminished in exactly that same amount.

It is for these reasons that the Association then wishes to express to you, Mr. Examiner, and to the panel, a recommendation that there be no cost justified discounts allowed any third party payor, any insurer, or any group.

Thank you.

MR. BRUVIU: Mr. Hearing Examiner, if I may just add a couple of quick comments, Mr. Van Hauer noted that in his belief the legislative record does not support the interpretations of the statute that the Board is proposing by this rule relative to cost justified dis-

coun[redacted].

Under Minnesota Law, unlike Federal Law, the legislative record cannot be used in interpreting the statute. One must base the interpretation of the statute upon the statute itself as passed, plus any canons of construction in Chapter 645 of the Minnesota Statutes. Accordingly, the legislative record which was cited is inappropriate and of no value in interpreting the meaning and the extent of this statute.

It is my belief that if the legislature had wanted to prohibit price differentials rather than price discrimination, they would have used the words "price differentials." This was not done.

A final comment regarding the burden on hospitals, which Mr. Van Hauer indicated could be imposed by this rule, it seems to me that the language of the rule is permissive, not mandatory. Hospitals are not required to provide discounts. They are permitted to provide discounts. If it is unduly burdensome they may choose not to do so.

EXAMINER MIHALCHICK: What happens to those contracts with payors like Blue Cross?

MR. BREVIU: Those contracts are negotiated between the parties as within a contract.

EXAMINER MIHALCHICK: I wonder if that is a real alternative.

MR. BREVIU: Well, if the argument is that cost justified discounts are so burdensome that hospitals cannot do it, then clearly that is a real alternative. I think the experience goes to the contrary. It is

obvi[redacted]s that hospitals are doin[redacted]that.

MR. SATTLER: Currently it may be accurate to say that they are giving discounts. On the other hand, it may be inaccurate to say they are cost justified discounts. In other words, I think that this does impose some effort at least, you know, on the part of the hospitals and the system to determine if any discounts are in fact cost justified. In other words, I think we would have to very specifically analyze the situation.

There are two things working here. One is the inclusion of incremental differences from charges so to speak, or the discount portion in financial requirements, which is one thrust of the rules, and the other is the legislative and legal mandate that there is no discrimination, and I think under both circumstances it is up to the system to determine what is reasonable, what is cost justified and what isn't, and what is discrimination and what isn't; not just discrimination, but that it is cost justified.

That is why I suggested earlier the system should look at this whole question and come up with parameters and guidelines as to how to go about handling this particular problem, do it uniformly, and we will have a basis for judging.

EXAMINER MIHALCHICK: Okay. Anything else on this? Yes, sir.

MR. KLAS: Since I have not previously testified I will give you my name. I am Terry Klas. I am representing North American Life and Casualty Company, and I would like to just speak to the limited point of the

legal opinion with respect to the rate discrimination.

It seems a little incredulous to me that we cannot rely on the legislative history to determine the proper interpretation of this law, yet we can refer to such other laws as Robinson-Patman, which is clearly a Federal Law, to use to interpret this law. That seems to me to be a bit strange, but, even so it is normally a legal maxim that the word "shall" is a mandatory provision, not discretionary and, therefore, I think the word "shall" is pretty clearly demonstrated in this language, as is the word "prohibit".

Now, to say that the word "discriminating" in rates fails because they didn't use the terminology, Mr. Hearing Examiner, of "price differential," I think is begging the question somewhat.

I think when you recall Mr. Thames' comments about how the definition of insurer was so determined in the law, very clearly in the minds of the legislature what they are talking about very directly is the very well known practice, which has just been referred to by Mr. Sattler and by you, of Blue Cross paying one rate, the private insurers paying another, and it seems to me that when you look at the definition of "insurer" here and they are talking about just those two groups, and you use the words "prohibit" and "shall" and "discriminate" in rates, it is self-evident what they intended, and no reference to Federal legislation notwithstanding should, I think, allow these regulations to permit something which the legislature, I think, about as clearly as they possibly could meant to permit.

SATTLER: I would like to make one comment about this particular language. At the time that this bill was originally drafted Mr. Frank Baker, Executive Director of the Washington State Hospital Commission, came out here to testify before Senator Cuzinski on health care costs, and this particular language is almost -- and I say almost; I think it is exactly, but I will just say almost, for the record at this point, word for word from the Washington State Legislation. In fact, Washington State has interpreted that language, "prohibits discrimination," to mean reasonable differential, and, in fact, does allow Blue Cross specifically -- and I am not arguing that Blue Cross should in this case, by the way, but I am just pointing out the interpretation of the language -- a 4%, or I will say a discount, from the normal -- quote "normal charges," and I do believe that other states in specific legislative language have language very similar to this because this particular bill, by the way, was pieced together from lots of other states where this practice does go on. I think we happened to take the toughest stand with regard to discounts in that we require that they be cost justified, while other states are variable. I know Maryland does allow, and they are undertaking studies as to the appropriateness of the size of the discount, as is the State of Washington, so this is consistent with other rate review programs, and while that may or may not be germane to the legislative language, I think it does relate somewhat.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: That language [redacted] both Maryland and Washington is this -- I may be wrong -- that "rates shall be set equitably without undue discrimination."

I will buy anybody lunch that shows me that language is incorrect. I am almost positive that is correct, "without undue discrimination."

I think the word "undue" may be critical here -- I don't know -- but it is not the same as this statute.

EXAMINER MIHALCHICK: Do you know if that is what it does say?

MR. SATTLER: My memory does not serve me as well as Mr. O'Hare's, so I would prefer not to state the exact language.

MR. O'HARE: Because in our shop we argue about that, "Wouldn't it be nice if it said 'rates shall be uniform,' and get rid of all that bologna about discounts?" Then we say, "Well, maybe if we just left out 'undue,' and say 'rates shall not be discriminatory.' That would make it uniform across the board," so the reason I am pointing it out is I am aware about what it reads because we get into arguments at home about it.

MR. KIAS: My only response here is that the language is about as clear as I think anybody on the street could interpret it, and for that reason, why, particularly with the testimony of Mr. Thames and the definitions, I just don't see the flexibility that counsel has built in.

EXAMINER MIHALCHICK: Thank you. Mr. Lamson.

MR. LAMSON: One point, the wording is "cost justified discounts." Therefore, if theirs was cost justi-

fied as Mr. Van Hauer has stated, they could have many different areas or many different insurers looking at a discount, cost justified discount.

MR. SATTLER: It says also rates should be related to costs, and I think that the cost justification language does get back to the intent of the legislation. It says that if rates are related to costs then we must also relate costs and rates to the various payors, including insurers. I think that to discriminate implies sort of an arbitrary assignment of various rates between people without regard to the true cost; in other words, just because you are Blue Cross no matter what you do you get a lower rate, or just because you are a commercial carrier you get a lower rate. I don't think the intent of the cost justified is to discriminate, but to equitably and rationally relate costs and rates.

EXAMINER MIHALCHICK: Mr. Klas.

MR. KLAS: Well, earlier your consultant, Mr. Jackson, pointed out that there are various forms. The one for changing the law is not here; that is over at the legislature. Here you are simply to draw regulations implementing the law that was passed, and it seems to me that this interpretation is very clearly putting something in the law that isn't there, and I base that, in addition to my other reasoning, on the basis that also a fairly common legal basis for interpretation is the fact that when you have a general statement followed by a specific, the fact that it follows and the fact that it is specific has relevance, and here the reference that

you [redacted]e, Mr. Sattler, in terms [redacted] rates reasonably related to the hospital's aggregate costs is followed, and is followed by very specific language, and to permit your provision (bb), and the other letters that go with it frustrate that intent.

MR. SATTLER: One question. If your insured's costs were $100 and some other insured's costs were $95, and you charge both $100.00, would or would not, according to this language, be discriminating -- would the hospital be discriminating?

MR. KLAS: Well, that illustration or hypothetical is -- are we talking about the same treatment? Why is his cost different from mine? We can go on from there.

MR. SATTLER: The exact same medical treatment.

MR. KLAS: Well, for the same exact same medical treatment I would suspect that the costs should be the same.

MR. SATTLER: Then for other related expenses that get outside the medical area?

MR. KLAS: Well, I don't know how far you want to protract this.

MR. SATTLER: Within the scope of the financial requirements that is stated other than the discounts.

MR. KLAS: My point is that it is very easy to waffle over in Federal law, in Federal regulation, in other state laws of similar import, but keeping these things very simple and basic you have a law which has a provision which on its face, I submit, is very clear, and no matter what I would like it to read, even though I agree that, you know, under your proposed regulations

I ha[redacted] the same chance as Blue C[redacted]ss-Blue Shield, the fact of the matter is I don't think you have that latitude, and that is all I am saying.

MR. BREVIU: To follow up Mr. Sattler's question, would it be your belief that any difference in charges to two individuals for the same services, by the same hospital, would be discriminatory?

MR. KLAS: Well, the difficulty with the word "any" is that, you know -- the law school I went to that is automatically true; false, that is false, you know, "all," "everybody," and I think it may well be possible. I am not aware of any, but, again, I think what you have to focus in on is the language, and just as I take issue with the panel and your consultant, the grant of authority, I think is a good deal stronger than he read into it. He turned me to a different forum to change that grant of authority. I am simply pointing you to the same door.

MR. SATTLER: This puts me in somewhat of a difficulty in understanding this because I don't understand the law very well, but I understand something about finance. I would like to, if possible, come back to that forum so I can properly respond.

Let's take two identical patients, identical medical treatment, and exactly the same situation within the same hospital, yet one company pays a hospital immediately upon discharge of the patient and one pays 180 days after discharge.

Can you tell me then what the cost relationship of those two patients to the hospital is? Are they the

same [redacted] does one patient cost m[redacted] than the other patient?

MR. KIAS: I am aware that there is a time value to money, and I was interested in your earlier comments before lunch when you talked about finance charges, but interestingly enough neither the panel nor the drafters nor your consultant talked about finance charges. That is not the phrase you use here. Yours is much broader than tacking on a finance charge.

Now, if you really are only concerned about whether or not a hospital ought to be permitted to tack on a finance charge and your concern is will that then lead to discrimination, which would then be in violation of the law, I think we are talking about an entirely different question.

Now, I myself personally feel that, yes, a finance charge could be tacked on, and that might be a proper method of calculating rates, but that is not the system you are talking about. The system you are talking about is much broader than that and, in fact, what I would like to see or what I think makes sense is really of little value here because we have the legislature speaking very directly about it, and for that reason I think you have to go back to the drawing board.

MR. SATTLER: You are saying that the legislature would prohibit a finance charge? We are getting away from my question.

MR. KIAS: I think they would permit a finance charge, not a rate discount or a -- I don't have the copy with me, the phrase you used.

MR. SATTLER: I would submit a finance charge, by the way, is exactly the same as setting a charge which includes the time value of money or an average payment, and then if anybody pays less in a faster period of time --

MR. KLAS: Isn't there a variety of ways one could justify discounts? Volume. "We are going to send our 93,000 constituents to you, Mr. Hospital. Give us a break." Isn't that permitted?

MR. SATTLER: I, by the way, did not want to get into the specific methods of calculating discounts. What I would like to suggest at this point is that a larger analysis, if not by me personally, be an appropriate forum of determining discounts.

MR. KLAS: All I'm saying is your rule goes beyond just finance charges. You may have an argument for permitting finance charges; I am not sure, but all I am saying is that I think your proposed rule falls for failure to comply with the very clear mandate of the legislature. Whether even finance charges are permitted is for your counsel to determine -- I don't know -- but beyond that the other methods that would be permitted I think very seriously might abrogate the intent of the legislature and so, no, I think you need best hone in on these specific terms and go from there.

MR. SATTLER: Well, what I would like to get back to is the cost question, forgetting about finance charges. If, in fact, a patient that pays on the date of discharge costs the hospital less than a patient who pays 180 days after discharge, and you charge those two

patients the exact same dollar amount for their stay, is that discriminatory or not, is my question, in your eyes, given the language of the law?

MR. KLAS: The term "cost" is a relative term, I think. Rates are not. Rate is a specific figure. A rate is a specific figure, I think; hence the legislature says you will not discriminate in rates, so I don't really think that your hypothetical is really germane, and I think it leads you into a waffling area whereby you miss the very clear legislative mandate.

MR. SATTLER: So now we are getting to the point that I just want to clarify for my own mind. Since that particular sentence follows the sentence that talks about the relationship of rates and costs, do you think that it is discriminatory; that rates must be constant among all insurers, takes pre-eminence over the relationship between costs and charges, or rates and costs? In other words, as long as the system sees to it that all insurers pay the same amount of money it doesn't really make any difference where those rates are set in relationship to costs; is that right?

MR. KLAS: I charge the same rate; is that what you are saying?

MR. SATTLER: I am trying to clear this up because one takes pre-eminence over the other, --

MR. KLAS: Yes.

MR. SATTLER: -- and what you are saying, I think, possibly is that hospitals could set rates anyplace it wanted to without regard for the cost associated with the treatment. As long as insurers were paying the

same thing the system would be satisfied by seeing to it that the rates were the same and not really getting involved in monitoring costs and the relationship to rates and so on.

EXAMINER MIHALCHICK: That doesn't follow at all.

MR. SATTLER: It doesn't?

EXAMINER MIHALCHICK: No.

MR. SATTLER: Okay. I wanted to be sure.

EXAMINER MIHALCHICK: You are talking about a specific case between insurers?

MR. SATTLER: Yes, okay, that is where we get, I think, if you let this last sentence take pre-eminence over the preceding.

MR. BREVIU: Mr. Hearing Officer, I believe the argument is that in regard to Section 7, Subdivision 1, you must attempt to give effect to all parts therein.

It has been argued that the last sentence takes precedence in regards to rates among insurers. I believe -- correct me if I am wrong -- that Mr. Sattler is attempting to show that you must, number one, relate rates to costs; and, number two, not discriminate among insurers on rates, but that does not mean that differentials based upon costs might not exist and might not be permitted by the statute.

EXAMINER MIHALCHICK: Well, the problem is with the definition of "rates," but why don't you put the rest of it in writing?

Yes, sir.

MR. FEARING: I am Clifford Fearing, representing MIA also.

e of the other potential eas here that perhaps is an area that is really creating a lot of the interpretation problems is the area of cost justified and non cost justified differentials.

Mr. Van Hauer has stated our preferred position on this issue. Perhaps a fallback position or an item position which could clarify this, at least from our standpoint, would be a definition that all, regardless of the intent of the law as to whether discounts are allowable or non-allowable, be given; that all discounts not specifically required by the law shall not be built into the rates, so that no other payor would be responsible for a discount provided to another payor.

In other words, the private insurance companies would not be responsible to pay for the discounts provided to the HMOs, provided to Blue Cross, etc. If there is in fact a discount provision to be given it should be given to the individual who, quote, "earns" it.

MR. SATTLER: That was our intent, I believe. The intent was not to set up a system where we have a cross-subsidization of hospital costs by the various payors; in other words, to recognize that cost justified discounts once cost justified, that particular payor should get the benefit of that reduction in cost to the hospital directly, and there would be no lapover to other payors who had to assume part of that discount burden, so it is just strictly recognizing the fact if it occurs anyplace, and I don't know at this point if it does or not, that, yes, some payors do things to reduce the cost

to t[illegible] institution of treating [illegible]ose patients and, if so, they should reap the benefit of those reduced costs. That is really the intent.

EXAMINER MIHALCHICK: Any other comments?

MR. SATTLER: If you have language to make that more explicit we would be happy to have it.

MR. FEARING: I think if that is the intent, which I think it was from being involved in the drafting, I think that some of the language should be cleared up because it is specifically included in here in such a way that it looks like it can be passed on as a financial requirement to other payors regardless of whether they are insurers, third party payors, etc.

EXAMINER MIHALCHICK: Do you want to proceed to Plant Capital Needs?

MR. SATTLER: Plant Capital Needs begins on page 34. I forget what number we are on.

Plant Capital Needs would be 487 A.1.b.

We do have some amendments but they come later, on page 37, and possibly I will wait until we get to page 37.

I might want to take this a little more slowly than some of the other sections because we have some debate; there are some very fine points here so, Mr. Hearing Examiner, if you have no objection we will move through fairly slowly to be sure we give everybody an opportunity, first of all to be sure they understand what is happening and then to comment, if necessary.

EXAMINER MIHALCHICK: All right.

MR. SATTLER: This general section addresses what

we generally call the depreciation area of the financial requirements.

It addresses those areas where depreciation is an expense in an accounting sense, and the attempt is to recognize that these expenditures for buildings, building equipment and movable equipment do exist and how they should be treated.

Just also a little bit of background. Generally speaking most reimbursers, cost reimbursers, meaning Medicare, Medicaid, Blue Cross, do recognize depreciation explicitly as an expense, and I think there are some other requirements in this particular section that go beyond that. I think that is where some of the discussion will occur.

The first area recognizes that these expenses do exist, and on page 34, b.(1) it is stated that the financial requirements that are expressed by these expenses and the revenues then generated to meet these financial requirements or expenses should be placed in an identifiable fund in order to be considered financial requirements.

In other words, the institution should establish a plant capital fund, place money in that particular fund. Then out of this fund it should meet its various plant capital obligations.

Now, the calculation to determine the size of the annual increment is as follows: One, it will be the greater of the annual debt principal repayment on buildings, building equipment and movable equipment, and that will be computed as though it were a level

payment set up over the life of the debt instrument.

The annual increment just takes cognizance of the total level of the debt principal and spreads that out evenly over the life of the debt instrument, and establishes that as one area to be looked at in determining the level of the financial requirements, or the annual straight-line depreciation expense on buildings, building equipment and movable equipment. The hospital can choose the greater of the two.

The rationale here is that, number one, -- well, let's take (ii). The annual straight-line depreciation expense. I don't think there will be any problem. It is recognized by Medicare, Blue Cross, Medicaid, and all third party payors as being a reasonable and includable expense.

The problem may come in with, on page 34, (i), annual principal repayment. The rationale for including that is that the institution may have certain cash obligations that it must meet that the various segments of the program may not allow for in the debt principal area, and in order to meet that cash requirement the program will recognize that in any given year the annual debt principal may exceed straight-line depreciation, so the attempt here is to recognize the cash requirements and there are situations which can come up where the debt instrument has a shorter life than the building, for instance, and those payments may be elevated initially. The attempt here, by the way, is not to encourage institutions to go about borrowing large sums of money for short periods of time.

w, the reasonable nature the debt instrument itself is always in question, and it is felt that debt instrument is wholly inappropriate.

Some comments can be made with relationship to (i). I would like to stop here because I think you might have some questions and comments about this particular thing.

EXAMINER MIHALCHICK: Are there any?

MR. O'HARE: Mr. Examiner, my particular concern on this item, this section, that Mr. Sattler has just reviewed for us is specifically that what you end up having is an excess payment over the life of the facility if both of these are held in either/or position without further amendment.

Let me give you an example. If you have a $30,000,000 institution which is, let us say, equity financed at $10,000,000 and debt financed for $20,000,000 over a ten-year life.

Let's say that that is for a ten-year amortization. This means that according to this system that that debt would be paid off over the ten-year period, which means it will be a payment of $2,000,000 per year for ten years, which, of course, exceeds depreciation, which is $1,000,000 a year over thirty years, and that is fine up to that point, but then when you reach the point at which the note is retired, now what do you do?

You then go back to depreciation at $1,000 a year for the remaining twenty year life of the building. That is on the face of it, unless we redefine discriminatory again. The face of it is that this would be

$1,0[illegible] a year, therefore, the t[illegible]al payment over the life of the asset would result in $40,000,000.00.

Therefore, I think this is not acceptable. I don't think Medicare would accept it; Medicaid would not accept it. It is an excess payment. In other words, depreciation payment is paid. One of the primary reasons it is paid is to retire any debts that are outstanding. Interest is a separate item; therefore, this would result in excess requirement, financial requirements, and I would move an amendment that would save that in any event the total payment should not exceed depreciation payments over the life of the asset under this section, and in effect then what we are requiring is an offset or a credit against the future depreciation which now is being plowed in at an earlier time or paid at an earlier time to retire the debt, so I agree with the argument that if there is a cash requirement it should be paid because, you know, if there is a reasonable financial obligation, but that once that is retired in no way should it fall back against straight-line depreciation. That is clearly, in my mind, an excess which is not recognized by any agency as far as I know.

EXAMINER MIHALCHICK: What you really mean to say is that the total amounts paid in the capital fund should never exceed the basis of the thirty million value of the asset?

MR. O'HARE: Well, it should never exceed -- we are talking here about straight-line depreciation. We haven't gotten to that section yet.

The total payment for debt --

MR. SATTLER: Over the life of the asset the total payment should not exceed the full thirty --

MR. O'HARE: That's right.

MR. SATTLER: -- the cost, the historical cost.

EXAMINER MIHALCHICK: That was my point. Your comment says it should not exceed straight-line depreciation over the life of the asset. That is the total life of the asset then?

MR. O'HARE: Well, that's right.

MR. SATTLER: What you are really saying is you would accept some form of accelerated depreciation in the years when debt principal payments exceed straight-line depreciation?

MR. O'HARE: You can call it either way. What I am saying here is that the cash requirement would take precedence if there is such a requirement, but that after -- in my example after than tenth year you don't go back to $1,000 a year depreciation for twenty more years because the total of the debt which you had retired and the depreciation payments would come to $40,000,000.00, which is $10,000,000 over the original purchase cost price of the asset, so what I am saying is, fine, pay the cash requirement, but then reduce the following year remaining twenty-year life payments to what -- $500,000 a year; is that right? Yes, $500,000 a year, which would make it come to $10,000,000.00. Then the $10,000,000 reduced depreciation payment, plus the debt amortization payment will equal $30,000,000.00, which is the depreciable amount of the asset.

[redacted] SATTLER: You are talki[redacted] about accelerated depreciation?

MR. O'HARE: Well, call it what you want. Accelerated depreciation has about five definitions as far as I know in accounting terminology. One of them is not to equal debt payment so it is not accelerated depreciation. You have got double declining balance, the sum of the year's digits, etc.

EXAMINER MIHALCHICK: We have written comments from Blue Cross, but do you have anything further?

Go ahead, Mr. Lamson.

MR. LAMSON: On page 34 we propose that (a) "The greater of:" be deleted, and that on page 34, paragraph (i) be deleted in its entirety; and page 35, delete (ii) and insert the letter (a) in its place.

Blue Cross suggests that straight-line depreciation expense on buildings, building equipment and movable equipment, plus inflation factors, provides reasonable allowance for annual debt principal repayment requirements.

The situation will occur where a loan includes as large a balloon as the final payment. It is believed the system does not intend to make provision for this type of payment to be made in full and expects the balloon amount to be refinanced.

One other point. We propose that on page 34, paragraph b. that the following sentence be added to the end of the paragraph, quote: "In order to include depreciation expense and inflation factors in payment charges the hospital must have received a certificate of

need approval when required."

I have some other comments later on on some of the other pages.

MR. SATTLER: Right. Just a quick comment on the certificate of need.

We have intended that that be in. I think we do address it later on, but possibly not explicitly enough for this section.

MR. LAMSON: I think that is a good place, at that point on page 34, to include it. It is not explicitly included, and I think the intent probably was there.

MR. SATTLER: Yes, we have no problem with that, but as far as the other, well, we are on record as to our position.

EXAMINER MIHALCHICK: Mr. Van Hauer.

MR. VAN HAUER: Mr. Examiner, gentlemen, generally we find the section dealing with plant capital needs to be satisfactory as drafted, but we would like to suggest changes, rather minor in nature, on page 34.

Under paragraph (i) at the bottom, it reads, "The annual debt principal repayment on buildings, building equipment -- " etc. We would like to see interpolated the words after "repayment," the words "land and land improvements," because these are quite often part of the annual debt and there is no practical way actually to separate them in most cases, but the fact that they are not mentioned gives us some concern.

On page 35 we would like to make the same suggestion applicable in four places; one in the paragraph labeled (ii) at the top; the second is in paragraph (b);

the third in paragraph (i) towards the bottom, and the last in paragraph (ii), and it is the same change in each case, and here we would like to see interpolated the words "land improvements," not "land and land improvements," which we have suggested earlier, but just "land improvements," because land improvements are regularly subject to depreciation, and for that reason then in all of these sections which deal with depreciation we would appreciate the inclusion of land improvements so there can be no question about their inclusion in the rate base, and, lastly, and this is a small matter of semantics, the bottom of page 35, paragraph (ii) it speaks of hospital buildings. This is the only place that we find buildings specifically named as hospital buildings, and we would think that the word "hospital" could be eliminated so that this language would be consistent with language throughout the preceding paragraphs. Thank you.

MR. O"HARE: I would like to ask a question for clarification. As I understood it at the point I made my comments we had not proceeded to the inflation factor section of this document; is that correct? We are now going to proceed to that?

MR. SATTLER: Yes. Just a point of clarification.

On 34, when we talk about (i) you are saying that under certain circumstances you borrow money to purchase land and to make improvements upon that land; is that correct?

MR. VAN HAUER: In effect, yes.

MR. SATTLER: Cash to pay that back?

MR. VAN HAUER: That's right.

EXAMINER MIHALCHICK: Excuse me. Aren't you talking about parking lots and other such improvements like that?

MR. VAN HAUER: Yes, ground lighting, sidewalks, and all the rest of that sort of thing.

EXAMINER MIHALCHICK: They are actually considered building and equipment depreciable assets?

MR. VAN HAUER: Yes, they do depreciate.

MR. SATTLER: I am just curious when I am going over this if any of the other payors have comments about this. I would appreciate hearing if they do.

(No response.)

Okay. Then under (ii) when we talk about depreciation we are excluding land but we are talking about land improvements which are normally, under generally accepted accounting principles, depreciable?

MR. VAN HAUER: Yes.

MR. O'HARE: How about construction in progress? That is another section. We will get to it tomorrow, I guess.

MR. SATTLER: I am just trying to clarify this point because they are additions.

EXAMINER MIHALCHICK: I'm a little confused here. Aren't you saying make the same change all the way through?

Well, (1) and then (a)(i), paragraph (ii)?

MR. VAN HAUER: Yes, sir, I am.

MR. SATTLER: This is a suggested addition and I am just trying to be sure that we don't have any comments on additions at this point.

EXAMINER MIHALCHICK: What I am saying is -- maybe I understood you, but under (a)(i) did you also want to include land there or just land improvements?

MR. VAN HAUER: This is on page 34?

EXAMINER MIHALCHICK: Yes.

MR. VAN HAUER: On page 34 we wish to use both land and land improvements. That is the only place, however, where land will appear. All of the other suggested corrections are confined solely to land improvements because land is not a depreciable item, in the accounting world at least.

EXAMINER MIHALCHICK: Well, that, frankly, doesn't make sense to me in the context of this whole subparagraph (1), which talks about the fund which relates to building, building equipment and movable equipment. I don't think you could include raw land in that account by any process.

MR. VAN HAUER: What paragraph, Mr. Hearing Examiner, are you referring to? I would like to help clear this up.

EXAMINER MIHALCHICK: Page 34.

MR. VAN HAUER: Yes.

EXAMINER MIHALCHICK: b.(1), and all these are subdivisions of (1), but that starts by saying, "Finances which relate to building and building equipment and movable equipment shall be placed in an identifiable fund." Then you have the two ways of allocating the

costs.

Actually are you saying we should include something in one of these alternatives that you don't include in the other?

MR. VAN HAUER: I think, Mr. Examiner, the answer would be that (i) under (a) is related to annual debt principal repayment. Annual debt principal repayments typically do include land and land improvements, as well as building, building equipment and so on.

The (ii) refers to a different matter, and that is depreciation, is the topic there, and so only those things which can be subject to depreciation would be includable.

In the accounting world land is not considered depreciable, and so it is eliminated then from being interpolated.

MR. O'HARE: I would like to ask a question of how the rest of the world treats land when it is purchased? I really am at a loss to know. If a hospital goes out and buys an extra acre of property and finances it by cash, how is that picked up in the reimbursement mechanism under Medicare, Medicaid and Blue Cross for that matter? Just a question of fact.

MR. SATTLER: I am not going to answer it, but I would ask the same question.

MR. LAMSON: Well, land is not depreciable.

MR. O'HARE: Right, so you couldn't get your debt payment from the depreciation. Where would it come from? Interest, I guess, would be all right, but where would you get the principal payment?

(No response.)

Is it implied then that full cash payment is necessary for the purchase of land? I don't think that is right either. I guess I do not know the answer to the question. You might give us some guidance here. I don't like the idea of putting in depreciation for land. I would like to see what other alternatives are in existence.

EXAMINER MIHALCHICK: There is no clear answer. I think you pay for that out of investment.

Mr. Thames is going to give us an answer.

MR. THAMES: Just think how sad all the other owners of land would be that they didn't buy their acre. Do you get the analogy?

MR. VAN HAUER: You are a lot of help.

EXAMINER MIHALCHICK: Let's take a fifteen minute recess and come back at 2:45.

(Whereupon a recess was taken.)

EXAMINER MIHALCHICK: Back on the record.

I am expecting to go until 4:30 today. That is just essentially my capacity to listen. The hearing will resume at 9:00. We have this room until 2:30. If we don't get through, the next date is the 10th, which is Monday. If we don't finish tomorrow we will recess until Monday, the 10th.

MR. SATTLER: Okay. we are now into page 35, (b).

talking about plus inflation factors.

We have built in inflation factors into the system to recognize the fact that inflation does erode the ability of institutions to replinish themselves at appropriate times. Particularly in the experience over the last decade it has been the rising cost of everything, health care included, but particularly buildings and construction.

We did not believe it was the intent of the legislature to cripple the health care delivery system in this state at this point in time, as it has been the intent in other states, so as a result we have built in an inflation factor which would be placed specifically upon buildings, building equipment and movable equipment, recognizing the rising costs of both inflation and technology, etc.

Let me go over to page 36. There we mention that the inflation factors will be placed at 100% of that particular factor for a hospital that is considered to have no excess capacity, and if an institution is considered to have excess capacity that inflation factor, or a percentage of that inflation factor, will be reduced accordingly.

Okay, the system also has to check with the appropriate health system agency and the State Health Planning and Development Agency to receive input and comment on its determination of excess capacity, although I would like to point out that it is possible for the system to deem an institution to have excess capacity even if the State Health Planning and Development Agency and the

health system agency says that the institution does not have excess capacity, although I would like to point out it probably will not be overwise for the system to do it, but the possibility does exist.

I would also like to point out that this particular method for providing funds to meet capital obligations may not be sufficient to retire existing debt at this time. We recognize there are outstanding obligations currently and the system was not designed to handle obligations that were already outstanding.

We would also like to point out that annual interest earned on the plant capital fund should be offset to the annual inflation factor requirement. As an example, if the inflation factor, or the index applied to the annual depreciation expense were to mean that the institution should receive an additional, let's say, $1,000 above normal depreciation, any interest on that fund would be offset to that $1,000 increment. If the interest were $1,000 for that particular year, then there would be no increment for inflation that year.

We also allow for the institution, if approval is granted and there is a strong necessity, to engage in other plant capital activities or to add new facilities and sufficient financial resources are not available from the fund to meet these requirements, then the institution can go and get funds from, you know, the following sources, which brings us over to page 37.

First, sources other than patients; well, such as grants, donations or things of this nature. Secondly, they go borrow or acquire leases to do this. Thirdly,

I would like to point out that here we have an amendment on page 37 (c), and let me read it to you. The third line after the word "in" we would like to insert the word "the" and cross out "(i) or (ii) above," and insert the words "plant capital fund or funds," and going down two lines "current," so it reads "lower cost to current patients."

I would like to emphasize that this is a hierarchical procedure, going from grants, gifts, endowments, things of this nature; then to borrowed funds and leased funds, and then finally to rates, and to undertake these particular capital additions the institution must really get approval from the local HSA and the State Health Planning and Development Agency. The intent here is to recognize that HSA and the State Health Planning and Development Agency may require institutions to do certain things in the coming years in their respective health service areas which they may not necessarily have the funds to do at this time, and we don't want to preclude the institutions from undertaking these capital ventures because of the lack of ability to raise money.

Okay. I think that we should take comments on this whole area of inflation, price level adjustments, and the ability to get money from other places, and then finally rates.

EXAMINER MIHALCHICK: Page 35 (b), any comments? Any questions or comments? Mr. O'Hare.

MR. O'HARE: My comments refer to the section 487 A.1.(b)(1)(b), page 34, the whole issue of price

level.

I would suggest that this section be amended to eliminate price level depreciation as inappropriate, inequitable and unnecessary.

EXAMINER MIHALCHICK: Anything else?

MR. O'HARE: To go into a few details about that, first of all it is inappropriate for the following reasons: Price level factors to be included in the rates will exacerbate hospital cost increases at a time when they have already increased substantially and are placing a severe strain on financing mechanisms, both public and private.

These price level factors, in addition, will transfer substantial amounts of money from the community in effect through rates to hospitals for no specific identifiable purpose in the near term.

The cumulation and availability of these funds to hospitals in effect will back the driving force behind future capital expenditures which may not be in the community interest, and will put pressures on the appropriate planning agencies to approve projects which in effect are unnecessary. Let me just give an example. For instance, if in effect I am given a substantial amount of money to purchase a home for my family -- this is an example of the pressure that might be generated through these funds being available. If I am given, say, money by the Federal government to purchase a $50,000 home because that is the price of the home, or given a substantial percentage toward that, let's say to give me $40,000.00, I might all of a sudden decide

that what my family needs is an $80,000 home and I would take that $40,000 and put it as a down payment and borrow the rest.

In other words, the availability of funds becomes a driving force for justification for more expanded projects, is the point.

Okay. The next point is that -- well, one last point on that. You can see what this in effect means over time. It is almost like everybody instead of purchasing their home through mortgage financing is paying a substantial amount of cash for it. Imagine what would happen if that happened to every homeowner in the country, if every family in the country was now given the ability to purchase with a substantial amount of cash, what a drain that would be on the economy.

Well, I think there is a parallel here in the health care economy of pulling this kind of finances out of the community to establish these kinds of funds over time in a hospital fund. I think it is inappropriate.

The next point of inappropriateness is that it arbitrarily assigns to each hospital a substantial amount of capital which is unnecessary to meet operating expenses and disregards that facility's current and future needs for plant capital.

This is true because the price level factor is applied on the basis of the mere fact of historical cost and historical depreciation, which is really a completely inappropriate way of measuring a hospital's current and future needs. You see, depreciation expense does not involve any consideration even of the reason-

ableness of the cost of the facility itself, so it is arbitrary. In other words, the reason we are trying to preserve the hospital's capital is so that it can meet future needs -- agreed -- but is this the way to do it, arbitrarily give every hospital price level depreciation on all its plant?

That does not regard in any way, shape or form the need of that community in the future which may be greater than that or less than that, those amounts of money. It is a very arbitrary way, which is also a very costly way, of providing this needed financial requirement which is, you know, to keep the capital base of the hospital sufficiently replinished so they can provide service to the community.

The point is that it may not in this fashion, as set out here in the regulations, the institution may not need to replinish itself in the same fashion that it was established previously, so why fund depreciation in this price level manner?

All right. The next point is it is inequitable. This price level factoring is inequitable. In effect, this generation's patient is made to pay for the next generation's facility by funding the replacement of the facility.

The patient using the hospital today, is he not paying for the debt retirement on that hospital? He is paying straight-line depreciation, let us assume, historical cost, on that facility; he is paying all operating costs and the increases in new technology and all the rest associated with health care cost. Why is it

that he must now have to pay to replace that facility for the next generation? I think that is an overwhelming argument. Think about it. The next generation should pay for its own hospital.

Now, another area of inequity is that Medicare and Medicaid will include only standard depreciation computed by generally accepted accounting principles. The private patients, including self-pay and those insured by Blue Cross and insurance companies will not only be required to pay these unnecessary price level factors for their portion of the hospital's financial requirements, but they must also pick up the unmet financial requirements left behind, so to speak, by the government programs, Title XVIII and XIX and Title V, you see, so it is sort of like two people buying a car and both paying half the price for it, and only one able to drive it. That is inequitable, and inequity is appropriate if there is a good reason for it, and I think in this case it is intolerable and really shows a complete, you know, I think, disregard for the resources necessary to pay these funds.

Interestingly enough the Minnesota State Department of Public Welfare doesn't recognize price level depreciation, and they don't recognize it, and have never recognized it, and I bet they never will, and I find it kind of strange that one agency is in the process of approving certain regulations which another agency will not accept and. — do you want me to stop?

MR. SATTLER: Just on this one point, to make the record clear that the Minnesota Department of Public

Welfare is precluded from recognizing price level because it is a Federal law, and not because it would not want to. I think that should be made clear.

MR. O'HARE: Yes, it should, although we might also indicate that there is the opportunity to petition HEW for a variation in the reimbursement mechanism, and I dare say I don't think that they would do so because of the increased payment that this would require from not only the Federal trust fund but also from the matching funds of the State of Minnesota.

MR. SATTLER: Have you had discussions with them concerning this point?

MR. O'HARE: No.

MR. SATTLER: We are negotiating at this time for the DPW to pay on the basis of the system.

MR. O'HARE: Well, if I was a betting man I would bet you they will never accept it in this fashion.

Anyway, the next point, the third point I was making is it is unnecessary. This section on inflation factors on building equipment and major movable equipment should be eliminated as being unnecessary. It is understood that the inclusion in this section of inflation factors is meant to preserve the hospital's capital assets; however, when one considers that Minnesota has more beds per thousand than any other state in the nation, with one exception; it has 5.9 beds per thousand in Minnesota versus 4.3 is the national average, and the fact that occupancy levels in Minnesota hospitals are well below the national average -- occupancy levels are 76.7% in the United States and 72.9 in Minnesota -- it

appears to me a substantial amount of evidence that there is a very real question that can be asked if in fact the hospitals in Minnesota are already over capitalized. Therefore, what need do we have to preserve current levels in all cases, as this would do, not to mention increasing them through price level factors?

Therefore, the conclusion is that the price level factors for all hospitals in the State of Minnesota in the arbitrary, across-the-board fashion condoned by these regulations, is clearly unnecessary.

There is no hospital rate process, either voluntary or legislative, or contracting agency, Blue Cross, Medicare and Medicaid, that recognizes price level depreciation in the same fashion -- I emphasize the same fashion -- as set forth in these regulations, and I dare say it is a pretty tough argument to make that all those hospitals in those other states are in severe financial difficulties.

We have a program in Wisconsin, a voluntary program; one in Kentucky, one in Indiana and all three voluntary programs, none of which recognize price level depreciation in this factor, and I think those are financially sound, stable hospitals, and serving their community well. I find it difficult to accept the need in this case.

I would like to conclude with an example which may or may not be correct, but to the best of my knowledge it is a way of looking at it in terms of what this does to increase hospitals' capital assets to a substantial amount.

Let us assume a hospital capital project of $5,000,000.00, with 80% debt financing, which is $4,000,000 on loan, and 20% through equity. If the life of the asset is forty years and the total price level factor for that asset over the forty years amounts to 200%, just picking a figure out of the air, the hospital will have received payments in total -- well, payments of $5,000,000.00, which was the original cost of the asset, through depreciation, plus an additional $10,000,000.00 through the accumulation of price level payments and the interest offset which was addressed in these regulations, but between the two they will come to an additional $10,000,000 for a total of $15,000,000 in payments now or in funds paid to the hospital for that original asset which cost $5,000,000 of which they only put down in payment $1,000,000.00, 20%, so of the $15,000,000.00, $4,000,000.00 was used to retire the debt, so at the end of forty years the hospital's equity has grown from the $1,000,000 that they put down as a down payment to $11,000,000.00, an increase of 1,100% to the extent that now if the facility has to be entirely replaced, which is unlikely, the assumed cost of $15,000,000.00, which is the replacement amount, the hospital will now have $11,000,000 in cash available to replace that facility. That is a rather astronomical increase in the asset, capital amounts available, and I just don't think that growth in amounts in that fashion are appropriate in the best interest of the community.

I guess maybe the assumption is being made here that

it is better to pay cash for replacement than it is to debt finance. Well, I will tell you when I bought my home the interest rate was 6-3/4%, and if I had paid cash for that house at that time I would have been kicking myself today because I can get a better return on that money by investing it, so I don't think we should -- if the implicit argument here is that there needs to be a very substantial amount of cash in order to acquire plant assets, I think that is false, and I haven't investigated the fact that you have a bond authority, tax-free bond authority, in the state. If you do I would say what is that for? That obviously was established by somebody for tax exempt bonds for hospital construction. I don't know if you have such authority here, but many states do.

That concludes my comments on price level.

MR. SATTLER: I have a few to make. You have made so many points it is kind of hard to remember them all.

I would just like to ask a question on the last point of your assumption of how much cash would be available to meet future replacement, for instance, of an institution? What is your assumption concerning the availability of funds that this program provides toward that replacement?

MR. O'HARE: Well, my assumption is that -- we did have discussions during the break, and I guess we had a difference as to how much would be provided, but I guess I was making the assumption from my reading of these regulations that in effect either substantial or total replacement funds would be available at the con-

clus[illegible]n of the life of the asse[illegible]

MR. SATTLER: Well, let me just clarify that point. The total replacement is virtually impossible under any reading.

Secondly, the system would provide for at maximum 75%, given the calculations that I have made, and would be reduced depending upon the amount of existing debt on the facilities accordingly, and could run as low as -- I think given reasonable numbers -- as low as 30 or 35%, probably being in the range of 45 to 60%, which would probably be more of a reasonable basis, so we are not really advocating going to full cash payment for replacement.

What we are advocating at this time is recognizing the need to refurbish and replinish, and the ravages of inflation all the time, so that is really what we are doing, which is not all that inconsistent with what other programs, as I understand them, in other states, do provide for.

Secondly, I can refer you to a pamphlet or booklet which was edited by myself, which contains a series of papers and talks that was delivered to a conference that was sponsored by the Social Security Administration on the very topic of rate setting and rate review, and at which Professor William Dowling from the University of Washington spoke and made reference to having all rate setting programs have the ability of hospitals to accumulate funds to meet future needs for expansion, replacement and other capital projects built into the rate setting system, and we would be happy to make that

available for the record.

He felt that it would actually reduce costs over time, particularly in the area of interest expense which would have to be paid for bond insurors and bond payors.

I certainly do agree with your point that we don't want to encourage hospitals to pay 100% cash for buildings. That is not a common practice, and this system is not established to do that, but we do feel it is appropriate to have institutions accumulate cash.

Next you made a point about too many beds. As I am sure you are aware, the Institute of Medicine just issued a policy statement concerning the fact that we do have too many beds nationally. I believe their figure was 4.4 beds per thousand rather than 4.3 as you have mentioned, and they suggest moving to 4.0 beds by 1980.

We here have attempted to recognize that in a way in these particular rules in a section that we will be dealing with later, entitled "Excess Capacity," but you will notice that in this section we do reduce the inflationary component or the inflation index by the determination if there are too many beds, and the methodology that you will see later on uses the mean for a peer group so that right off the bat, I think, we are saying a substantial number of hospitals who will have excess, excess beds, will not be receiving, quote "full" 100% of the inflation factor.

As far as your comments about passing on the cost to the next generation, what price level really does is

recognize the current cost and charge that current cost to current users. In other words, if we built a facility ten years ago for $100,000 and right today it cost $200,000 to replace, we should recognize that additional incremental cost today to the users of today, not charge them a depreciation rate based upon something that was built ten years ago, so we are not really passing on the cost to the future, but recognizing current costs in the current year. In other words, tear down the hospital every year and rebuild it, what would it cost today to do that? That is what current payers should pay, and they are not even paying all of that. They are paying just a portion of that.

Okay. You also mentioned that we might be providing too much or too little, and it is rather arbitrary. Well, to a degree I do concur in that. We believe it is important for any financial enterprise to have the ability to gain surplus and to really build that into the system.

Our particular system does not offer any kind of a return. As a matter of fact, the way the Administrative Procedures Act is written I understand that we really can't, such as the Washington system, for instance, say, "Well, we will look at what you think you may need every year and give you that amount." It may be nothing. It may be 10 or 20%.

Correct me if I am wrong, but I think our Administrative Procedures Act says we have to explicitly enumerate what will be given. I also know that theoretically there has been nothing written that can theoretically

justify a given rate of return for an institution, such as a hospital. There have been guesses, and one particular article I know that was written by Professor Yoolong in the National Systems Publication suggests a rate of return in the area of 10% would be appropriate. I know there are other estimates floating around that range anywhere from 5 to 10%. It has been our experience the plus factors in this program -- we will be coming to another one which is working capital -- would be in the area of 3-1/2 to 5%, so we think that we are, if anything, going on the low side, but, true, it is somewhat arbitrary in that it may be pegged on historical costs.

We did build in a methodology on page 37, Section (c), even though I amended it slightly, which will allow the institution to gain more funds if necessary, and, on the other hand, if not necessary and the institution does have excess capacity, we can cut back on the inflation factor, so that we are attempting to go both ways at this.

I think that to say that we have too many beds in this state, I may well concur but I think that is a planning decision. We have HSA, the State Health Planning and Development Agency, and I think certainly with 93-641 it is their responsibility to make those decisions, not the rate review function at this particular time.

If in fact the legislature mandates us to do something about that, appropriate steps will be taken to do that in the future.

far as the cash drain on society, insurance companies like to have money, hospitals like to have money, I like to have money, we all like to have money -- nothing more we can say about it.

MR. O'HARE: Well, it certainly follows that the transfer of funds that are not -- you know, if you are not recognizing price level and you go to it, you are going to end up transferring a substantial amount of money from wherever it is coming from to the hospital setting, and I just want to point out that in terms of this excess that you need to preserve the institution, I think the arbitrariness is rather outstanding.

Secondly, this is an increment each year. If that adds on 5% each year, you know, what have you got at the end of ten years or twenty years? In other words, it might be a question of the true proportion as to what is really needed, and how you go about it.

Let's go back to Professor Dowling. Well, I would agree with what you stated he said, but he did not say that you should do that by price level depreciation on every asset, capital asset, of a hospital. They don't do it in Washington where he said substantially they look to that Washington commission, but they do it another way. All I'm saying is what is the equitable way to go about it? This way is not the equitable way.

I guess I still question -- you say it comes out to 75%. My point is that is one heck of a lot of money.

MR. SATTLER: At the maximum, and that assumes there is no prior existing debt on the asset.

MR. O'HARE: You say it is at the maximum. If you

are so convinced it is the maximum, why don't we put it into the regulations? If we come up with an appropriate ratio between debt and equity, let's put it in the regulations.

Maryland, for instance, thinks 20% is the proper thing on facility replacement. They do go for price level on major movable and fixed, but, again, I would not draw a whole lot of parallel with Maryland because that is a mandatory program. It sets rates, so they can afford -- they are setting rates so they have a lot more accountability in the system, but even on buildings they recognize 20% equity is the proper level.

Now, you may quibble about that, but, in other words, you know, it is so open-ended. You say it can go to 75%. Well, I guess I would still have to do my homework and be convinced that is right. It looks to me as if it can go beyond 75 but let's say it only goes to 75; I think that is far too much.

MR. SATTLER: I would like to point out 75 on both movable and all assets, movable equipment, buildings and building and equipment.

Now, the 20% figure for Maryland, as I understand the program, only applies to building and building equipment. They do provide 100% for major movables.

Now, when you take the weighted average of those two, I would suggest that you are somewhat in excess of the 20% level. I don't know exactly where it is; it varies from hospital to hospital, but it will certainly be in excess of 20.

MR. O'HARE: Yes, it is almost 50 - 50. Maybe I am

wrong. I think buildings might be half of depreciation or close to it. Some other people could probably correct me on that.

MR. SATTLER: You are talking 20 and 100 -- that is about 60%, so ours is a maximum of 75, assuming no prior debt, and if you allow for reasonable levels of debt, which I think most hospitals have, we are down as I mentioned -- I think Blue Cross would generally concur -- in the 45 to 50, as high as about maybe 65 level, so that we are not that far away using this approach as you would like to suggest we would be.

MR. O'HARE: Well, I don't know if you split it into separate funds, as they would, I think, in Maryland, for instance, so, in other words, you just can't sort of take Maryland and say, "This is it as far as the good part goes and as far as the rest of it goes, let's forget about it."

MR. SATTLER: No, we are not.

MR. O'HARE: It is an entirely different situation. We are just looking at it for what, you know, the rest of the world is doing.

MR. SATTLER: No, we are just trying to say if you use that as an example that ours is not all that far away on this particular point.

MR. O'HARE: Well, you don't -- you know, in other words, Maryland does put a limit and it does require the categorization of funds, and it does require a limit on the facility replacement fund, which you don't have here.

What I am saying this is so open-ended here that I

think it can lead to excesses that are not in the best interest of the community, and that if you keep it that somehow there should be some cap put on it, and I think given the fact that -- I read the report you did and I brought it along -- I wish I had read it more thoroughly, but I thought you were projecting a rather substantial -- or that the bed needs now were equivalent as needed for 1980. Maybe I misread that, but there was a chart in there.

MR. SATTLER: By the way, we do not argue, and I think the rules do address the excess question, and the fact that the numbers that you are projecting will not apply in cases where the system determines that there is excess capacity, by its very nature -- we will get to this section somewhat later; I don't know exactly where it is. Excess Capacity is on page 44. It is 487 A.4. We use the mean of the group to determine excess, so that, you know, right off the bat, and the reason -- by the way, I will get to why we have to use mean later on but right away you can see if the mean of the group is the level that assuming a normal distribution about half of the hospitals are going to have excess capacity within a group, so that we are reducing, you know, payment to these hospitals on the inflation factor right off the bat.

MR. O'HARE: Well, my position on that is they probably shouldn't even be paid depreciation if it exceeds debt amortization for that portion related to the unneeded beds, so we are getting into another section where I would not agree. In other words, that argument

that you are not giving price level just doesn't mean anything to me because not only should you not be giving price level, reason almost dictates that historical depreciation, unless it matches the debt amortization for those debts, probably ought not to be paid, so I guess that kind of bounces off me.

MR. SATTLER: Maryland is involved in a very interesting situation with this. They do not pay depreciation. They pay a capital facilities allowance, as I understand it.

Has that been determined in the courts yet, whether that is appropriate or whether depreciation really is the appropriate method?

MR. O'HARE: It has been determined in the courts that the Commission's definition of reasonableness is paramount and, therefore, that the Commission can continue with its capital facilities allowance. That was one of the points of the law suit that was going on there, and it was decided in the Commission's favor, that it can decide what the reasonableness criteria are. Part of the reason they are saying the Commission has taken that approach other than a capital approach is that the rest of the hospital's financial requirements are guaranteed. They no longer have to use their funded depreciation to pay for unmet costs of care for medically indigent people, and now that is guaranteed. This is what they were using depreciation funds for before so it is now -- you have got a whole host of different situations so it is not appropriate, but I guess we could go on all day. I think I will stop at

tha

MR. SATTLER: There is one other point that the system has the obligation to assess the financial status of all the hospitals in the state, and over the next year or so we will be doing that. Until such time we don't feel that it is appropriate to do too much in this area to, number one, either enhance the financial standings of the institutions or to arbitrarily cut back and, as such, you know, we have kind of taken the middle ground here.

Admittedly for some people it is far too liberal; for others it is not nearly liberal enough --

MR. O'HARE: Right.

MR. SATTLER: -- so until we understand what is going on in this state and get an opportunity to discuss with HSA --

MR. O'HARE: Maybe this is an appropriate time to ask a question. It seems like you are really in a hurry to get this thing going and in reading this, the appropriate sections of Senate File 60, I wonder what the rush is. In other words, it doesn't say you have to start a certain day. I think there is something in there about getting hospital rate schedules, but, in other words, why is this big rush on? Why can't you take time enough to set up the complete system and just get the reporting requirements going before you start reviewing? Is there a legislative mandate of rush? Because the section starts out, "The Minnesota Health Board may review hospitals," and so it "may" do this, so it is almost not obligatory or mandatory. It is

almost like you can take your time, and this argument keeps coming up, "We are in a hurry. We haven't got time to figure it all out. We have to do this and do that." I just wondered why is this big crunch on.

MR. SATTLER: This particular piece of legislation was passed with the idea that the Hospital Association did have a new process for wanting it. The question of integrating that particular program into the state's was on the mind of the Department, I think, at the time and the legislature was interested in determining what the Hospital Association was doing, and I think that this might have a bearing on that. Other than that I really can't say.

MR. BREVIU: The statute was made effective last August 1st, and prior to any rate change the hospitals have to undergo the system, so until such time as there are some rules implementing the system it makes it very difficult and defeats the legislative intent, so the Department is attempting to proceed accordingly.

MR. O'HARE: But it is a voluntary system, so how can it be --

MR. BREVIU: It is not. It is a mandatory system.

MR. O'HARE: Okay. That is nice to hear you say that.

MR. SATTLER: It is mandatory in that review and comment, and that filings be made.

MR. BREVIU: A rate change cannot be made unless one goes through the system. The system does not have the power to determine rates, however.

MR. O'HARE: Well, okay. We are getting off on a

side issue.

I would just like to finish with one or two sentences. I think price level depreciation factors are unnecessary, arbitrary, they are not related to the community's need for future services, and that to include them in this manner is without precedence throughout the country.

You know, it is almost like flying in the face of other hospitals that are completely well-founded financially and serving their communities, and no threat of financial disaster, and they are not getting price level depreciation, and I just find it somewhat incongruous, especially at a time when national health care costs are taking extreme increases, and I guess I would think the system here would in a sense be some sort of an accountability or reasonableness system, and to find price level so arbitrarily put in in a state in which it is acknowledged there is at least a question of over bedding, it is beyond my expectation of reasonableness. Thank you.

EXAMINER MIHALCHICK: Mr. Lamson.

MR. LAMSON: In reference to page 37 we propose that Paragraph (c) the comma and the words following "approved inclusion in rates," up to "when a hospital -- " on line three should be deleted. The specific words are, "when the hospital can demonstrate that sufficient resources exist in (i) or (ii) above, or -- " end of quote.

It is our position that charging today's patients the total cost of equipment acquisitions would be an

unfair practice. The patient charge now includes depreciation expense based on historical costs, plus an adjustment for price level changes, and patients should not be expected or required to provide funds for this purpose in addition.

In reference to plant capital needs we propose that the following be added to the plant capital needs section of the rules, and specifically that the depreciation fund should be used for the following purposes:

(a) Principal payments on capital debt; (b) Replacement of buildings, building equipment and movable equipment; (c) Purchase of new equipment, and (d) Major repairs to building and building related equipment.

We believe this is the intent of the rules, and the purpose of this suggestion is to clearly state the intent.

Also it is proposed that consideration be given to the addition of a paragraph which would provide for limitation upon the amount of funds that may be accumulated to meet the replacement costs of needed facilities.

This suggestion is reasonable on the basis that today's patients should pay for those costs related to the use of today's facilities, and tomorrow's patients should pay for the costs related to the facilities which they use.

Rates should include only one provision for the costs of facilities for tomorrow's patients; namely, for a reasonable down payment on replacement of buildings and what is reasonable is for conjecture. To some

people a reasonable down payment is 10%; to some people a reasonable down payment is 50%. I don't know.

MR. SATTLER: May I just ask a question?

MR. LAMSON: Yes.

MR. SATTLER: I was a little confused when you were going through page 37. I have your written comments. Just for clarification, you would like to delete --

MR. LAMSON: Delete that part that states, "when the hospital can demonstrate that insufficient resources exist in (i) or (ii) above, or -- "

MR. SATTLER: You would like to delete that part.

MR. LAMSON: You amended that.

MR. SATTLER: Okay. I don't quite understand the thrust of that suggested change. I wonder if you could help me out.

MR. LAMSON: My interpretation of that is that the hospital can depreciate the item in its entirety in one year. Now, is that correct? If you bought a $10,000 x-ray machine, or a $50,000 x-ray machine, this year you could depreciate the whole thing if you didn't have funds available from the other sources in (i) and (ii)? That is what I interpret this to mean.

MR. SATTLER: Well, let me tell you the intent of this section and possibly that might clarify it to see if possibly it doesn't read that way.

The intent here was to say that if an institution, and we are particularly thinking about the HSA saying, "Go do something," and you go to your fund and you might only have 2% of the funds necessary to do this, and obviously you don't have enough equity to do it,

right, and you say, "Okay. The MSA says we should do it. We have to do it. It is needed in the community," etc. "We have got all the appropriate approvals. How can we go about getting the money to undertake this particular project?"

What we are saying is after you have exhausted all other possibilities, meaning grants, gifts, down the line, borrowing money, etc., and we still need additional equity capital, let's say, to go into the capital market. I can raise rates enough to bring in these funds in that year."

That was the intent of this section. I don't know if it reads that way, which may be a problem, but does that help clarify it?

(No response.)

What we then go on to say is, "If we raise 10% cash during the current year for this asset, I can then not depreciate 10% of that asset in two or three years. I have depreciated the full 10% up front," and that gets into this, "Any portion of the annual equal amortized historical cost of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated."

That is what that sentence takes care of. That is the thrust of that particular section.

MR. LAMSON: If there was a limitation here, Fred, that might be all well and good, but the way it reads at the present time you could take 100% of it in one

yea[illegible] which I don't think shou[illegible] be allowed.

MR. SATTLER: Well, okay. I suppose it is theoretically possible. Let's say we had a $100,000 asset, and you said "We want to raise the $100,000 in cash to raise rates." Now, this, of course, would be subject to review by the system again, and my feeling is that with (a) and (b), which say you have to go through this hierarchy, a logical question should be, you know, -- well, let's get you back. If you are down in (c) and you say, "I need cash; I have to go to rates," how can we get you back up to (b) to borrow money first? Well, we can do that by giving you 10%, let's say, or 2%, or whatever is necessary, in cash; then we can get you to borrow the rest.

I don't know if that is necessarily reasonable to infer from the way this is written, but we may need language to specifically do that, but I would think that it doesn't -- well, it is not inconceivable given the review process whether it was intended -- well, would language to that effect help solve this perceived problem?

MR. LAMSON: Clarification of the language definitely would help so that you did not end up with a possibility of 100% replacement in one year.

MR. SATTLER: Because we would hope to maximize (a) and maximize (b) and hold (c) as the last resort.

EXAMINER MIHALCHICK: Any other comments on this section? Mr. Van Hauer.

MR. VAN HAUER: Mr. Examiner, members of the panel, in my last statement to you I apparently overran the

limits which had been set for discussion at that time and I apologize for it.

I had been engaged in looking for some material and turned my hearing back on just as Mr. Sattler said that he was closing at the end of Paragraph (ii). On page 35 there happens to be one at the bottom of the page I was looking at so I went inadvertently further than I intended to.

Just for the record let me again say that we suggest in Paragraph (b) and in Subparagraph (i) and Subparagraph (ii) the same inclusion of the words "land improvements" before the word "buildings," so that the statement would read, "useful lives of land improvements, buildings -- " etc., and "replacement cost of existing land improvements, buildings -- " etc.

Turning to page 36, in Paragraph (2) at the top of that page, the term "inflation factors" is used three times. We would suggest as a matter of semantics that the term "price level depreciation" end of quote, be used instead.

That term "price level depreciation" is now a recognized label for a specific accounting concept.

Going on further down, we heard with interest the suggestion of Mr. Lamson that a statement be added describing how the fund may be used. We would heartily support such a statement because it appears now in the Minnesota Hospital Association rate review system.

Those points were that the proceeds of the fund -- and I am paraphrasing Mr. Lamson -- could be used only for the following:

(1) The payment of principal on long-term debt; (2) To replace existing capital equipment; (3) To make major repairs to plant and equipment, and (4) to acquire new plant and equipment as authorized under the certificate of need process if a certificate is required.

I think too that we may be able to help Mr. O'Hare understand the pressing necessity for including price level depreciation by citing a simple example.

The life of buildings is typically forty years; sometimes a little less. Typical long-term debt spans twenty-five years; sometimes a little less. Taking those two time periods, the building life of forty years translates to depreciation of 2-1/2% per year, and amortization of long-term debt over twenty-five years would require an amortization rate of 4%.

Referring back now to Mr. Lamson and the uses of the fund he describes, and considering then the first use, payment of principal on long-term debt, you would be paying out of the fund 4% for long-term debt and putting back into it only 2-1/2% from depreciation.

Obviously some augmentation of the fund has to occur. This is the primary reason for the development of the concept of price level depreciation.

Mr. O'Hare has apparently not encountered this concept before, but it is gaining wide acceptance in the field of professional accounting. Not only that, but the Securities and Exchange Commission of the United States of America has concluded that the customary use of historical depreciation and the presentation of balance sheets and earnings is distorting the true

values of capital stocks being offered on the stock exchange and may very well amount to defrauding purchasers of such stocks. The concept of price level depreciation is an idea whose time has come.

There was considerable discussion between Mr. O'Hare and Mr. Sattler about the size that such a fund could eventually amount to. Now, I have just pointed out in the simple example I gave you that unless the fund is augmented by something other than straight-line depreciation, it won't even keep pace with the payments on long-term debt, but then he said, "What happens after the long-term debt is paid?" The answer is that after that period of time, which is approaching twenty-five years, major repairs and replacements to the building have to be made to keep it operational. Roofs have to be replaced, elevator machinery has to be replaced, ventilating and air conditioning machineries wear out, and these things are truly expensive.

The point is then that referring to Mr. Lamson's suggestion about the description of the uses of the fund, the third use; namely, to make major repairs to the plant, decidedly comes into play towards the end of the life of the plant itself.

Mr. Sattler had opined that it was unlikely that this fund could ever reach more than 75% of the total replacement cost, and the discussion seemed to bring it down to 60%. Mr. O'Hare was skeptical that it would get that low. It is our opinion, gentlemen, that even those figures are too high.

Our own experience in the operation of the rate

review plan in the State of Minnesota, the insight that we have gained through access to the operating records of our state hospitals over two annual periods, has convinced us that there is not the slightest danger of the fund ever reaching a level that would permit a new plant to be paid for without further borrowing. Indeed, it is more likely to go the route which Mr. Lamson has suggested in his comments; namely, that about the best the fund will do will be to accumulate enough for the down payment on a new plant, with the remainder then to be borrowed.

I would like to address specifically Paragraph (4) on page 36, which takes up the matter of interest earned on this fund, and I would tie this fact to the example I gave you; namely, that straight-line depreciation will not begin to even maintain the fund, much less permit it to increase, that the utilization of price level depreciation will help make up some of that deficit and in similar fashion the interest earnings on that fund will help make up the rest of the deficit.

We would have no objection and, as a matter of fact, we will suggest that Paragraph (4) be modified as follows:

It now reads, "The annual interest income earned from an investment of this fund annually should -- " we would then interpolate the following language: "should remain within the fund until the fund balance equals 100% of the replacement cost of equipment and 50% of replacement cost of buildings. Once the fund reaches these percentages the interest income should be

used."

Then we go back to the original language, "to reduce the inflation factor requirements for plant capital needs which are included in rates."

We are confident that such a provision will not result in there being an excess of funds, and I would hope that that will allay Mr. O'Hare's concerns on that point.

On page 37 the Department has suggested an amendment to the language and we find we can very readily support that change.

I would like to suggest, Mr. Sattler, in Paragraph (c) on page 37, and this was the point that was troubling Mr. Lamson, where it reads as follows: "Approved inclusion in rates, when the hospital can demonstrate that insufficient resources exist in the plant capital fund," and then we find the word "or." I would like to suggest that be replaced by the word "and," so that it would read to the effect when there aren't enough resources in the fund and the hospital can demonstrate that inclusion in rates would be better than borrowing they be permitted to do so, which I think speaks to the sense of Mr. Lamson's concern. Thank you.

EXAMINER MIHALCHICK: I have a question as to the 2-1/2% depreciation and the 4% amortization. Wouldn't in fact back under (a) on page 34, 4% be put into the fund based on this alternative, the amount of the principal repayment, or am I approaching my time limit and not understanding it?

(No response.)

Doesn't that say the greater of the depreciation rate or the repayment, which affects some of the argument, I would think -- maybe not the entire thing, of course, but that would seem to maintain the fund at an even level.

MR. VAN HAUER: I would agree with your observation, Mr. Examiner. That is the way it reads.

EXAMINER MIHALCHICK: Well, does that affect your experience then with your review system as to the amount that might be expected in that fund?

(Whereupon, Mr. Van Hauer and Mr. Fearing conferred.)

MR. VAN HAUER: Mr. Fearing's comment was that we are not able to determine that because our present program doesn't operate that way. I would guess I would make the following comment too:

The Subparagraph (i) at the bottom of page 34, to which you referred, Mr. Examiner, contains an assumption that the payments would be computed as though they were on a level payment basis, which they almost never are.

The result is that when you get into the later years of the debt repayment the principal becomes quite sizable and will very greatly exceed the depreciation rate from then on.

In short, this contains the assumption for the pur-

pose of making a point, but in practice it isn't possible for the hospital to maintain the level rate of principal repayment. Debt repayment, yes, but the big chunk of that, as we all know, in the early years is interest, not principal. In the later years it reverses.

EXAMINER MIHALCHICK: Mr. Sattler, was that the intent of this (i), which is the proration of the principal payment, or of the whole payment including interest?

MR. SATTLER: Interest is handled under a separate section, so it is just principal payment. The reason we set up a level payment basis is really not necessarily going to recognize the peculiarities of various repayment schedules, which any, you know, debt issue can have when we said on a level basis, unless it is a heavily front-end loaded debt repayment structure, which is really not typical. Typically they are more back-end loaded, so that the institution will have an opportunity to get equal payment put in the fund and have the money available in the later years when the higher payments usually come into being.

We did make an assumption in setting this up in that regard. It was also set up to allow a certain amount of flexibility.

MR. VAN HAUER: Thank you.

MR. SATTLER: Just one question about the 100%, 50%, Mr. Van Hauer.

This would appear then to be virtually guarantying the build up in the fund of about 75%, while the system

we have set up would not necessarily guaranty such a build up but would make it possible given substantial amounts of equity, but if the institution was heavily indebted and did not have a good share of equity, it would allow it to enhance its equity position but not necessarily get up to 75% overnight, and I want to know if that was really the intent, if that is the intent of the Hospital Association to see to it that every single hospital in this state has the ability to build up that fund to that level.

MR. VAN HAUER: Mr. Examiner, Mr. Sattler, we don't see that this in any shape or form guaranties it is going to happen. This is simply to speak to the concerns expressed by other persons who spoke before me, and to assure them that we won't have a fund that contains 100% of the replacement cost of buildings and all the plant and all the equipment. We know ourselves it will never happen. We are willing to guaranty that it won't happen, but this does not insure that the fund will ever build up either. This simply puts a lid on it.

MR. SATTLER: I was just reacting to the fact that you are saying that, if I understand it, that the annual interest income will be allowed to remain in the fund until it reaches that level, and what we are currently saying is that there should be no interest income allowed to remain in the fund. Thank you.

EXAMINER MIHALCHICK: Anybody else? Mr. Klas.

MR. KLAS: I am sorry, but I feel the need to express a frustration; it is a continuing one, and to

speak from a variety of places here because I had been participating in the voluntary rate review program and I had trouble with price level depreciation there, and I have the same problem here, and a few years ago when I was at the University and I was taking accounting courses in the business school, and they were treating depreciation in one way; then going over to legal accounting at law school they treated it another way, whereby they were presuming that automatically meant it was a pot of money at the end of the period, which would then allow you to replace things with. That just didn't make sense with what they were teaching in business school, and we have talked about earlier the Presidential advisors, and one of them that I have talked with was Charles Evans Wright about that, and he dismissed me accordingly as an uninformed freshman, and since then I have never totally understood it, but the frustration I have here is that when we talk about the price level part of it, it seems to me we get a little confused between whether we are trying to spread the cost or whether in fact we are trying to prepare for replacement.

If we are spreading the cost, the cost is the cost that it was. If we are trying to get ready for replacement, then very definitely today's market rates have to be taken into account and tomorrow's too if we can guage it, and I think that is one of the problems we have here when we talk about people occupying hospital beds today having to pay off what the costs are going to be tomorrow; consequently, for that reason

-- and that is the way it seems to me, it is implicit in price level depreciation, and that is why I have an objection against it.

Sitting on the rate review panels for a year, a little over a year now as soon as they resume, I have seen so many hospitals in this state which had capacity of under fifty percent and, consequently, when you talk about price level depreciation and the necessary implication that there should or will or very likely is expected to be a replacement, I have to get concerned.

It is true these proposed regulations and the excess capacity provisions on page 44, which Mr. Sattler referred to, address the question and then later on they talk about peer groups at I think, about page 46.

The difficulty is there seems to be a lot of these about the same size and very likely are going to be thrown into the same peer group, and I sit on these panels and I find that one of the standard questions is "How close is your next hospital," and very frequently it is fifteen or twenty miles. Then we find out what their capacity is -- bang, also somewhere between 40 and 60%, so I guess that is my frustration with adding on the additional factor of price level for inflationary factors.

There is a necessary implication there that, particularly in this state, I have difficulty with, and since the overall intent of this Article II, or this portion of the law, really is addressed towards cost responsibility, cost effectiveness, and while now it is a reporting kind of a provision the obvious impact

is that if they don't like what is reported the legislature is going to go further.

You know, I just really question the propriety of having included here those future considerations that are part and parcel to the inflationary factors, and what things are going to be like in the future.

MR. SATTLER: We have discussed this enough so that I think, you know, I am generally in agreement about the problem in this state.

In the drafting of these rules though there was a real concern given to a division of label of responsibility, if you will, between the rate review system and the health planning people, and I would suggest that, you know, again at this time that it is really in the health planning, and that when the signals from the health planners come, if they come, to the rate review about this problem, that the system will do something about it, but until that occurs I think we are in a very delicate situation here.

By the way, the State of Wisconsin applies inflation across the board to every hospital on a specific price level, and I can show you in my office a copy of the program.

As I understood it when we were drafting these rules, and I would like to, you know, clear this up at this point, that we do not have the ability to arbitrarily say Hospital X should get something because, "Yes, you are running at full capacity quota," and Hospital Y, "We can't give you anything."

I think we have to spell out, or we attempted to

set up a formula to determine this and had a great deal of difficulty with that, so as a result this has come out. Part of this and maybe most of it should be when we discuss the excess capacity issue per se, but very clearly when you are talking about rates you are talking about building in or permitting to be built in that aspect, that future aspect, that present and future aspect, as opposed to what we are looking at now.

The enforcement part of it is here even though the philosophy is on page 44, so that is why I am bringing it up now. We can get into it later.

I think we should recognize the fact that at least over the foreseeable future we are going to have some hospitals in the state. That is the intent of both the legislature, the Department of Health and I think the community in general, to have hospitals in the State of Minnesota. Is that a reasonable assumption?

MR. KLAS: Did you say in every town, hamlet and village?

MR. SATTLER: No, I said generally speaking we are going to have hospitals.

MR. KLAS: That we can agree on. We always have.

MR. SATTLER: And that they should be able to perpetuate themselves in some form or another; that we will need them tomorrow, we will need them five years from now and ten years from now?

MR. KLAS: Yes, we are going to need hospitals, yes.

MR. SATTLER: But the problem is in determining

who and when.

MR. KLAS: And where and how many, sure.

MR. SATTLER: So I think here all we are doing is setting up a mechanism to allow institutions to perpetuate themselves. Maybe in the excess capacity section we will get into maybe we shouldn't give this to everybody; it may be more appropriate to discuss who should or shouldn't receive it.

MR. KLAS: My problem is that -- I didn't mention it, but part and parcel with these same hospital discussions they are very quick to tell us of their substantive recruiting efforts to continue their existence by all sorts of very high priced arrangements with surgeons who will build their hospitals, you know, and you have sat through those as I have and, again, if they don't have the funds they are not going to be able to engage in open bidding like that, and I for one certainly don't think that that is in concert with what the legislature was trying to accomplish here, and to permit them to do so by allowing them to build up through their depreciation accounts, through their charges, through their rates.

As we pass them on the panel I have a great deal of difficulty because it is really frustrating the intent. Many times we have looked at numbers and seen really substantial losses projected, which really are losses only if you take into account the price level and some of the working capital assumptions that go along with it, and then there doesn't seem much point about quibbling about some of the other allocation of

cost, which we might have questions about in the budgeting process, inflation factors that they are using, because even if we made those in tune or suggested that they be in tune with what the rest of the hospitals are doing in the state, we would still be so far away from meeting their needs with the price level depreciation factor that, you know, the panel just throws up its hands and goes on to the next hospital, and that isn't getting done the legislature's job either.

MR. SATTLER: I think that your latter point, the implementation of the program, is going to change somewhat, I think, from what has been experienced.

Secondly, we are actively as a system seeking to improve input, improve relationships with PRSOs throughout the state and with the health system agencies.

Now, I guess there are two routes that a system like this can take. Actively get into the PSRO business and say that you are having inappropriate utilization and cut financial requirements based upon those situations, which I think is a dangerous area for rate review to be in at this time; the same thing for determining appropriateness.

On the other hand, we can try to integrate all three aspects of the system; the rate review, the health plan and the PSROs.

I know that the Foundation for Health Care Evaluation of the Twin Cities is going to be introducing written testimony in this regard to try and write in places where they should be informed and consultation

should occur so rate review and PSROs aren't going off in opposite directions, so we are attempting to do things along those lines too. I think you know it will take some time. We are cognizant of what the problems are.

MR. KLAS: As I think we both know, no one program is going to have the total answer. It is going to be a multi-faceted effort by all of the various bodies and the cooperation that is existing between the various parties is very helpful to it, but specifically to include future consideration such as this very directly permits excess capacity to continue.

EXAMINER MIHALCHICK: Okay. Anyone else? Mr. O'Hare.

MR. O'HARE: Just one small comment. I hate to make a comment after Terry's most articulate presentation of the area, but I would just ask were other avenues -- I think what he has delineated is that depreciation is an expensing over time of a cost. That may not be quite right, but it is expensing over time and prospective accumulation of capital is another question, and I am just wondering if other considerations were given to how to go about prospectively accumulating capital.

For instance, one could say, "Well, let's not have price level. We will just pay historical depreciation and have the hospital submit a proposed capital accumulation budget every year, along with their regular budgets, and we will do it in that fashion and consider it as a separate item based on their projected

need and that would be put in a fund. When they have to get final approval, if it is above limitation, then they will have to get approval but we will start funding it.

I would see that as a more rational alternative, and I wonder why the two have gotten so confused in this thing.

MR. SATTLER: Yes, we did investigate. Now, I am only commenting as I have sat on the other side. We did in this process look at a number of different alternatives. From my understanding, from dealing with Steve Jackson, who was the consultant and representing the Department, the other methods that were suggested would never make it through the Administrative Procedures Act.

EXAMINER MIHALCHICK: All they have to do is be well drafted.

MR. SATTLER: The problem is it gets to be somewhat arbitrary. In other words, the requirements were left up to, you know, review panels or the system's determination at the time that the filing was made, which becomes problematical.

I am only giving a somewhat second hand version of this.

MR. O'HARE: Well, maybe it is a question of identity. I see the price level factor as having the same, similar problem. It is really not identified with any particular cost strictly speaking.

I think, you know, what we are talking about here are financial requirements and doing it by price level

as opposed to a prospective accumulation through a proposed capital budget. That is the same kind of problem. If one could slip by I think the other could. I think the latter is a more rational approach tied to some anticipated needs by the hospital.

MR. SATTLER: The problem is with the amount. Here the amount is fixed in that we are giving parameters; apply, you know, an index to a cost, and come up with a number. It is done the same way for everybody. It is a part of the problem to see that everybody gets it obviously. On the other hand, who is going to make the decision that Hospital X should, and Hospital Y shouldn't?

You might want to comment on the Administrative Procedures Act.

EXAMINER MIHALCHICK: It is just, to my mind, a matter of establishing some standards. Welfare does it all the time.

MR. BREVIU: Welfare has also lost three sets of rules recently because they were unable to do it.

I am not extremely familiar with the specifics of what they might have attempted to do in the drafting stages. My guess is it was felt that standards should not be prospective standards, but I really don't know the specifics.

EXAMINER MIHALCHICK: At any rate, it is not here. We are looking at this one.

MR. SATTLER: We have recognized, by the way, throughout this entire set of rules that the whole rate reviewing process is one that is going to be

changing, not necessarily in this state, but, you know, the whole country is trying, you know, many new things. There is no one right answer, everyone familiar with the process will agree, and we do intend to change as appropriate, you know.

Why don't I finish (6), (7) and then we will get to (c)?

(6) on page 37 deals with very special kinds of emergencies that might come up; for instance, a tornado and the roof gets blown off the hospital, and it has no way to generate funds to replace this except through rates, so we will be working with HSA to see if indeed the roof should be put back on; then they can increase rates for that period to generate enough cash to do that kind of thing.

Page 37 (7) we do have a suggested amendment. Let me just read it. Let me just read the whole paragraph.

"If a hospital can demonstrate that the assumption of any specific capital debt will result in a greater cost to current patients than depreciation or retirement of that debt under consistent financial practices of that hospital which differ from the determination of plant capital needs as stated by these rules, then a hospital may choose an alternative method of meeting its plant capital needs. In this instance, the hospital should provide complete information to the system regarding the precise method . . ."

Just for clarification purposes and to help with the language in understanding the intent of this section, the intent again is to give some flexibility to

institutions if they can come up with ways which will be in the best interest of current patients financially and can prove to the system that this is the case, the ability to go and finance in other methods. It really is a flexibility clause, although the burden of proof is very definitely with the institution to prove that what they come up with is indeed to the benefit of current patients and all payors, so I think that gets us just to (c).

EXAMINER MIHALCHICK: Any comments on (6) or (7)?

MR. O'HARE: I guess I would like an example of how those situations could occur, say in (7) particularly.

MR. SATTLER: Frankly, off the top of my head, quite honestly I can't think of any, but that does not necessarily preclude other people from coming up with a way that may well be beneficial.

Before coming to the health care field I worked on Wall Street for a number of years, and found that those people have no end to the ways in which they can come up with making things more attractive than the way they used to do it, so given changes in capital markets and given changes in the whole field of finance, we feel there is no need to preclude the possibility of someone doing this, yet the burden is very definitely with the institution to show adequate proof.

EXAMINER MIHALCHICK: Any other questions or comments?

(No response.)

We will recess until 9:00 o'clock tomorrow morning in this room.

(Whereupon, at 4:35 o'clock p.m. the hearing was recessed to January 6, 1977, at 9:00 o'clock a.m.)

* * *

ORIGINAL COPY

STATE OF MINNESOTA

BOARD OF HEALTH

In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System

Docket No. HLTH-77-035-SM

VOLUME II

The above-entitled matter came on for hearing before Steve M. Mihalchick of the State Hearing Examiners Office, on the 6th day of January, 1977, at the Minnesota Department of Health Building, 717 Delaware Street, Southeast, Minneapolis, Minnesota 55440, commencing at approximately 9:00 o'clock a.m.

* * *

APPEARANCES:

Frederic L. Sattler, Consulting Director, Minnesota Hospital Rate Review System,, Minnesota Department of Health.

John Breviu, Special Assistant Attorney General, representing the Minnesota Department of Health.

Kent Peterson, Chief of Planning & Resources Control, Minnesota Department of Health.

Stephen M. Jackson, Legislative Analyst/ Health, Minnesota House of Representatives, Former Consultant to Minnesota State Board of Health.

* * *

WHEREUPON, the following proceedings were duly had:

* * *

EXAMINER MIHALCHICK: The hearing will come to order. This is the recessed hearing entitled In the Matter of the Proposed Rules of the Board of Health Governing the Hospital Rate Review System.

I will just remind anybody who qualifies as a lobbyist to register.

Mr. Sattler, you may proceed.

MR. SATTLER: I believe we left off on Page 38, the middle of the page, Incremental Operating Cash Needs.

This entire section deals with what is commonly known in the accounting profession as working capital requirements. It suggests that a necessary financial requirement is working capital of institutions, and it outlines the methodology for calculating the working capital, incremental working capital requirement annually.

We move over to Page 39. There we see (2). This talks about working capital and that it is dependent upon the number of days charges in accounts receivable, and it lists some statement and reporting requirements.

Under (a)(b) it talks about the method of calculating the number of days charges in accounts receivable, and follows through with a discussion of receivables and what net receivables are, and how to calculate those receivables.

Then we go to Page 40. It talks about inventory and incremental changes in inventories, those being includable in the calculation; other net payables, and what those are.

(6) on Page 40 discusses the reasonableness of the working capital requirements and sets parameters for the magnitude of that requirement, and I ask if there are any comments or questions concerning working capital?

EXAMINER MIHALCHICK: Would you just state the basic

method of computing it?

MR. SATTLER: The basic method, without getting into the specifics is the net change, the incremental net change in liability -- in the current section of the balance sheet. It is rather standard accounting methodology, accepted in the public utility field, and unless anybody has any specific problems either with the calculation or the parameters I don't think we have any problem philosophically with the basic concept.

MR. VAN HAUER: Mr. Examiner, at what poing are our discussions limited; how far down are we?

MR. SATTLER: I think we can run over to Page -- the very top of page 41.

MR. VAN HAUER: Down to Paragraph 2. On Page 41?

MR. SATTLER: Yes, sir.

MR. VAN HAUER: Mr. Examiner, I would like to make a comment, if I may.

EXAMINER MIHALCHICK: Surely.

MR. VAN HAUER: My name is Mr. Van Hauer.

Generally we find the section beginning on Page 38, Subparagraph c. and the provisos on Page 39 and Page 40 acceptable. These are common accounting principles.

We do, however, have concern with Subparagraph (c) at the top of Page 41. That paragraph reads, "The amount of finances a hospital may hold in reserve funds," and this is under the caption of the preceding Paragraph (6), which reads, "The reasonableness of the working capital allowance depends upon factors including:" this includes the one which I have just recited.

Our concern is that the words "reserve funds" is a bit ambiguous. A hospital may, for instance, have its depreciation fund -- this is a matter which we debated yesterday at some length, and which Mr. Lamson suggested that the use of that fund should be described for four purposes.

In addition to that depreciation fund the hospital may have restricted funds which will come from whatever sources they may be, but which are recognized in the rules here as restricted. A hospital during a construction period may have construction funds arising from short-term interim borrowing.

To say that any of these three categories which I have just outlined, and there may be others, ought to be made part of the determination of reasonableness of working capital would be, I think, an injustice to the hospital.

Members of my team, do any of you have any other things to add?

(No response.)

At least those three major types of funds would be of concern, and it would follow then that the term "reserve funds" needs further definition or delineation because I don't think that it is the intent of the rules to overrun these items which I have just described.

MR. SATTLER: We certainly don't intend to get into the area of restricted funds. Obviously the use of

those restricted funds can only go to the purposes that it is restricted for. I think the intent was to just look at the overall current position of the hospital in determining the reasonableness of the requirement, so it would really get more into the unrestricted area.

EXAMINER MIHALCHICK: I don't understand how the reasonableness is measured. It just says reasonableness depends upon these factors. It doesn't say how it depends upon those.

MR. SATTLER: Yes, in (a) for instance, the number of days charges in accounts receivable for a hospital compared with the number of days charges in accounts receivable for other hospitals, similar institutions. In other words, throughout these rules we are generally looking at comparative groupings, and so in most cases we really don't have any other standard for them. They may be developed over time, but at the present time the best we can do is compare them, so throughout we will be looking at days charges in the comparative sense, inventories, with similar institutions.

We are devoting a great deal of time and energy to developing comparative groupings, groupings of various similar type institutions. We feel we can overcome a lot of the drawbacks in the whole system by developing these groupings and then relating hospital to hospital within that peer group.

Okay. (c), that would be one case where we probably could not look at comparative groupings, but would have to look strictly within the institution and

make an assessment as to the current financial situation and how that would impact the working capital financial requirement.

In other words, it may have a great deal of quote, "free funds" which may go to this purpose and may have very little so that we could apply zero of these free funds to meeting the working capital needs, so we would have to go back and look at the net changes in that area.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: Yes, I am Tom O'Hare.

I would just like to follow up on the dialog that just took place between you, Mr. Examiner and Fred Sattler. It seems to me that the meaning of Senate File 60 is that there would be a reasonableness determination in all these areas, and now we are in the working capital area.

If I understood Fred correctly, he said we will be establishing comparisons, but we would have no norms. I must ask the question as to on what basis then would the reasonableness determination required by Senate File 60 be made? In other words, if you have no norms what are you going to do with these comparisons?

In other words, if you have an array of hospitals classified and everybody has varying working capital requirements, you must have some yardstick to measure, so I am saying in order to be in compliance with Senate File 60 it is not sufficient to say we will develop comparisons. It must be a normative kind of thing.

Well, I would ask that question.

MR. SATTLER: Throughout these rules we talk of the peer group mean. We talk in terms of, for instance, in changes in inventory things that we can justify due to inflation, for instance.

I think the rules are replete with these kinds of standards.

MR. O'HARE: Well, for instance, you mention the mean. I don't know if it mentions the mean here. It says it will be compared with other hospitals, but does not say anything about the average amount of the comparison of the hospitals being compared would be challenged as being unreasonable, not necessarily that it would be unreasonable, but that would be the standard beyond which you would then determine this is open to question.

MR. SATTLER: I believe in number (6) we say that the number of days charges in accounts receivable -- which, by the way, I think we all recognize as being the most important aspect of any incremental change in working capital -- compared with the number of days charges in accounts receivable for other hospitals determined by the system to share common characteristics.

MR. O'HARE: Compared -- you know, I am six foot one; somebody else might be five foot ten. So what do you do now? Compare them and there is a difference of three inches -- so what?

I guess what I am getting at is trying to follow up specifically on your question, Mr. Mihalchick, what is the norm for comparison? There really isn't any.

There is a comparison made, but the question is what is the outcome of that comparison or how will a reasonableness test be established specifically, and not necessarily that a reasonableness test would be an arbitrary limit, but that it would set parameters and say at this point this is open to question, let's say at the mean or the 60% level or something of that sort.

MR. SATTLER: As we have specified in inventories.

MR. O'HARE: Perhaps we could suggest that be included.

I had just two other questions, I guess, on this section. Specifically on page 39, under the calculation there, under (2)(b), the formula.

It doesn't seem consistent. I am not sure what the implications are for the program. You start off with a numerator as being the total net accounts receivable, and then in effect you are dividing it by a further calculation, which is based on total patient charges for the same accounting period.

There should be consistency. Either then the numerator and the denominator should be total net accounts receivable, estimated, as in the case of the denominator since it is not known, or the numerator should be changed to total charges.

In other words, you are dividing one by the gross amount, or using one as the gross amount and the other as a net amount. You are not being consistent. I am not sure what implication that has. It is not quite correct, as I see it. I am not sure if it has any implications as long as you keep doing it the same way,

but just as a point so if it is appropriate that might be clarified.

The second question I would like to ask is under the way this is arranged, suppose -- well, I will try to answer a question if you have one on my point on that.

In other words, the numerator is a net amount, which is the net of a fractional allowance, and so on. The denominator is total gross charges, which, of course, is a much larger figure. The overall impact, of course, is to reduce the number of days in accounts receivable artificially, not that that would make any difference as long as it is being applied to everybody else, but it is an inconsistency. I don't want to spend a lot of time on it. I am not sure of the impact or the effect on the program.

Second I just ask the question under -- let us assume that every payor paid at discharge. What would be the working capital requirement of the institution? Under these rules would there be a working capital requirement under these rules?

MR. SATTLER: It is possible that there could be one, yes, sir.

MR. O'HARE: Could you --

MR. SATTLER: It is possible.

MR. O'HARE: What would be the rationale for that? I guess I am coming from the position that if in fact everybody did pay on discharge, making that assumption, so that there would be little need or almost no need for a working capital allowance and --

MR. SATTLER: That assumes that -- well, resources are used while the patient is in the hospital, which would receive payments to the extent that they are financing the purchase of supplies, drugs, salaries, prior to discharge.

MR. O'HARE: Of course, oftentimes payment is delayed, you know, in the sense too of you are using and not paying.

MR. SATTLER: You can compare that with the payables position. As I said, it is possible. I am not saying that they would.

EXAMINER MIHALCHICK: Will you explain that?

MR. SATTLER: It just depends upon the situation of the balance sheet actually, how the hospital's payable situation relates to its receivables situation; in other words, if they could structure it so that they delay payment on those particular items until payment is received. If they had to pay cash when they purchased, then there would be an investment.

EXAMINER MIHALCHICK: Anyone else? Mr. Lamson.

MR. LAMSON: My name is Ernest Lamson.

In reference to Paragraph (1) on Page 38, we propose that unrestricted cash and investments be included in the determination of working capital needs.

The rules now give consideration to unrestricted funds from non-patient sources, on Page 42, 2.b., and state that such funds should be used to reduce the total financial requirements of the hospital.

We believe our suggestion is reasonable as it would encompass changes in the cash position of the hospital

for all unrestricted funds, and would be included in the form which will be provided for calculation of working capital needs.

Also we propose a system be developed or we develop parameters for an acceptable rate of turnover of inventories by hospital peer groups.

MR. SATTLER: Let me answer that point first. We would hope over the next year or so that we would collect enough data to solidify the groupings; we would be able, of course, to form normative standards, such as you suggest. At the present time we don't have the ability to do that.

MR. LAMSON: No.

MR. SATTLER: We hope to move in that direction. Secondly, we do think that Mr. Van Hauer's worry does encompass your worry also, although you are on opposite ends of the worry scale.

I think (c) is the system's ability to look at those items and make judgments as to the applicability of those funds to the working capital requirements without specifically requiring that they come into the calculation as such, because we can see situations where it may not be appropriate to utilize the cash position in this calculation. In other cases it may be highly appropriate to utilize cash, and in another restricted funds in the particular case.

Again, it is one of allowing for some more flexibility rather than completely locking those items into the calculation, so we are trying to address that problem without being highly structured in approach,

so we are cognizant of actually both concerns, the concern that it be too highly structured for us and, on the other hand, not take it into consideration to the extent that we don't satisfy anybody.

MR. LAMSON: Okay.

EXAMINER MIHALCHICK: Anybody else on this subject? Yes, sir.

MR. EGO: My name is Charles Ego. I am a member of the Minnesota Hospital Association Rate Review Advisory Committee, and I would like to speak just a moment on this point for the Association.

The way the rules are constructed two things have been excluded from the calculation of working capital requirements. One is the cash plus investments that Mr. Lamson mentioned. The other one is the liability which might exist to third party payors. Those two things were excluded for a very good reason, I believe.

The liability to third party payors will fluctuate between years, depending upon the rate of holdback. Take Medicare as a for instance. If they are holding back or estimating a discount of say 10% from everything you bill them, and it later develops based upon the retroactive audit that the 10% should have been 5% or 15%, you are going to have a change in your liability to Medicare at the end of the year.

The reason both of these were left out was on the basis that if the liability is too high this year the chances are, or there could be an offsetting increase in your cash balance. During the next year you are going to use that cash to get rid of or pay off that

liability, so at the end of the next year your cash balance is going to go down.

For that very reason, due to these timing differences, I think it was very well to exclude both of those elements from the calculation.

Another point on that is the fact that what this calculation is trying to measure is how much cash should be tied up in the form of accounts receivable, inventories, minus the payables. To do that you complicate and you really confuse the calculation if you include in there as one of the elements the very cash figure you are trying to determine.

If the cash is going to be the same at the end of two years, it has a zero impact on the calculation anyway. To the extent that the cash balance is going to change between years because of more or less liability to third parties, then you have an actual distortion unless you bring both elements in, so I think the rules were properly stated by excluding both of those.

Thank you.

EXAMINER MIHALCHICK: Mr. Van Hauer, did you have something?

MR. VAN HAUER: Yes, Mr. Examiner. I would like to speak to three matters.

One is a small suggestion, a language change, on page 39 in Paragraph (2) in the last sentence. The last sentence reads: "These days charges should be stated in aggregate for an accounting period -- " and we would like to insert the word "also" following the word "and," so it reads, "and also a statement of ac-

counts receivable by payor."

The purpose is just for clarification, because there are two different statements to be compared.

We would like next to speak to two issues raised by Mr. O'Hare. One is to assure him that the fraction set forth in Paragraph (b) on Page 39 is the one customarily used. What it means is this: The total receivables on the books at the end of an accounting period are divided by the fraction below, and the fraction below is the average charges per day which have been accrued for that period. By taking the total charges for the period, dividing it by the days in the period, you arrive at an average charge per day. Then the question is by dividing those into the total receivables you determine the number of days charges which the hospital is carrying on the books.

You will find, as we have, by examining the records of the hospitals in the State of Minnesota very typically these fall in the range of 55 to 60 days. It is hard to get them under 55 days because the laxity of payment is not that great. If it gets over 60 days, then the business office people get busy to try to speed up the collection process and bring it back down.

The second point which Mr. O'Hare raised is whether it would be possible for a hospital to operate with zero working capital. This would not be possible for the reasons which were advanced in part by Mr. Sattler. There does need to be provision of inventory, and while it might be said that you can put off paying the inventory, in a practical sense that doesn't work either.

There are other charges which require that there be cash on hand. Among them payrolls have to be met, so that the notion that a hospital could function without working capital is an ephemeral dream and not one which could be realized even if everyone paid cash on the barrelhead at the time of discharge. Thank you.

EXAMINER MIHALCHICK: Mr. Sattler.

MR. SATTLER: The only comment I was thinking about that calculation on Page 39, (2)(b) is that actually it results in a lower working capital requirement than would be suggested.

MR. O'HARE: Yes, I am fully aware of that, and the inconsistency, of course, results -- you know, a hospital that has lower contractual allowances, the lower reductions in income, revenue, will have a different figure under this system than another hospital providing say equal services with a lesser amount of reductions from charges. In other words, it is sort of a distortion.

What we are trying to determine here is how many days working capital are necessary and the working capital is really based on, you might say, the -- you know, it should be based on the net really if it is going to be figured out. It shouldn't be based on the gross. It just brings up all sorts of inconsistencies. It is going to make one hospital's accounts receivable, days in accounts receivable, look distorted versus another's merely because of the contractual allowances between the hospitals. One may have more reductions in revenue, is what I am saying. It is not a consistent

formula.

Maybe it is uniformly used in this manner. I have seen it stated in other places, using net in the denominator for that lower calculation; therefore, if you are using both the same you are coming out with consistent figures.

We are looking at working capital and trying to relate it to ongoing expenses of the hospital. Gross charges are not related. You know, in other words, that is an ephemeral figure, to use the same word. That is not a realistic figure. What you are trying to do is figure out how much the hospital needs to meet its ongoing needs in a short term, and charges don't relate to that because that is not what you use. Really you start with charges, but then when you start reducing the charges down to what you are actually going to get, you take out contractual allowances, bad debts and charity, and, well, that is the figure you work with. To use it here, I think, creates somewhat of a distortion between hospitals because each hospital's reduction in revenue is going to be different.

MR. SATTLER: We will take a look at it.

EXAMINER MIHALCHICK: Anybody else on that section?

(No response.)

I see none.

MR. SATTLER: Okay. Page 41, Income from Sources other than Patients. This section deals with a whole area of income from endowments, gifts, donations, things

of this nature, and the method in which they will be handled to determine the institution's total financial requirements; in other words, which are to be offset and which are not to be included.

If we look down at a.(1) we see that generally speaking restricted endowment funds should be used for the purpose that they are restricted to or restricted for. The specific purpose funds should be used for those particular purposes, and gifts that are restricted by the donors should be used for the purposes that the gift was made for.

We have an amendment on page 42 to (5), and it is basically to delete the entire section. The reasoning behing that is that is redundant. Here we are stating in (5) that income from restricted funds to be used for charity care must be used for charity care, and if it is restricted for that purpose it has to be for charity care. We state that above, restricted funds have to be used for the purpose for which they are restricted, so we think it is redundant and, therefore, not necessary to include in the rules.

Then we jump to --

EXAMINER MIHALCHICK: Let me interrupt you and go back to (3). Would you explain why that is in there? It is fairly obvious, but would you explain why?

MR. SATTLER: Okay. (3) deals with the possibility where the hospital receives a gift for a specific purpose and then chooses to undertake that particular purpose; in other words, you get money for an x-ray machine and you choose to purchase a new x-ray machine,

and then for one reason or another decide to go out and borrow funds for that x-ray machine rather than apply funds that are set up in this endowment or gift.

We are initially saying that, number one, you should use that gift or those restricted funds for that particular purpose but we are essentially leaving some flexibility in the approach and saying that if it really is in the patient's best economic interest to borrow money for some alternative use and for something else, and again it is incumbent upon the institution to prove this point to the system, we are saying that they may well borrow funds and it will be recognized as financial requirement.

One, it is a section that is put in for flexibility purposes. It is not intended to be used with great frequency or regularity.

EXAMINER MIHALCHICK: Mechanically how does the system protect itself? Are all restricted funds listed and the purpose listed, and then you go through and compare them?

MR. SATTLER: We get a listing of the restricted funds on the order, on the financial statement, and then in the reporting requirements.

EXAMINER MIHALCHICK: Is it fairly easy to tell what the purpose of the restricted fund is, or are there questions there?

MR. LAMSON: It should be laid out pretty clearly on the balance sheet. Normally it is.

MR. SATTLER: It might be an area that we should look into on the reporting requirements. I think it

might not be that explicit. It may well be in footnotes to the balance sheet and may not necessarily be all of the specific purposes.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: I was just going to refer to the revenue and expense report in the reporting section does, unless it has been amended out, ask for a statement of any change, source, application of funds, but again, I guess it would probably break down restricted and unrestricted and further Board restricted would fall under unrestricted, but I don't know if it would show exactly what the purposes are. I don't think they generally do.

MR. LAMSON: No, they wouldn't necessarily show specifically it was for a piece of x-ray equipment, to build a wing -- well, in that case it might, but there would be backup which you might have to go to to determine specifically what it was for. The backup would have to be there.

MR. SATTLER: We do not require in these proposed rules an enumeration of the purposes for the restricted funds.

EXAMINER MIHALCHICK: Well, we are back to my original question. How does it get caught? How do you find it?

Mr. Fearing.

MR. FEARING: I think potentially in the submission if there was an erroneous statement it might not get caught, but the rules also call for an audited financial statement to be submitted, and one of the things

the auditors do is to review the background Mr. Lamson was talking about of these funds, and they classify on the balance sheet the funds between restricted and unrestricted, so you could catch it that way in a subsequent period if there was an erroneous statement in the submission.

MR. SATTLER: A question: Would they in their audit comment on the alignment of funds for the specific -- you know -- you have restricted funds for x-ray, the purchase of an x-ray machine. Do they require or do they make some comment that while you had a specific purpose fund it was or was not used for that particular purpose?

MR. FEARING: I don't believe they would, but I think Mr. Potts could probably answer what they do in that situation.

MR. POTTS: I am Robert Potts.

No, generally not unless it was very significant.

MR. SATTLER: Not unless it was large?

MR. POTTS: They indicate that there is a usage of a different dollar amount for a different piece of equipment. It would be shown in the total as restricted, not by what it is restricted for.

MR. SATTLER: This is an issue that we might want to get back to in the reporting requirements.

EXAMINER MIHALCHICK: Mr. Van Hauer.

MR. VAN HAUER: Yes, Mr. Examiner and panel, I would like to speak to some matters on Page 42, not taking them exactly in sequence.

I would like to address Paragraph c. Auxiliary

Enterprises. I would like to suggest that the word "profits" be replaced by the words "gains or losses"; that between the word "should" and the word "be" be inserted the word "not" so it would read just the opposite way: "should not be," and I would suggest that the word "primarily" be struck. It would then read, under Paragraph c. Auxiliary Enterprises. "Gains or losses from such enterprises operated by hospitals should not be used to offset the financial requirements of a hospital."

I would further suggest that the next sentence be deleted in its entirety.

Now, the reason for this suggestion is related in part to the definition of Auxiliary Enterprises which is on Page 2. These are significant continuing revenue producing activities not related directly to basic care, but are found in institutions for the convenience of employees, physicians, patients, visitors.

A very typical enterprise is a parking ramp, and that parking ramp may remain a self-sufficient and profitable, and yet it may be an absolute necessity. We would suggest that neither the gain nor the loss from such an enterprise be used in determining the financial requirements but to simply set it apart.

I would like then to speak further to Paragraph b. on that same page. It is the position of the Association that we are totally opposed to the provisions in Paragraph b. dealing with unrestricted funds, and indicating that such funds should be used to reduce total financial requirements.

The reasons why we are completely opposed, and this is one section -- one of the very few points in the entire rules where we find ourselves in complete disagreement with the rules -- the reasons are first that this will preempt the authority of a local hospital board who can best determine what the intent of a donor may be and what the needs of a hospital's community may be.

Once this becomes a rule this is bound to have a serious and an adverse effect on philanthropic giving in the future. Philanthropy has diminished to some extent within recent years, but certainly no agency should undertake to formulate rules which would further discourage the possibility of wealthy people providing funds to a hospital.

I have in mind, for instance, one of our hospitals which happens to be in South Dakota -- thank God it won't be subject to this rule -- where a wealthy woman left a considerable sum to the hospital and entrusted it to the governing board of that hospital to use. Now, in discussions with the deceased's attorney, and with members of the board, I find that there was indeed an intent on the part of the donor that this not be used up in the daily operations of the hospital, but that it be put to some permanent use.

Now, you might argue that that individual could have gone on to specify in detail what that use was. The individual, however, in discussions with the hospital board was persuaded that it would be better to entrust it to their hands; after all, they are trustees

and trustee does embody obligations. It would be better to entrust it to the group of people for their decision as how best to employ those dollars in the future.

A second point is that when such funds are by decision of the governing board earmarked to be kept for long range plant and additions when such improvements are authorized by a certificate of need, the amount of borrowing for those additions can be reduced, and the eventual cost to patients by not having to pay interest can be reduced and, further, the interest earnings on these funds can be used to further reduce the borrowings, all of this being to the best interest of patients.

It should be noted that it is only patients who will eventually benefit by such deployment of funds because there is no other place for the fund to go. They either go into investment in the plant or they are eaten up in operations. It can't be diverted to profits or bonuses or otherwise taken out of the health care system.

Lastly, it doesn't make sense that patients in one year should get a free ride just because a windfall legacy materialized during that given year.

I know that the point has been made by other speakers that it is today's patients who should be benefitted, but today's patients shouldn't be charged for tomorrow's patients, but these are rather short range considerations. We are looking at a health care system. We are not looking at one year of operation. We are looking at a long and continuous period of opera-

tion, and we do have to make judgments and these rules happen to be formulated to support such judgments that in the long run the best interests of all of us is served and not just the short range. Thank you.

MR. SATTLER: Okay. I have not had a chance to justify those sections, but I will justify them in the light of Mr. Van Hauer's comments perhaps.

First, b. on unrestricted funds. It is the position of the Department that, number one, it would be appropriate to offset unrestricted funds to financial requirements because we feel it would be in the current patient's best interest to do so. We feel, as you pointed out, a donor could well restrict the funds if it was truly an intent to do so to specific purposes. In the long run we believe that through the price level depreciation and current depreciation we do provide funds for future expansion, so that funds are built into financial requirements to meet these needs, and that it would be appropriate then to offset unrestricted funds to current operations.

In addition, accountants generally, and I think always, under generally accepted accounting principles classify unrestricted donations as current income, and, therefore, it should be used to offset current expenses.

Also, the Internal Revenue Service in dealing with trusts and gifts, particularly trusts, do make a distinction between revocable and irrevocable trusts, and that if the Board is going to designate -- the Board of Trustees is going to designate these unrestricted gifts it is in the form of usually an irrevocable

trust and, therefore, they can change the intent of those funds year to year, and IRS would then see that any trust situation that is irrevocable -- revocable -- I said it backwards -- if it is a revocable trust is subject to normal taxation, and while we are speaking of a non-profit corporation which does not involve itself in taxes as such, I think the principle would still apply to revocable and irrevocable, but if the donor were to make a gift and restrict that gift that is in the form of an irrevocable trust, and, therefore, would be sheltered and used for that specific purpose. If it comes in as unrestricted it would be Board's prerogative to designate those particular funds, and the accounting profession makes a distinction between restricted gifts and a board-designated gift -- board-designated fund, as IRS would with a revocable trust and, therefore, subject to normal taxation, so we think there is precedent both in the accounting profession, tax law, and generally the argument that it is necessary in the long run I think we cover through other financial requirements and we believe that it is in the current patient's best interest to handle those gifts as an offset to financial requirements.

EXAMINER MIHALCHICK: I don't think that revocable and irrevocable have anything to do with restrictions to particular uses. That statement confuses me.

MR. SATTLER: Okay. I think the distinction is that if the Board were to designate unrestricted gifts, the restriction is a matter of form. In other words, they can restrict a given amount of money this year

for Purpose X; the next year they can turn around and take that same money and designate it for Purpose Y, and they can constantly change their designation, "we will use it for this one year; this another year, something else another year," and see it as a method for accumulating sums of money which it was argued yesterday may not be in the best community interests, but in the way of sheltering these dollars to maximize financial requirements.

EXAMINER MIHALCHICK: Mr. Lamson.

MR. LAMSON: Fred, it may be possible to do what you have suggested at a hospital, but in actual practice I don't think it is done.

I would propose really that this be handled the same way as it is on the Medicare, and that is allow funds to be Board restricted.

EXAMINER MIHALCHICK: Medicare does that?

MR. LAMSON: Medicare allows funds to be Board restricted.

MR. SATTLER: Medicare does not allow for price level depreciation --

MR. LAMSON: Correct.

MR. SATTLER: -- and other plus factors which this particular program builds in to purposely cover some of the contingencies that Mr. Van Hauer talked about and things of this nature.

I think there is a real possibility here of taking these rules section by section and not saying how each one of these sections relates to the total.

MR. LAMSON: I agree with that, Fred, but what I

am saying is that if there was something in the rules that would specifically control what you are talking about, that is restricting it one year and changing it in the next when you have a Board restricted fund. I think that there are several institutions where fairly large sums of money have been donated to the Board, to allow them to restrict it as they have seen fit.

MR. SATTLER: There really is very little saving to the public if you take these funds, restrict them for capital use in the future and use them for capital use. The only true savings is in the interest area because we are still providing for price level depreciation on these assets, and straight-line depreciation on these assets, so that the patient only benefits to the tune of the interest, while if it comes in as a dollar for dollar offset to financial requirements the patient benefits to the full extent of those dollars.

I think if we were to put in a provision that if these funds were restricted to use for capital purposes that we don't depreciate them, we might be getting more to the heart of the matter here, if it is truly a gift. I think that might be a reasonable compromise in this area, and say, yes, the Board may feel that it can divert these funds to areas where it is needed and maybe shouldn't go directly into operations, but, on the other hand, we do provide, I think, to a great extent the coverage for capital financial requirements of accumulating funds over the years. We allow the institution to go into rates, as a matter of fact, to accumulate more money, if necessary, to meet expansions.

We are not limited the way Medicare limits institutions from getting money, and, you know, Medicare recognizes the fact that, yes, it is quite constraining in its approach, and all they are interested in is not paying more dollars out of the trust fund. They say, "well, if you get additional money through gifts it doesn't cost us that much necessarily, so we will let you restrict it."

Here we are taking a much broader approach, I think, than Medicare does.

EXAMINER MIHALCHICK: I wonder in trust law if you are designated to the Board as trustees to apply the restriction, isn't that as a matter of fact donor-restricted?

MR. BREVIU: You are talking about a sum of money which is designated to the Board of Trustees of the hospital to do with as they choose?

EXAMINER MIHALCHICK: Yes.

MR. BREVIU: The question really you are asking is, is that revocable or irrevocable?

EXAMINER MIHALCHICK: No, I am asking if then the Board could designate the restriction in their position as Trustees rather than the recipient; isn't that in fact donor-restricted?

MR. BREVIU: I guess it would appear to me that since they are also in the capacity to change their restriction at any point in time, and since they might be regarded to a certain extent as beneficiaries, I can hardly regard that as donor-restricted. I think that they would not be fiduciaries in the true sense of the

word.

EXAMINER MIHALCHICK: The purely donor-restricted ones aren't limited to not changing the restriction, or are they?

MR. SATTLER: Yes, I believe they are.

EXAMINER MIHALCHICK: They are.

MR. SATTLER: If it is donor-restricted it has to be for that purpose.

EXAMINER MIHALCHICK: Okay. Mr. Van Hauer.

MR. VAN HAUER: Mr. Examiner, members of the panel, we are not at all persuaded by the arguments which have been advanced by Mr. Sattler and by you. This still constitutes an invasion in the area of the private sector. To have an agency take away from the private sector the right to make judgments in the course of their trusteeship is an unwarranted intrusion, and one which should be resisted by anyone who is concerned about the continuing encroachment of governmental agencies into the realm of private business.

The argument has been advanced, which we think is a somewhat spurious argument, that if a Board can restrict a fund this year, they can change that restriction the following year. Now, let's pursue that just a moment.

The following year they have the same two options, either to apply it to the operations of that year or to continue to restrict it for some other capital fund purpose. To take away from the Board that right is again unwarranted. Changes in technology are constantly occurring in the medical field. What today is an appro-

priate use of funds may tomorrow no longer be a useful designation. That is why you have Boards of Trustees who are empowered, who are carefully selected for their ability to make these kinds of judgments. This is their primary responsibility.

Now, the point has further been made that the price level depreciation takes care of replacement of the funds. Well, it might or it might not, as we saw yesterday in the discussions we had, as to whether or not that fund with price level depreciation, with interest earnings, will in fact ever completely reduce the need for borrowing, and we were not persuaded that it was, but even if it were, this would simply say that the state of the art will remain as it is, and all that we will have to be confronted with is inflation and the cost of maintaining the state of the art, but the state of the art is not static. It continues to advance and expand. Constantly we are being presented with new technology. The current example, and everyone in the health care field in this state and elsewhere is thoroughly familiar with it, is the computerized tomography units, known as CAT or CAT Units. This is a new advance in the field of radiology, extremely important and valuable, and usually an extremely expensive one. A CAT Unit installed and running represents somewhere in the range of $650,000.00. Two years ago there wasn't any need to add such a piece of equipment to the hospital's armamentarium. It didn't exist. Today it does exist. If we are going to continue to improve the quality of diagnostics in our hos-

pit[redacted]s, then those tools which [redacted]end themselves to better diagnosis must be provided. If it was your illness that was being diagnosed you would want it, and so would I.

So then getting back to this matter of whether or not unrestricted funds should be thrown into that particular year's operation, we must continue to most strongly oppose it for the reasons which we have advanced, and we are not persuaded as to the validity of the arguments to the contrary. Thank you.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: I would just like a point of clarification on unrestricted. What is meant by unrestricted funds? Is that the corpus of the fund, plus the income on the fund, and I don't think the intention here is to take a substantial amount of money and throw it against operations in a single year. Is that what you are intending here?

MR. VAN HAUER: That is what it says.

MR. SATTLER: Well, a number of things. First it is not intended to attack the corpus of substantial existing unrestricted funds in hospitals now. We don't think that would be fair, to go back retroactively and start applying those funds. On the other hand, we do think it is reasonable to get at the income of those particular funds, so that is the first.

In the next case, for current gifts in the unrestricted area, we think that there really should be some latitude in the way that is handled. In other words, if an institution will get a gift of a million

dollars we do not necessarily think it is appropriate to put that million dollars into operations in the current year. It may be appropriate, and I just throw this out as an example, to set up a schedule where over a ten-year period interest and principal will be depleted throughout operations.

The intent is to provide some flexibility and work both in the patients' best interest and in the institution's financial interest. We are not here to bankrupt institutions, nor are we here to bankrupt insurance companies or payors. You may disagree with that.

EXAMINER MIHALCHICK: Where is that allowed; where do you apply income and prorate it?

MR. SATTLER: Well, the specific language isn't there, I would admit, but it seems reasonable. Again, this comes into the problem with the Administrative Procedures Act and some of the other things we are talking about, the methods of handling certain items which are apparent should be handled in one way or in another, and where the system needs some discretion in applying these rules.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: I guess I somewhat agree with Mr. Van Hauer's point, and somewhat also feel that these monies were given for the use of the community, derived, in effect, from the community or a wealthy person or foundation in the community, and should be used for their intention and should not be considered outside the purview of the program, but I think when you say unrestricted funds -- maybe it is vague enough that it

doesn't mean much, but if I were taking a very strict interpretation of this wording, it would mean unrestricted funds, both the income and the corpus could be thrown against operations of the hospital in a rather arbitrary fashion. I think that should be clarified as to a standard, insert something, a standard would be developed for how this would be spent based on moving averages of previous years, or something like that, but I think the way it is stated right now I can certainly agree with the point being made by Mr. Van Hauer that it is just a little too loose. As much as I am on the other side of the fence saying the total financial requirements should be -- the source of income should be disclosed and utilized as appropriate and should not be outside the purview of the program, but I think it should be clarified.

MR. SATTLER: There is one thing you have to realize with these rules. This is a review and comment situation. Under no circumstances is a hospital forced to comply with any of the comments that are made and as such has the right of public hearing to any comment that the system shall make to determine if in fact the system was reasonable when applying these rules, so that in many instances in these rules we quire possibly have been a bit vague, but it is basically a review and comment. Now, we are not saying that we are setting rates based upon these rules.

EXAMINER MIHALCHICK: We are going to end up with a comment that this was questionable and the hospital is going to say no, it wasn't, they think it should have

been restricted for this purpose.

MR. SATTLER: I think this is why we have recourse to public hearing, you know, when the system comments upon rates, costs and charges of an institution.

These are guidelines, by the way. They are not 100% fixed criteria for determining what a hospital's rates and charges should be. In any one instance there may be some variance. The institution may be at variance with the rule and that overall rates may still be considered to be reasonable.

I would also like to point out that I do submit that funds for any contingency and any purpose that an institution may feel it needs to restrict gifts for are provided for in -- well, beginning on page 34 b., plant capital needs. Careful reading of those pages under that section will, I think, readily show that the institution can, when necessary, receive additional funds to meet the needs for new technology, new equipment, either via the depreciation method, via the price level adjustment, or on page 37 (c) approved inclusion in rates when the hospital can demonstrate that insufficient resources exist, and what we are saying is that we are accumulating funds. Let's see when you need it. Let's not just take an unrestricted gift that was given to an institution and put it away someplace and mothball it. We do make adequate provision. If we didn't, I would say that you might have a point.

EXAMINER MIHALCHICK: Mr. Fearing.

MR. FEARING: Just a couple of other comments which

are pertinent to this issue, and that is Mr. Sattler mentioned that there are other provisions for the plant capital needs, but as we have come through the regulation I think we all realize there are areas that are not provided for. Charity is an area which is not significantly provided for unless covered by the law; research is an area which is very restricted in here; Mr. Van Hauer's earlier comments with regard to auxiliary enterprises, that the hospital support a position where these areas be eliminated from these rules, and we allow it to be self-sustaining on their own and not supported by patient care at all. This is another area that can be supported through unrestricted contributions from auxiliaries, Women's Auxiliaries, and so on, so I think there are areas where funds, provisions have not been made for utilization or for covering offsets incurred by the hospitals which they cannot recover through this program. Thank you.

MR. SATTLER: I didn't get to auxiliary enterprises.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: Going back, if I may, to page 41, it says, "Income from endowment funds or gifts restricted by donors to provide for buildings and movable equipment should be used to reduce the designated building and movable equipment capital needs, as appropriate."

I think while I certainly agree that income is appropriately thrown against those capital needs, I must ask a question in light of the discussion yesterday on price level depreciation as to why is it not appropriate to consider the entire amount of funds so

restricted as an offset to these price level factors?

If what we have to do is preserve, you know, allow the hospital to preserve its status, and in fact it is getting straight-line depreciation and it is funding it and all its other financial requirements are being met, why is it then that in lieu of, or as an offset to price level the entire endowment fund should not be considered as an offset?

MR. SATTLER: Just a quick example. The terms of a trust may read as follows: "When the appropriate time comes in two years," or whenever, "you should use these funds for the new wing." While they are sitting for the two years we are using the income to offset the capital requirements in the current situation. We don't have a new wing. We can't use it to offset the capital requirements on the old wing. That is why.

MR. O'HARE: Well, okay.

MR. SATTLER: Now to (4) c. First I would wholeheartedly agree with some of Mr. Van Hauer's suggestions, changing the word "profit" to "gains." I would have no problem with that change. Changing "profits" to "gains or losses" I might have a problem with that and then putting the word "not" in there.

I think the intent of the Department was to circumscribe the way in which monies can be used within an institution and to limit those to patient care areas.

We find it possible for hospitals to expand their scope of enterprise in these auxiliary areas to many other things, including medical office buildings, parking ramps; we even have some with racquet ball courts,

things of this nature, and we would hope that, and actually require, these enterprises if the institution wants to get involved, fine, but let's not ask the patient in bed to pay for that racquet ball court, and say "if you want to run it at -- " well, I could also go along with saying that it should be profitable. I don't think they have to be profitable. If the hospital would like to run those enterprises at a loss, that's fine also, but they shouldn't be subsidized by the patient, and if the institution wants to get involved in these particular enterprises, that any profit should accrue to the benefit of the patients rather than the institution per se, or Board of Trustees or the administration.

EXAMINER MIHALCHICK: Mr. Van Hauer, your comment would have made these completely separate?

MR. VAN HAUER: Yes, standing completely apart from the hospital operation. The patient would not bear the loss, neither would the patient gain by any profit should a profit eventuate.

EXAMINER MIHALCHICK: Would these be reviewed in any manner?

MR. VAN HAUER: What purpose? I have no objection to it being reviewed, but what purpose would it serve if the outcome, either plus or minus, is not to be made part of the determining the hospital's financial requirements?

EXAMINER MIHALCHICK: Any other comments on auxiliary enterprises? Mr. O'Hare.

MR. O'HARE: Just a side comment. I was just

wondering what happens; how does the system consider such enterprises as medical, physicians' office buildings?

MR. SATTLER: Auxiliary.

MR. O'HARE: Auxiliary? They would fall in this category?

MR. SATTLER: Yes.

MR. O'HARE: Boy! I don't think I would like to see all that outside this program's purview in terms of both losses and gains. I would expect they should be able to break even and hopefully be able to supplement the income of the hospital because they are actually there for the patients, for the patients' benefit.

MR. SATTLER: The physicians' benefit, which may not necessarily be the patients' benefit.

EXAMINER MIHALCHICK: Except that your own definition talks about "physicians, patients and/or visitors."

MR. SATTLER: Whereabouts?

EXAMINER MIHALCHICK: Back on page 2, 472 D. "business like activities commonly found in health care institutions for the convenience of employees, physicians, patients and/or visitors:"

MR. SATTLER: I don't understand the question.

EXAMINER MIHALCHICK: Well, I thought you just said you regard all these as benefits for the physician.

MR. SATTLER: Medical office buildings specifically. In other words, there are things in here that -- for instance, you may have a coffee shop. Most hospitals have a coffee shop. Who should be bearing the financial burden of that coffee shop? Should it be the

patient in bed or those who use the coffee shop?

Our contention is those that use the coffee shop should bear the burden of the coffee shop. That's fine. We are saying that if there is a loss incurred in running that shop this should not find its way back into the patients' charges, and I don't think there is any argument from any side that that is inappropriate.

EXAMINER MIHALCHICK: You are saying any profit should find its way in?

MR. SATTLER: Right. The reason we are saying that is it does take a great deal of time and effort, and it is located on the premises; it is an enterprise that the hospital is involved in and, therefore, the benefactors of any of those enterprises should be the patients.

MR. VAN HAUER: Mr. Examiner, I would point out this is obviously a one-way street. It operates only for the benefit of the system. If the operation makes a profit it is to be to the benefit of the patient, but if it operates at a loss that is not to be allowed. Obviously this is illogical. That is what led us to propose that neither gains nor losses be charged to the hospital's financial requirements; simply set this aside.

I think the coffee shop should operate to break even. If it doesn't, management better make it arrange to do so.

MR. SATTLER: We also provide for the total institution for the patients, we do provide for excess in earnings so that we do provide for, in the true, pure

accounting sense, a profit on the operating statement for the total institution.

EXAMINER MIHALCHICK: I am just looking at that definition again. I guess strictly speaking it wouldn't be an auxiliary enterprise if it didn't produce a revenue.

MR. SATTLER: Or it can be a cost associated.

EXAMINER MIHALCHICK: Does it say revenue?

MR. SATTLER: It says, "An activity is significant if either its revenues or direct costs exceed twenty cents per in-patient day." It could produce zero revenue and have a cost associated.

EXAMINER MIHALCHICK: Okay. Any other comments on that?

(No response.)

Let's recess until 10:55.

(Whereupon, a recess was taken.)

Back on the record.

MR. SATTLER: On page 43 d., Special Projects Income. Here we are saying essentially that if there are special projects going on and funds specifically designated for those special projects, that these funds be considered offsets to financial requirements.

We move on to e., "Income from Sources Other than Patients used as Offsets to Rates should never result in a condition where charges are lower than the actual

cost of providing care for purposes of reimbursement by third party payors or by governmental programs."

Here again this is in reference to Public Law 96-203, Section 223, where the Medicare stipulation is that they will reimburse at the lower of cost or charges. Here again we want to be careful that we don't impose offsets that Medicare does not impose, which will cause the hospital to use potential Medicare reimbursement solely on the basis of charges being lower than costs.

MR. O'HARE: I would merely like to ask a question. Somewhere I recall that section in the amendments of '72, and there is sort of a roll over provision into the subsequent year in that if you get stuck one year you have the opportunity of picking it up by picking it up the following year. By being "stuck" what I mean is if you do hit the charges lower than costs for Medicare, in the year that occurs they will not pay higher than the charges in that case but, as Fred is pointing out, apparently two years is allowed, and I would anticipate that that would be taken into account here.

MR. SATTLER: What we are really addressing here is the offset situation. In other words, when we look at costs we are saying that prospectively if the institution sets the charges at a certain level based strictly upon say Medicare approved costs, and their actual costs are higher than those approved costs, they may well suffer lower charges perhaps. What we don't want to do is force an institution into that situation as a result of the way in which we handle certain items

of financial requirements, such as offsets and things of that nature. That is the reasoning for Paragraph e.

EXAMINER MIHALCHICK: Any other comments on d. or e.?

(No response.)

MR. SATTLER: Just as an additional follow up on Mr. O'Hare's point, it is possible to roll over if -- we do have a section where we do some volume adjusting of rates. If it was found that due to inaccurate projections that the rate actually should have been higher in the preceding year, we would then allow that situation to follow through for Medicare purposes, but it is more appropriate to discuss that under that section, which is the following section.

Any other comments on that?

(No response.)

Page 43, 3., Variations from Budgeted Volumes of Activity and Service. This addresses the point where the Department will see a need to possibly make an adjustment in the institution's rates in the year following the prospective or budgeted year, and the reason is we realize that budgeting volume is perhaps difficult and we would like to make the impact of volume neutral. In other words, if an institution should overproject its volume for a given year it would necessarily mean that its fixed costs per unit would be set at too low a rate, or the cost per unit could be

higher than anticipated. As a result we would like to be able to adjust for that inadequacy in the rate in the coming year and, likewise, if an institution under-projected its volume its fixed cost per unit would be lower than initially, but the rate would be too high, therefore, we would have to lower the rate in the coming year, so the attempt here is to make volume neutral and recognize the true fixed cost per unit that an institution has in a budgeted year.

I would also like to point out that we are offering an amendment on page 44, Subparagraph b. We would like to add the following words in the second to the last line of that paragraph between the words "the" and "budgeted" we would like to add "differences between the actual and," budgeted income of that service center.

That is consistent with the wording in Subparagraph a., and actually makes it the appropriate way to make that calculation. We had an error in the calculation methodology by omitting those words.

By the way, this particular approach is being used in other states in their rate review and rate setting systems for hospitals.

We have also offered a rather lengthy justification in methodology for doing this in the justification, and reference three alternatives. You might not have had an opportunity to read those.

That justification runs, by the way, from page 61 to page 67 in the Statement of Justification.

EXAMINER MIHALCHICK: Do you want to take comments

on that section?

MR. SATTLER: I think we better.

EXAMINER MIHALCHICK: Any comments? Mr. Ego.

MR. EGO: The Hospital Association is of the view that this Paragraph 3 is very complex, very difficult to administer, and should have further study before it is implemented.

In the meantime we would propose that the method of trying to adjust along these lines be handled in a different manner, and I would like to explore those points with you.

In the first sentence in Paragraph 3 you start out talking about changes in rates, and I think it is important as we read that to remember what the definition of a rate is, under which program. There is a single rate for the institution, and this rate is the adjusted income for adjusted admission, so that is an overall composite picture of the hospital.

I think it is easy to confuse the word "rate" and think in terms of what is defined herein as charges, charges being the specific amount that we put on a patient's statement for a specific service, so in this first sentence if we are saying that changes in rates may be necessary during a budget year as we observe that the volumes of activity and service are not coming up to expectations, it is not as simple as just changing a few numbers because the entire rate structure would have to be addressed in order to have the impact on the overall average.

I am not sure why this thought was brought in here

because under the a. and b. which follow we are not talking about that rate, but we are talking now about the specific services in a specific service center. When you do that you are talking about something different. There is a relationship, but it is not a direct one.

In a. you talk about volume, and in the latter part of a. you talk about the income loss. We are a little confused by that wording.

I think Mr. Sattler has probably clarified it when he said that both a. and b. mean the same thing even though they are stated differently.

In b. it is quite clear that what we are talking about is a difference between the actual and budgeted income, so I think that point has been clarified. That is the same thing as under a.

Both a. and b. make reference to fixed costs for a service center. We find this to be a very difficult concept to have in here and we will go into that further in a moment.

I would like to quote from the justification that Mr. Sattler referred to earlier. On page 61 we have these words, which I think are very pertinent: "The purpose of this provision is to allow for equitable rate adjustment to losses resulting from unrealized budgeted activities. Consistency then requires that hospitals not be rewarded for exceeding projected volumes. A word of caution about this provision. Since methods of assessing variations as needs are not particularly well developed, the system cannot extricate

a more precise rule. It is likely to be several years before a pertinent review system regarding this issue is developed."

Going on to page 62 it says: "It is widely acknowledged that techniques for volume forecasting lack sophistication and accuracy."

Going on to page 63: "Examples of these fixed costs include such factors as interest, depreciation, insurance, allocated costs appropriate to a specific revenue center, and staffing and supply costs necessary to maintain minimal services within the revenue center."

I would like to direct your attention there to the phrase, "allocated costs appropriate to a specific revenue center," and what that means, of course, is that certain so-called fixed costs in a hospital would have to be prorated among all of the revenue centers in that hospital. That would be a necessary step in order to arrive at a judgment of the fixed costs for a revenue center.

On page 64 we see the following comments: "Empirical studies in the identification of fixed and variable costs is extremely limited in the hospital field."

Going on, on the same page: "The system will initially apply fixed to variable cost ratios varying from 80% to 20%, and 60% to 40%, to hospitals as they increase in size and complexity of services. Each institution's fixed to variable cost ratios will obviously vary according to the age of the plant, the amount of fixed long-term debt, repayment schedules, and interest, as well as the level of utilization of the services pro-

vided and the level of productivity attained within each cost center within the hospital."

Page 65: "In recognition of these factors, the system proposes three alternative procedures for identifying the costs related to increased volume or reduction in expenses anticipated resulting from decreases in volume as compared to original budget forecost."

Then it goes on to outline three alternatives, each one of which is a different way of trying to compute this element.

Many of the Twin Cities hospitals have 50 or more service centers which would fall under this provision. That would mean that for each of those 50 or more service centers the hospital would have to make a calculation for the prior year's activity; that is the one that is supported by the audit report. It would have to make a similar calculation for the current accounting period, which is the one in the middle of which we are budgeting the budget year, so there would be numerous calculations which could be very complex and difficult.

This addresses itself ideally to the question of fixed costs, and we previously heard how there are differences of opinion as to what is a reasonable ratio of variable costs and fixed costs. We also learned that these could vary from hospital to hospital, and obviously could vary from revenue center to revenue center within the same hospital, so that would mean that we would either end up using an arbitrary ratio of 60-40, 80-20, 50-50, or some other number, or else

your hospital would have to go through the very laborious task of not only allocating costs to each revenue center, but also having to keep those costs separated as to what is fixed and what is variable, a very difficult task.

This method of making an adjustment ignores some other significant features in the hospital financial picture, features which we believe are of equal importance to the question of whether the forecasted volume has been met or has not been met.

We get into such questions as the mix of the type of patients coming into the institution and his impact on the rate, and also his impact on the rate, and also his impact on the various revenue centers in the hospital. It can make a difference whether he is an in-patient or an out-patient. It can make a difference whether he is one who requires more or less surgery. It can make a difference whether he is going into the intensive care unit or is not going into the intensive care unit, and it does not address at all the question of cost performance in the hospital or in any department of the hospital.

For example, in the budget the hospital has projected a cost of medical supplies. They can spend more or less than that amount. It could have spent more or less because of the change in volume of the budget, or it could have spent more or less because the inflation factor that was used in the budget was either too high or too low. That latter point is not covered at all under this calculation. Were the salary costs projected

too high or too low? Were the food costs projected too high or too low? These are all being projected in the range of 2 to 4 to 6 months ahead of the start of the year, of the budget year when they are going to be used. We could go on and spell out other items in the budget but I don't think that is necessary.

I would like though to refer to Page 23 of the Regulations. We have not reviewed 23, but there is a very close tie in between the concept in this paragraph under consideration and on page 23, Subparagraph d. Subparagraph d. talks about making retrospective assessments of the hospital's compliance with requirements, and talks about what is reasonable and what is unreasonable, and it possibly can be construed as somewhat punitive. It is hard to see how that concept and this concept in Paragraph 3 can be made to fit one another in view of these difficulties, the complexity, the large amount of work that would be required in order to do a decent job of allocating fixed and variable costs due to the fact that by having done all that you still are omitting the variation in the actual cost itself which may be due to purely the cost of an individual unit of purchase.

We think a more equitable way to move into this program while it receives further study would be to use the system presently in use under the Minnesota Hospital Association program. In that program it was recognized that it is very difficult to project the volume of activity; it is even difficult to project the inflation rate or various costs in the hospital,

so how to make proper adjustment for this which is fair to the patient, to the third party payors and to the hospital? The way we did this was to compare for each year the total charges to the patients with the total financial requirements for that year. If there is a gain that would be carried forward to the next year as a reduction in that year's financial requirement. If there was a gain in the prior year that would be carried forward to the current year and used to reduce the current year's financial requirements. If there was a gain in the current year that would be carried forward to the budget year and used to reduce the requirements for the budget year, so that in that circumstance the payors would receive the benefit of these variations.

On the other side, if the charges were less than the financial requirements so you had what we could term a loss, the loss would be carried forward but with some restrictions so it wouldn't be a blanket easily done thing.

When the budgets are prepared it is almost impossible to set the various charges so that you come out exactly even with your financial requirements for the year because there is going to be an unusual budget gain or loss. Some institutions have not priced their charges up to the full level of financial requirements for various reasons of their own.

One of the rules that has been followed is that if there is a budgeted loss in a year, and if there is a loss in the year that budgeted loss amount cannot be

carried forward and added to the next year's financial requirements, so there is a limitation on that capability to carry forward.

Secondly, any loss that is carried forward and added to the next year's requirements is subject to scrutiny, review and challenge by the rate review panel, which gives them the opportunity to delve into such areas as volume differences, differences in inflation rates, and cost performance generally.

We propose that this plan be used until such time as the more complex calculations can be studied further and probably brought into play at some future time. Thank you.

EXAMINER MIHALCHICK: Do you care to reply? You are aware of his system and the rules proposed?

MR. SATTLER: After working with that other system I found it was not satisfactory from my point of view of being involved in the administration of the program.

I think that, number one, it probably overstates the complexity of this task in actually going through the analysis of fixed and variable costs. I think we offer here in justification three alternatives. Institutions can use the one that is the most cost effective.

Admittedly, alternatives two and three involve additional calculations which, as I understand it, the institution normally goes through anyhow. Cost allocations down through the departments are normally undertaken, allocations are made, or if those are too complex they can go to gross overall average determination of fixed and variable, and utilize that comparison

depending upon what the institution feels.

We think it is important to have a system of incentives built into the program to encourage institutions to in fact make a profit above and beyond what the budget builds in, additional profit if it can actually better the budget, but not profit merely from the fact that it underprojects.

One big determination in the actual rate that is set is the volume level that is projected in any given year. Admittedly there are certain difficulties.

Mr. Ego read some of these sentences out of context. He didn't follow up with the one, you know, that precedes or follows it, but we do admit the difficulty with this area, but we think it can be handled, and particularly given the review and comment situation we do have.

We find this particularly difficult for the reviewers to sit down in the following year and determine, you know, what really is a reasonable loss, should it be carried forward, and what to do on volume, what to do on price.

We don't really want to look at prices in the following year. We think that once we establish a reasonable rate at the beginning of the year, that that should be what carries through. That, again, is part of getting away from this whole system of cost reimbursement.

If we were going to have a cost reimbursement system with final settlements, I don't think we would have had the kind of legislation we do, review and com-

ment to go through these complex rules. The attempt is to set fair prices and reasonable prices at the beginning of the year, and live with those prices much the way the rest of the economy does.

It would include a much larger segment of third party payors than we have before. We will reimburse based on cost, but we will chip away the base of the financial requirements. We think we are accomplishing a reasonable trade off, broadening the base of financial requirements by putting some kind of limit on the money that is reimbursed within each financial requirement area, so that is our basic reason.

Frankly, the other approach that has been used by the Hospital Association, we find it more difficult to administer than we think this one would be.

EXAMINER MIHALCHICK: Any other comments?

MR. EGO: Not to get into an argument with Fred, but just to comment on a couple of points that he raised. He is correct when he says that hospitals presently do a cost allocation down to revenue centers; however, we don't do that in the detail of a fixed and variable element. We do it only on the total cost number, and that by itself does not solve the problem that this requirement gives us.

The other approach -- of course, there are alternatives, as he said. One of the alternatives is an overall average for the hospital, but different departments in the hospital have quite different fixed-variable ratios, and you are getting then back to the arbitrary -- probably not quite as bad as the 60-40 or 80-20

number that some other system might be using, but you still have that bad choice of an overall average that may not be appropriate, or go into considerable effort to get a more refined number.

He is also quite concerned about the results of the hospital underprojecting its volume. The method that we have outlined, I believe, does take care of the impact of that situation. If there is a gain it is automatically carried forward to the following year and is reflected in the rate structure for that year. That is quite automatic.

The losses, on the other hand, while it may require a judgment on the part of the review panel, at least they do have the opportunity to challenge any unusually large numbers that the hospital has attempted to carry forward, so it is somewhat different from -- maybe quite different -- from the traditional retrospective audit that is performed by third party cost payors. Thank you.

EXAMINER MIHALCHICK: Anyone else?

(No response.)

MR. SATTLER: My only last comment is that in order to clearly assess what should be carried forward in any period, gain or loss, you still should factor out and find impact. In other words, the gain that is carried forward may well not be as large as it should be or may too large, and in order to really assess the reasonableness and correctness of that gain carry forward you

should do a volume adjustment that particular gain to see if there is in effect the, quote "right" number so under any circumstances it would require a volume adjustment which would take the form of alternative 1, 2 or 3.

EXAMINER MIHALCHICK: Okay. The next one.

MR. SATTLER: We are now on page 44, number 4., Excess Capacity, and let me note that I am suggesting an amendment which does not change the meaning of the rule as originally proposed.

If you will recall, I changed the -- we proposed that we change the definition of "beds" back under the definitions section, so as originally proposed the definition of beds was "staffed and set up beds," so that reading the original proposed rule we see beds on the basis for the determination of excess capacity is "based upon staffed and set up beds," so I propose we change the definition of beds to "licensed beds," so now I am proposing that we qualify beds to mean "staffed and set up," as was originally proposed. Do you understand?

EXAMINER MIHALCHICK: Yes.

MR. SATTLER: Any comments?

(No response.)

This particular section actually relates back to the plant capital needs section, which was 487 A.1.b. (1), where we talk about the application of the price level factor to depreciation, and state that in cases

when the system has determined that there was excess capacity that it should reduce the percentage of that price level index.

We are now here laying out the way in which the system will determine excess capacity. In the first case it will be based upon staffed and set up beds, which is reported to the Department annually as part of the normal licensure requirements, as I understand it, and will be required to be reported to us in the rate review system also.

In addition, when the system makes a preliminary determination that there is low occupancy and when there is excess capacity we must communicate with the State Health Planning and Development Agency and the appropriate health systems agency. Hopefully we will get a reply.

The determination of reasonableness will be based upon the mean for each peer grouping that exists in institutions. If the occupancy level is lower than the mean for the group then those won't be considered, at least preliminarily, to have excess capacity.

I believe that covers that particular rule.

EXAMINER MIHALCHICK: Mr. O'Hare.

MR. O'HARE: Just a question since you have changed the definition of "beds" to "staffed and set up beds."

MR. SATTLER: We really haven't changed anything. The original definition of beds was staffed and set up, so that when "beds" was originally used here in context it was staffed and set up.

We have proposed to amend the original definition of

"beds" to "licensed beds" so to be consistent with the original proposal we have to add "staffed and set up." In essence there is no change in this particular section.

MR. O'HARE: Maybe I am speaking out of turn. Have you progressed through the entire Section 4. a., b., and c. at this point?

MR. SATTLER: Yes, I covered all those points because -- just let me further say the rationale for this. Since we are providing for replacement price level adjustment, if there is excess capacity we see no need to replace that excess capacity portion so we would likewise reduce that price level adjustment.

MR. O'HARE: Well, let me give an example here of usually what I understand to be the definition here of beds that would be subject to the appropriate determination. If you have, let us say, a hospital which had a fairly low occupancy and as a result of that would have consolidated its operations and perhaps closed down a wing, let's say forty beds in that wing, and it closed it down. Those beds now could be set up but certainly not staffed and, therefore, would that fall -- in other words, would that become part of the determination of unreasonableness? I think your definition would almost knock it out because they are not staffed.

MR. SATTLER: But the incentive here is to encourage hospitals to appropriately manage. We realize they have fixed costs associated with that wing and these beds, but what we really would like to encourage is to

remove the variable cost components associated with those beds, which we all know runs -- just take labor; runs about 50-55% of the cost -- if we can reduce those costs and encourage the actual closing of those particular beds, we think it is also consistent with the intent of Public Law 93-641, where they are looking to have funds available on a trial basis for institutions who want to close beds or convert wings, things of that nature, so the intent is to set up an incentive to do that kind of a thing.

MR. O'HARE: But in that case though the system would continue to pay price level depreciation on that portion of the facility which is unused because in fact they are no longer staffed. Is that a proper interpretation?

MR. SATTLER: Okay. There are a couple of things working here. Number one, we use the mean as the cut off and let's make -- I think the assumption is reasonable that within any group occupancy would be normally distributed. If we use the mean we are saying about 50% of the hospitals in any group is going to have excess capacity based upon staffed and set up beds.

We will then reduce price level portion just upon that bit of excess which would be just on the staffed and set up, so on the closed wing we would still pay price level, but I think over time, and I don't know how many years, we will get a reduction of payments to these institutions.

We will get some rather clear signals of what institutions are actually closing wings and what institutions

by themselves will start to phase down in scale, so they are not needed because the incentive is to clearly go to staffed and set up because if they stay staffed and set up on all their beds then the level of excess capacity will increase substantially. Rather than, let's say, being 2% below, they may be 50% below and, therefore, loose even a greater portion of their price level.

We will then, I think, start to get a clearer picture of what is needed where; other institutions will then start to fill up within that group or within the region or an area because we are seeing that Hospital X is slowly closing itself down.

I admit that we are talking about time here, and in the short run again, we might have in essence built in too much of an inflation factor, but I believe that experience here would show that where we can get the institutions moving themselves in these areas the better the system will be, the more orderly we will move, and in fact just better in the long run.

MR. O'HARE: Well, I would exercise great concern about that, again on the inequity of arbitrariness of price level depreciation. I think it is highlighted here again in that you have got a facility that even acknowledges its own excess capacity or not needing that particular wing in that particular form at the moment, and yet we are continuing under this system to pay a price level factor which is being given for the purpose of replinishing a section of the hospital which at this point in time apparently is not in need of

replenishment.

It seems very arbitrary and capricious, and I find it very, frankly, unreasonable in that situation.

MR. SATTLER: Take the other side. Now we set up a system that will severely penalize the hospital for doing -- quote, what we think good management would suggest and doing what it should do, but there is excess so close it down; don't staff it. That is what we are suggesting by this system to set up an incentive to do that.

Let us say we base it on some other factor and encourage hospitals to staff fully, to increase utilization where it may not be necessary in spite of the fact that there are PSROs involved, and to stay at what I call marginal and just barely be getting by occupancy wise. I think the total cost to the system is far greater than looking at this rather small price level factor that we are talking about.

I realize we are spending possibly some additional funds here, but I think in relationship to the total effect on the total system it is relatively small.

MR. O'HARE: Well, I am not persuaded that this would set up an incentive for hospitals to close down a wing and, further, I think I would go so far as to recommend that not only the price level factor should not be paid, but in fact the depreciation should not be paid historical costs.

What you have again is a continuation of funding for a non-needed item; in other words, it is a non-cash expense as depreciation is, being paid for what

purpose? I do understand if there was an outstanding debt on that facility, that portion of the facility relating to the inappropriate part of that, that would have to be met. Obviously you can't attack the capital structure. I mean, the finance market would dry up almost immediately if you started denying the ability to retire a debt associated with such a portion of the facility, but when it comes to paying anything above that debt in the form of depreciation, it just strikes me as being unreasonable and an unreasonable situation because again there is no need for the community for that particular part of the facility.

It just doesn't strike me as being a necessary expense of sustaining that hospital in any way, shape or form at this time. It might be needed later. By not paying depreciation on those beds associated with inappropriateness, you are not taking that wing and throwing it away; it is still there, it is going to be used, if necessary, in the future. You are not doing any harm to the institution by not paying depreciation. I'm talking about price level and straight-line historical cost depreciation, so there is no damage done.

In fact, there is a savings to the community for what is acknowledged as a non-appropriate or unnecessary capacity. Why should the community continue in effect to pay financial requirement depreciable items for an unnecessary portion of the facility? It strikes me as being unreasonable.

Anecdotally, in conversations our staff has had with Paul Earl from the American Hospital Association, we were

going over our guidelines for planning, and one of the things we have in our guidelines is decertification, which is the ability of the state agency to promote mergers, insured services, and in fact closures. Of course, Paul, who is Vice President of the American Hospital Association, took exception to that kind of a policy, which is understandable, and further in talking with Paul we have asked, you know, there are cases where there is inappropriate allocation of facilities where you need a redistribution, at least until those beds are needed. How should that be taken care of? One of the things he indicated was that, well, the rate review process will take care of that, and in further asking him how will that happen, he said, "Well, it is unreasonable that the community could be continued to ask to pay for unneeded facilities or portions of unneeded facilities," and based on that anecdotal conversation, I think it is unreasonable to ask that expenses such as even historical cost depreciation be paid on unused capacity. I guess I would not quarrel with the definition which you are using of staffed and set up beds. I think it would almost need to be bed capacity of the hospital in some way or another; in other words, how would one figure the occupancy of a hospital if it closed a wing? All of a sudden is that to be based on its operational beds?

MR. SATTLER: That is what the definition says.

MR. O'HARE: Then you have got this whole other wing setting out there which has been paid depreciation, and in fact price level depreciation on top of it. I

think both are inappropriate and unreasonable in this case because it is a not needed requirement of the hospital unless there is debt attached to that particular section, which must be retired.

I will stop with that.

EXAMINER MIHALCHICK: Mr. Ego.

MR. EGO: In talking about occupancy we might get the impression that say a hundred-bed hospital has sixty beds occupied all day, every day, all year and, therefore, you have forty empty beds. It isn't quite that simple because the rate of occupancy during the year will fluctuate a great deal. You might have some days when you have eighty to ninety patients in those beds; you can have other days where you have got thirty to forty.

There is a very heavy seasonal pattern to hospital occupancy so that when you try to define and measure these things in a very precise manner, you are going to have a problem in that regard.

Another thing you run into is, let's take a hospital that has three floors which are, let's say, interchangable. During the busy season all three floors are going. When the occupancy falls off the third floor is closed. Now, is that third floor unnecessary because it is closed part of the year?

I think the way it actually works supports the rationale behind the rules. They are taking a mean on the average occupancy for the year. Now, every hospital is using more beds than its average. First of all, that is a point we have to keep in mind. You can't

exist on your average beds. You have got to have more beds.

By encouraging the hospitals to confine their patients to fewer nursing stations you are definitely going to cut back on costs for the hospital. You are going to cut back on nursing salaries, first of all; you are going to cut back on housekeeping salaries; probably cut back on maintenance salaries, etc., so the rule does nudge the hospitals in the direction of staffing as few beds as possible, which is, of course, a saving to the patient and to the third party payors.

To go then to the next jump of saying that we should therefore, not allow depreciation expense on some portion of the hospital, I think is really going off the deep end because most hospitals are in this debt position.

Hospitals are constantly needing to repair, and improve, update their facilities. You take a hospital built twenty years ago without air conditioning, at some point in time it is going to have to be air conditioned in this day and age in this city, and depreciation expense and the price level factor are parts of the sources for these things.

The depreciation on the so-called authorized parts of the hospital is probably not enough to support that activity.

I could see depreciation would be available under the rules of the facility, and to the extent later, say, the air conditioning had to be put into the third floor, which is now not used, I don't see any reason why the

program would not consider that as an allowable expense, but to just depreciate across the board I think is a question of what for? What is this expense, depreciation expense, needed for?

EXAMINER MIHALCHICK: Mr. Lamson.

MR. LAMSON: In Minnesota we do have a lot of areas, resort areas for example; let's take Detroit Lakes, where you run an occupancy of 100 persons in the summer months, and an occupancy of 50% during the other part. Now, they definitely will close down wings of the hospital.

In institutions like that there has to be some kind of a provision for that institution to have the depreciation on those areas that are not being used, and if they are staffing them, which accounts for 60 to 70% of the expenses, depreciation being a very minor part of those expenses, it should be allowed.

MR. O'HARE: Let me clarify what I was saying. I agree with most of what you say. Obviously a hospital can't run at 100% capacity, and that would be the standard of reasonableness, and there are seasons of fluctuations. I couldn't agree more. If you are running at 80% or a little bit above that, you are doing fairly well, so I understand all of that to a certain degree.

What I am saying is once you have made a determination of inappropriateness on a continuing basis, you know one that stands out, not a hospital that has a fluctuation because of resort type area or whatever; I am sort of arguing on a post-determination basis,

post -- after the system has determined what the standards of unnecessary capacity are.

I am not addressing how you determine that because you have to take into account all those factors, but I am saying after that is made now what do you do with that?

MR. SATTLER: I would like to point out that the Department does have other areas or provisions which deal with things like licensure, which we do not have under this particular system.

MR. O'HARE: I guess what I am suggesting is it really doesn't pertain to licensure.

MR. SATTLER: It very definitely does, but we might, again, take a longer look at this particular section.

MR. O'HARE: I don't think licensure coincides necessarily with the beds being utilized to capacity or that licensure is threatened because a wing is closed. I am not sure what you are getting at. At least I don't think so. Does the licensing authority have authority to -- what are you driving at? Decertifying beds or -- I think that is a side issue. What we are talking about is the community's requirements to pay for ongoing needed services in a situation where some portion of the hospital is unneeded at this time, and we are not talking about breaking down the building or wrecking it. We are just saying that depreciation expense at this time is unreasonable after you have made the determination on the basis of, you know, rational approaches, taking into account the needed variation of capacity fluctuations of the hospital set up.

won't say any more.

MR. SATTLER: I have nothing further to add to that.

EXAMINER MIHALCHICK: Anybody else on excess capacity? Mr. Klas.

MR. KLAS: Yes. I made some comments yesterday and Mr. Sattler then referred to this section, so I guess for your convenience in referring to the record I would just direct you to those comments I made when we were talking about price level.

Excess capacity is a problem in this state, in my judgment, having sat on the voluntary review panel and I guess -- I won't duplicate what I said yesterday, but it leads to some very questionable practices in this day and age with consumer protection when we talk about very active bidding for surgeons, and gets the hospitals into a variety of ancillary businesses of clinics and various assistants in specialized equipment, and I guess my problem with the procedure set up here first of all I would question, but my real quarrel really is with the peer concept, which on its face is logical but, fortunately, if the peer concept is to be similar to the peer concept presently utilized in the voluntary program now under way, we do have a grouping of a very large number of the same type of hospitals all with the same, relatively the same, occupancy levels, yes, in large part due to seasonal aspects, but not totally, and the occupancy levels being given are so low that -- now, I mean by that below 50% -- then I begin to have difficulty.

Now, the question I have of Mr. Sattler in this

procedure is there is reference to passing on information and a preliminary determination decision to the other agencies and that is very key. I very much sympathize with the hospitals having to deal with so many agencies, so the more communication there is between them that ought to be applauded, but the comments were prefaced that hopefully you will get a reply, and I guess I am not sure what happens if you don't get a reply.

The regulations state what happens if they agree with you, but I guess it gets to be inferential what will happen if they don't or you just don't hear. I presume you intend then to proceed with your preliminary decision although I guess I don't feel that is clearly set forth in the proposed regulations.

I do think we have to be very careful here as to what is excess capacity and in this state with the heavy seasonal nature of a lot of our activities it is not going to be the same as it is in many other states.

I would prefer, myself, to see, regardless of what it is, some minimum number beyond which it will be prima facie excess capacity because I am concerned when I look at a number of these hospitals and the peer groupings and the voluntary program presently underway.

The difficulty is the very close proximity of many of these within the same peer group and really the answer -- the logical answer seems to be, okay, when we are talking 15, 20, 25 miles apart between two hospitals, for example, that are running 45 to 50% occupancy, I think the peer concept is going to be frustrated or at least the overriding legislative concern is frus-

trated if you go to that kind of a concept.

MR. LAMSON: Is there anything in here that they can be recommending to the licensing body that maybe a hospital ought to be decertified?

MR. SATTLER: We plan to communicate with all appropriate agencies.

MR. LAMSON: When you run into situations like this, and I know; I have sat on the MHA board rate review program, and the question has come up many times as to well, why was the hospital built in the first place, or maybe that hospital has served its usefulness to that community.

I would hate to be the individual that told a community that they can no longer have the hospital in their community and they have to go 20 miles down the road, because I know that politically that is a problem; probably that is why it was built there in the first place.

MR. KLAS: No question about it, but the legislature has said, presumably from its constituents, that there is to be an overriding concern and that is costs of medical practice, and one of the key elements that everyone keeps talking about is the delivery system.

MR. BREVIU: Just in regard to the one point that was raised relative to the input of the comments received from the HSA or the State Health Planning and Development Agency. The system and the Board of Health is not in a position obviously to be delegating any decision-making authority to the Health Systems Agency or the State Health Planning and Development Agency. All it

can solicit from them are comments. They cannot be required to make comments. It is just an attempt to insure greater cooperation and receive comments from agencies which should be in a position to provide some invaluable input, hopefully. If they do not provide it the system has to proceed.

MR. KLAS: Yes, that's right, and I think after a reasonable period of time, whether it be 30 or 45 days, or some standard, they ought to be deemed to have answered or at least not to have objected, but I think that ought to be set forth so there is a clear understanding of what the ground rules are.

MR. SATTLER: Yes. We would actually plan to proceed. We would expect that if we are in error or the system was in error that the HSA or the State Health Planning and Development Agency would definitely let us know about it. We think if they concur they might say nothing.

Just to the question of your comment about minimum occupancy levels, I have done some work in this area, published a few things in this area, and have some familiarity with the planning agency and what has been done.

There really are no commonly accepted methodologies for determining occupancy or optimal or reasonable occupancy in hospitals, and I can refer you very specifically to the policy statement by the Institute of Medicine called "Controlling the Supply of Hospital Beds," published in October, and that is why we stayed away from any approach we would take to be reasonably

challenged by anybody. We desired to stay away from that.

As a matter of fact, the policy statement goes on to say that the only way to really approach the whole area is to look at national norms; that nationally we should have 4 beds per thousand, 3.8 beds per thousand, just pick a number that seems reasonable, and then they go on to point out that within any given area or any state that there may be need for more than or less than that national average, so they are not particularly helpful, and I would consider the people on this panel, who ranged from physicians, health economists, university professors and hospital administrators, to be an eminent panel, very conversant with this field.

We are using the mean of the peer group for this reason: we think that these hospitals within that group have many similarities, certainly size, scope of service, rural, urban, things of this nature; secondly, that every single hospital in that group can't be under utilized forever, for long periods of time.

MR. KLAS: Why not?

MR. SATTLER: Well, because eventually you start to find out the ones in the group that are and you start to do things with their reimbursement levels. Something is going to happen to them, and the ones above will naturally pick up patients.

Second of all, I think just to relate occupancy levels to size, you would normally expect, and statistically it is the case, that smaller hospitals should run a lower occupancy, down in the 50%; larger hospitals

should run say higher occupancy 70 to 80%, and I can point to Professor Schoenk of UCLA, who has had some work published in the Journal of the American Statistical Society back in the early '70s, who published an article where he estimated the distribution -- the probability density functions of various service departments, and it showed the tradeoff between the queue for entering an institution and the probability of getting a bed, and he pointed out we need to keep a substantial buffer zone, and the tradeoff between the buffer zone you want to keep to determine quota excess in the number of beds and the length of the queue or the lineup to get into these institutions is not very significant with the size of the service center, and I can make that available for the record.

EXAMINER MIHALCHICK: Mr. Van Hauer.

MR. VAN HAUER: Mr. Examiner, members of the panel, the whole problem of excess capacity is one of gigantic proportions. I would submit that it is beyond the scope of this particular program to resolve it.

The Federal government through the Department of Health, Education and Welfare, has commissioned studies to determine the extent of excess capacity, to find ways to define it, and to suggest means by which excess capacity can be reduced.

There is concern felt that the money market, the source of available funds to hospitals, may be threatened if excess capacity is to be arbitrarily terminated. Suggestions are being made that there may have to be a federal program to provide buyout funds to

pay off residuals of indebtedness on hospitals that are being closed out because they are determined to be excess or even just parts of hospitals which are being closed out.

The whole concept of the certificate of need is addressed to trying to get ahead of the problem of excess capacity, and to keep any more of it from occuring in the future.

The problems of local concern have to be dealt with. The point was made by speakers at this table that two hospitals 20 or 25 miles apart may fight to the death to maintain their own institution when a semantic case could be made that either one or both are excess in capacity.

Some way may have to be found to use up present facilities. The entire health care system may have to be retooled to make use of these residual facilities. There are shifts in population going on that are going to create problems of excess capacity, and for all these reasons this entire problem lies beyond the province and the scope of this program. I would submit that the program in its provisions dealing with excess capacity, wherein they propose that price level depreciation will not be allowed on that portion which is determined to be excess, is appropriate and is as far as this program can go. Thank you.

EXAMINER MIHALCHICK: Let's go off the record.

(At this time there was a discussion off the record.)

We will break for lunch for twenty minutes and come back at a quarter of one.

(Whereupon, at 12:25 p.m. the hearing was recessed, to be resumed at 12:45 p.m.)

EXAMINER MIHALCHICK: Back on the record.

Part B. Investigations.

MR. SATTLER: On Page 45, Part B. Investigations, this particular section refers to specific authority enumerated in Section 4, Subdivision 5 of the Act, and Section 7 of the Act, and lays out the procedure under which the system shall undertake a longer range investigation of any institution's rates. In other words, under the analysis of the rate revenue and expense report and financial requirements we have about sixty days to issue comment. Under certain circumstances the system would want to take a longer time to look at an individual institution's situation, and this Section B. Investigations allows that kind of a longer term analysis to take place and sets forth the requirements.

It deals with, number one, the investigation itself and the basis of the investigation, notification that the system has to give the institution for doing so, the analysis and the issuance of a specific investigative report.

EXAMINER MIHALCHICK: Questions or comments? Mr. O'Hare.

MR. O'HARE: The only question I have on this sec-

tion is whether or not the investigative report is due before the beginning of the new budget year or before the interim increase takes place?

MR. SATTLER: As I understand it, this particular authority gives the Department more long range investigative power.

The initial analysis of the rate revenue and expense report, which is that report that is filed sixty days prior to rate increase, will require review and comment by the Department within that sixty-day period. This particular entitlement allows for long range, a long range kind of analysis.

EXAMINER MIHALCHICK: Anything else?

(No response.)

Go ahead.

MR. SATTLER: The next section, Section C. deals with the review of reports and the purpose of this section is to set out a particular set of administrative standards for the review of any annual reports required by the Act.

In 487 C. 1, the general provisions are that they must be complete and that the system shall require completeness before a review takes place, although it does allow for some degree of interpretation on the part of the system. If a review can begin prior to completion, in the judgment of the system, then it can proceed in that fashion.

This provision also places responsibility on the

system to respond to the institution on its determination of completeness of the report and that the sixty-day time period for notification of intention to increase rates does not begin until a complete report is filed.

EXAMINER MIHALCHICK: Mr. Ego.

MR. EGO: A question of clarification on this 1. a. and b. We know about the sixty-day requirement. How does that relate to the ten days and the thirty days that are mentioned there? Is there any inference that the sixty days doesn't start until the ten days has expired?

MR. SATTLER: Let me get that exact wording. On the ten days, no. I would interpret this as the sixty days begins when the report is filed on the assumption that it is complete, and that we have ten days to get back and say if it is not.

MR. EGO: How about the thirty-day stipulation? How does that impact?

MR. SATTLER: I believe that if you take the additional thirty days and determine it is complete, then the initial filing date takes hold. If it is incomplete --

MR. BREVIU: If it is incomplete then there would have to be a refiling.

MR. EGO: If it was judged to be complete then that wouldn't postpone the sixty-day period?

MR. BREVIU: I don't believe it should.

MR. EGO: Thank you.

MR. VAN HAUER: Mr. Examiner, --

EXAMINER MIHALCHICK: Mr. Van Hauer.

MR. VAN HAUER: I would like, if it is timely, to comment on the bottom of page 47 and page 48. Are we up to that point?

EXAMINER MIHALCHICK: We haven't gotten to that yet. Do you want to make comment on that particular section?

MR. SATTLER: Okay. c. merely deals with the way in which the system has to respond with incomplete reports and notification of the institution; and d., it is retroactive in a sense that since the Act became effective on August 1st and there were certain filings made that for complete data purposes the system has the ability to ask that these reports do meet certain requirements as spelled out in the rules but prior to the promulgation of these rules the system did not have the ability to be very specific in the kind of information that was required.

I would also like to add that for those institutions who did go through a review of rates by a recognized -- or a system that would become recognized that would probably be considered to be adequate prior information.

e. This puts the burden on the hospital to see to it that its reports are reasonable and complete and without error when making the initial filing, and it goes on to state that if it subsequently finds error and informs the system within thirty days, that the filing can still be considered complete and accurate. If it determines that it has to amend that filing it is considered a new filing and, therefore, the sixty

days begins once again.

I think that takes us through f.

EXAMINER MIHALCHICK: Okay, Mr. Van Hauer.

MR. VAN HAUER: This last point, Mr. Examiner, which Mr. Sattler touched on is what was troubling us, and that was whether or not the filing of the amended report does set back the filing date.

The language that the amendment is submitted by a date determined by the system to be acceptable would seem to imply to us that the original filing date then holds, so it isn't all that clear.

Mr. Sattler's statement a moment ago, as I heard him, was that the submitting of the amended report rather automatically backs you off to a new filing date.

From the experience we have had with the system so far we do find that there are instances where errors of not any great magnitude occur, but which in the interest of accuracy ought to be corrected, and when hospitals discover these errors of possibly omission or commission they move promptly to correct them. Where it doesn't really disturb the operation of the system I think that penalizing them by setting back their filing date, which means in turn that rates can't be increased for sixty days from the set back filing date, is more penalty than was intended and, therefore, I have raised a question.

MR. SATTLER: I believe that on page 48 in f. (2) it refers to the system discovering an error, and if the system discovers an error and if the hospital has to -- well, if it discovers the error thirty days or

more after the date of filing, then a new submission or amended submission would trigger the sixty days once again.

If the system were to discover an error prior to thirty days and require a new submission, or in e. on page 47, if the hospital informs the system of the error within thirty days, we can then work out an agreement as to what would be an appropriate time period filing without suffering a penalty.

I think just to give an example of how this would work, we had some situations when I was working with the Hospital Association where errors were found, and it was literally months before the institution got around to refiling, and we are saying if it takes you a few additional months to get around to doing that there is no reason why you shouldn't incur the extra sixty days on top of that.

Given the magnitude of the problem, if we can come to a reasonable agreement that it is handled within a week, two or three weeks, we see no reason to -- you know, it is an incentive actually to get together with the system and clean up the problem and get the filing, is really what it is. I don't think it is going to be too burdensome.

MR. VAN HAUER: Mr. Examiner and Mr. Sattler, we would certainly agree with the example which you have given and conclude that that is covered by the language, "a date determined by the hospital and the system to be acceptable."

We assume under the example you have given that the

system would find that not to be acceptable.

The Association would like to suggest that under Paragraph f. (1), the first part of the first sentence which reads thus be deleted: "If the discovery occurs within thirty calendar days after the date of filing of the report," so the sentence would begin then with the word "require."

We also would suggest, if we may, that Subparagraph 2. be deleted in its entirety, and the reason then for combining Paragraphs 1. and 2., which is in effect what it would do, is this: That if the discovery occurs within thirty calendar days, etc., etc., by leaving the remainder of the sentence stand they would require the hospital to amend and resubmit the report by a date determined by the system and the hospital to be acceptable. The initial filing date is not affected.

Now, if the system itself doesn't find the error within thirty days, we see no reason why the hospital should suffer delay in its filing date. The system has some obligation to the hospital to be timely in processing of these things and coming to a decision as to whether the submission is acceptable or not acceptable. We would think that thirty days is not an unreasonable period of time.

To sum up then, we suggest the deletion in Paragraph f. (1) as I have described earlier, and the complete elimination of Paragraph (2).

Thank you.

MR. SATTLER: I think we have to see your exact wording in writing, but I think we concur that the

hospital should not bear the burden of the system's inability to deal with that. Okay.

Moving on then to 2., if there are no more comments on the previous section, 2. deals with the Review of Rate Revenue and Expense Reports and Interim Increase Reports.

To go somewhat out of sequence, these are the reports that deal with the filing of budgets and proposed budgets, and rates and rate increases. This provision clarifies that in all instances the cost history of the hospital with regard to its past institutional and service center costs shall be the basis for assessment of the reasonableness of the cost increases, and it also clarifies that comparison between hospitals may only be made on an institutional service center basis when these hospitals can be shown to share common characteristics or essentially peer groupings. We also plan then to go on and develop these peer groupings. The peer group shall contain characteristics that are listed on Page 49. They may also contain additional characteristics, or in fact may delete one or two of these, but in essence I think we don't have too much of an argument that these things should generally be considered.

In b., the system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the board and the public, and they shall -- the comments shall have some very specific requirements.

On Page 50 we are suggesting a change in (b), an

amendment, and the change is that we delete it. I think primarily because, frankly, I didn't understand it, and if someone here can and thinks it should be left in I would be happy to hear comments. Does anybody have any difficulty with deleting that particular subparagraph?

(No response.)

I don't think it adds anything specifically to the comments.

MR. VAN HAUER: We would support the deletion of this paragraph.

MR. LAMSON: I will concur.

MR. SATTLER: Subparagraph (2) is the bases upon which comment will be made. You know, this, I think gets back to the whole reasonableness criteria, which I think can be applied to either aggregate or the disaggregate elements of financial requirements, and here we talk about "rates deviate from the average of the rates then in effect for other hospitals in a peer group; (b) Rates provide revenue which is in excess of expenses which deviate from the past financial practices of that hospital, of hospitals sharing common characteristics, or which deviate from the principles -- " back in MHD 487 A., which we just spent some good hour going over; and (c) "Rates have not been demonstrated by the hospital to be necessary and consistent with the bases for judging established by MHD 487 A."

I think that this section really gets to, you know,

many of the reasonableness criteria that we discussed when looking at the specific elements of financial requirements.

Okay, I think we should take comments on Section 2. on page 48, running to D. Public Meetings.

EXAMINER MIHALCHICK: Comments? Mr. O'Hare.

MR. O'HARE: I guess I will ask the question which I previously asked really out of context relative to investigations, but I think it would be important that the comment by the system upon -- well, okay -- I guess that is assumed here. It is assumed that the comment on the reasonableness will be forthcoming prior to the implementation of the new budget or rate increase?

MR. SATTLER: We would expect always to have comment prior to the implementation of the new rates. We would also foresee the necessity to undertake longer term investigation, which may not have any comment forthcoming, but we would also look at the reasonableness and comment upon the reasonableness of the proposed rate increase.

As a matter of fact, we would probably comment on the reasonableness of financial requirements, whether they be a proposed rate increase or not.

MR. O'HARE: Through the investigative authority, you mean?

(Mr. Sattler nodding affirmatively.)

MR. O'HARE: I guess here I was seeing the timing of the comment as being somewhat crucial to the effectiveness of the program. In other words, the comment

should come prior to the implementation of the proposed budget, and I don't see that wording as explicitly here as perhaps it should be spelled out.

In other words, it says, "The comment shall state that a hospital's existing and proposed rates are reasonable or are in question."

I think that alludes to what I am stating here, but I would like to see it more specifically stated "prior to the implementation of the proposed budget or proposed rate increases."

MR. SATTLER: That is not inconsistent with our design.

Then on Page 50, D., Public Meetings. Basically this gets into the area of the responsibility of the Department when holding public meetings or when holding investigative -- investigatory sessions. These sessions shall comply with the existing statute on open hearings, and undertake reviews of institutional budgets.

MR. LAMSON: Does that mean that the individual rate review of hospitals then would be open to public hearing?

MR. SATTLER: We would expect that to be the case. We would expect if a question comes, you know, what impact does this have on a voluntary peer group system, we would expect that those reviews would be open.

MR. BREVIU: That would be my belief.

MR. SATTLER: I think, by the way, that that was understood.

Okay. E., on Page 51, Burden of Proof.

This states quite explicitly that the burden of proof for determinations of reasonableness of rates and components of rates for financial requirements that exceed the group need or the reasonableness criteria established on Page 50 is with the hospital.

In other words, it is perfectly permissible to have a rate that is in excess of the group mean, for instance, but the hospital has to prove its case to the rate reviewers.

F. Consolidation. It is an administrative help to the Department and the system, and if there are two or more investigations that undertake to look at the same issue, even though it is a different institution, the same may be combined. In other words, as an example, we might get involved in this cost justified discount determination for different hospitals, and yet we may be talking about the same issue so we can look at all of those at the same time.

Any comments on burden or proof, consolidation or public meetings?

EXAMINER MIHALCHICK: I have a question that I had mentioned to you before. The statute provides for administrative hearings for any aggrieved party, but especially for the hospitals whose rates are unreasonable for rate relief. How is that going to work, or is it? There is no provision in the rules for it and the statute is wide open.

MR. BREVIU: Well, about the only comment I can make at this point in regard to the rules is that there is no provision in the rules for it. We have to enforce

the statute as it is written. Obviously there are problems with the statute in terms of being open-ended. I can't tell you right now how the system intends to enforce that statute. Questions have been raised.

EXAMINER MIHALCHICK: Under the way the system presently works with the Hospital Association review, do the hospitals have some kind of input or at least notice of a preliminary determination, and a chance to make their arguments on reasonableness and everything else?

MR. SATTLER: Yes. Possibly you would want the Hospital Association to explain their position, but essentially every hospital is notified of a staff determination with regard to the reasonableness of the financial requirements. They get it approximately a week in advance and there are review panels made up of providers, consumers and third party payors, who review various hospital's financial requirements and propose rate increases. They also get the material. They meet once a month and there are six panels, so it would be six panel meetings a month.

Each hospital, if it so desires, can represent its case to the panel. If the hospital, individual institution, is satisfied with the analysis of the staff and feels that it is correct and does not want to comment, they do not have to appear before the panel, but in essence every hospital does get a public hearing of sorts, and I won't say public hearing because it may not specifically coincide with the legal definition that the Board has, but they do get a public hearing.

EXAMINER MIHALCHICK: Mr. Van Hauer.

MR. VAN HAUER: Mr. Examiner, speaking for the Association, we are somewhat troubled by the absence of any provisions in these rules for an appeal process.

The system now operated by the Hospital Association spells out the appeal process in quite some length and detail as to what grounds may be appealed as to the costs of filing such an appeal, who shall hear these appeals, and other matters pertinent to the whole process.

We would be much more comfortable if these rules did set forth in some detail an appeal process from the findings of the system with respect to rates. We have had, I think, in two years something like four or five appeal cases filed, so it is a situation which has occurred and reasonably can be expected to occur from time to time in the future.

We are aware that the statute is rather loosely drawn. It certainly doesn't imply anywhere that there shouldn't be any appeal. I would dare say that wouldn't be administratively proper for a statute to deny an appeal. The fact remains that these rules do not specify or set forth any detail or even infer that there is to be a process.

EXAMINER MIHALCHICK: Well, my concern is quite the opposite. The statute is quite clear anything is appealable, any determination. I think the wording is bad, but at least my concern is that that appeal should happen before the comment is made; otherwise it seems to me to be useless, and that would have to be handled

by the rule or should be. At any rate, I think there should be some clarification of that.

MR. BREVIU: Yes, I think the points you address are the ones that really go to future rulemaking as opposed to any current rule, and I am certain that that would appreciate any proposed rules that any interested party would submit.

In regard, incidentally, to the procedures to be followed once an appeal is instituted, Mr. Van Hauer, the Administrative Procedures Act and the Rules of the Office of Hearing Examiners set forth rather clearly the procedural aspects, the fundamental questions of when a right to appeal vests as the one which perhaps would be the subject of rulemaking.

EXAMINER MIHALCHICK: I think that was my point. Just going to the statute there is going to be an appeal to the Board of Health, it is going to be conducted by a Hearing Examiner, and the Board of Health is going to make the final determination, but the problem of when that can occur -- maybe there ought to be some preliminary type of staff review that might be able to prevent an ultimate hearing and be more efficient -- could be handled in the rules. I submit that for your consideration.

MR. SATTLER: This is something we would be concerned about and it should be drawn up and treated in future rules.

MR. VAN HAUER: Mr. Examiner, do I understand you to say then that the inclusion of an appeal process within the system itself is inappropriate?

EXAMINER MIHALCHICK: No, no. I think you can't go contrary to what the statute says, but there is a lot of preliminary steps, I think, that would be appropriate before a final appeal to the Board. It might better be at least initially considered by some other step in your agency or by Mr. Sattler for that matter.

MR. SATTLER: I think just to address your immediate concern -- let me just make an assumption that the Hospital Association program will be approved and will take the necessary steps to become approved. The appeals process set up within the Association would be -- let me just check to be sure -- that process which has been established would be applicable, so we can address that specifically.

MR. VAN HAUER: Okay.

EXAMINER MIHALCHICK: I would think you can still run the appeals process, but if the hospital were still unhappy with it, then they could still come under the statute and appeal to the Board of Health.

Mr. Klas.

MR. KLAS: I think I disagree because I think one condition for accepting the voluntary system is the fact that the appeals panel decision -- well, the final decision available under the appeals process is binding on all parties, and, therefore, this statutory provision would not be available to someone under that system who is proceeding on that system if they accept the system.

EXAMINER MIHALCHICK: I see your point.

MR. KLAS: Now, there are other hospitals who may

not be part of the voluntary system who may go through their way of doing things and obviously it is available to them until they come out with rules changing it, but if they accept the system which provides for binding arbitration, or whatever it is, then I don't think that is available to them except on constitutional grounds, which they are going to have trouble with.

EXAMINER MIHALCHICK: All right. If they go into the voluntary system it is just completely replacing the Board?

MR. KLAS: Yes.

EXAMINER MIHALCHICK: At least in that respect.

MR. KLAS: Well, they have given up their right in effect, the way I see it.

EXAMINER MIHALCHICK: Okay.

MR. SATTLER: At this point we can do one of two things; just continue on from page 51 through 60, or jump back to page 19.

EXAMINER MIHALCHICK: I don't know -- which makes more sense?

MR. SATTLER: I think it is up to --

MR. VAN HAUER: We only have one matter we would like to discuss to the end of page 60, and that, I think, relatively quickly. That is on pages 57 and 58 dealing with fees.

Under Paragraph A -- actually under the heading of 509 Fees, the language appears, "Hospitals whose rates are reviewed by the system as operated by the Board -- and then goes on with further language.

I would like to draw attention to the definition of

"system" which is Item Z on page 7, because we are having some difficulty in bringing these two together.

The definition under Z on page 7 reads "'System' means the Minnesota Hospital Rate Review System and any applicant approved to operate it or the board."

Turning to page 57 we find this distinction, we think being drawn by the words "system as operated by the board." It has been implied and, as a matter of fact, the speaker a moment ago commented to the fact that there may be hospitals who will not participate in the MHA system, and whose rates will have to be reviewed by the board under the system covered by these rules. If that is the case, and we believe that is the case, we would like to add a sentence following the first sentence in 509 which ends, "submitted to the board."

We would add this sentence: "Hospitals whose rates are reviewed by a voluntary non-profit rate review organization approved by the board shall submit such fees as are specified by that organization and at such time as the organization may stipulate."

Now, the reason for providing an escape from the fee schedules set forth on page 58 is this: A voluntary non-profit organization, and, of course, they have the Minnesota Hospital Association in mind, may need a different cash flow to maintain its operation. Acceptance of the rate schedule contained in this section would make it necessary to go back and amend these rules before any increase could be made, a time-consuming and a cumbersome process.

The Association has a steady level of expense to carry and cannot depend on an erratic flow of funds that is related to the random filing dates of 180 hospitals. The present MHA system requires an annual payment based on size, the same schedule as below, payable at a set date in the same manner as association fees, and in order to protect the economic integrity of the Association I would strongly recommend the inclusion of the sentence which I read to you earlier.

Thank you.

MR. BREVIU: Mr. Hearing Examiner, the statute, Chapter 296, Article II, Section 7, Subdivision 6 addresses itself to the question of filing fees. In that section it states that the Board of Health may prescribe by rule the filing fees for any report which is submitted to the Board.

Obviously Mr. Van Hauer is addressing the subject of those hospitals who choose the alternative system, which is provided in another aspect of the statute; that is voluntary organizations.

The rule which the Board is promulgating is related to fees filed with the Board, and a voluntary organization has its own costs, as pointed out. What is a reasonable fee for the Board may or may not be a reasonable fee for that organization, but I guess that is neither here nor there. The Board of Health when it promulgates a rule establishes filing fees. It must necessarily limit that rule to the Board of Health.

EXAMINER MIHALCHICK: You are saying it is not necessary to put that sentence in?

MR. BREVIU: Basically.

EXAMINER MIHALCHICK: And you want it in because somebody might claim that this fee schedule is binding on you?

MR. VAN HAUER: Yes, Mr. Examiner, because of the definition of "system" as I pointed out on page 7. It does seem to embrace in that definition both the system we would operate and any other system which the Board would operate.

MR. BREVIU: It wouldn't hurt to have that sentence in it. It would perhaps clarify the rule and wouldn't change the subject of the rule.

MR. SATTLER: Each independent system could have its own.

MR. VAN HAUER: All right.

MR. SATTLER: We have skipped over a number of pages, and let me ask in the interest of time from the Hearing Examiner's standpoint and from the organizations' standpoint, is it necessary to speak to all of the -- Page 51, MHD 496, which has to do with the approval of the alternative systems and the process by which they will be approved, and the criteria and this sort of thing?

EXAMINER MIHALCHICK: Well, I know the Hospital Association had a copy of the Statement of Justification on that. Do you have any questions on it?

MR. VAN HAUER: No, sir, we are comfortable with it.

EXAMINER MIHALCHICK: Does anybody else have any particular interest or a question on the approval of the voluntary organization?

MR. LAMSON: No, we don't.

MR. O'HARE: No.

EXAMINER MIHALCHICK: All right. We will stand on the Statement of Justification.

MR. SATTLER: Okay. The fees section essentially -- one comment on the fees section. Just let me state that in Minnesota the statutes and the Act require that the fees be charged and that they relate to the cost of reviews, and basically we have proposed an initial fee structure, and that is filing fees generally, and without further comment we will stand on the Statement of Justification if no one else has any qualms about it. They also only impact on the hospitals, so if the Hospital Association is comfortable with it --

EXAMINER MIHALCHICK: You say the complexity is strictly related to bed size?

MR. SATTLER: Not completely. Not completely, but if you look at size and at the various -- size does comprise more service centers, and the more service centers you have to deal with the more complex the analysis becomes, so you can use size as a proxy.

Also there are some equity questions. Usually we don't like to get into the area of public finance, but the ability to pay, and small hospitals have small budgets, so it just seems more equitable to have them pay somewhat lesser fee than the larger hospitals that have a larger budget.

MR. O'HARE: Does beds here mean set up and staffed?

MR. SATTLER: I believe it is licensed, as it states on the top of the page, the head of page 58, on

the top.

MR. O'HARE: I guess I am just trying to be cute. You know, in other words, the rest of the program is based on one definition of beds and I wonder what the reason here is.

MR. SATTLER: Well, I could change it to staffed and set up, but then we have to increase -- you know, we need so many dollars, that is what it amounts to.

MR. O'HARE: Mr. Examiner, I have one question -- I guess I missed a section -- talking about the annual increase limitation that could be provided for. Page 55, I believe it is -- yes, page 55, "Board Determination of Allowable Increase Limit."

MR. SATTLER: Okay, I'm sorry.

EXAMINER MIHALCHICK: We didn't talk about that.

MR. SATTLER: Okay. The justification is this: Recognizing two things; number one, it may be administratively to the advantage of the review system and the hospital to know that there is a review threshold that exists and that if rates are increased below that threshold, and if indeed financial requirements have been determined reasonable, then a review might not be necessary or a more expedient review can be undertaken of the institution if the rates are below that level.

It establishes if the institution then raises less than that level going into the year it may raise its rates up to that level during the year without necessarily filing an additional report. If the increase is above that level then it would have to go through a new entire filing, and it is a way of really easing

the paperwork burden and setting up a clearcut criteria for when you have to file again.

As we say, you have to file annually but if during the year you want to make a change in the rates for various reasons, "when do I have to go through a major filing?" So this is the trigger for that mechanism, and the Board shall determine what the reasonable increase limit will be for any given period.

MR. O'HARE: Thank you. My question relative to that is the implication I gather is this would be a single amount applicable to all hospitals, and it would be broken down then by classification, or would it be broken down by individual hospitals, recognizing that hospital expenses -- just taking salary versus salary and wages -- versus non-salary and wages can come up with different areas of, you know, bases for increasing based on those costs, and, therefore, a single across-the-board limit would prove rather arbitrary, although perhaps it is the only way to do it if you are trying to do it very simply. I just wondered what the intent was.

MR. SATTLER: Actually the intent here was initially twofold: Number one, to comply with some language in the legislation which says that rate increases that have minimal impact do not necessarily have to comply with the sixty-day prior notification, so we are trying to define minimal impact.

Next from an administrative standpoint, this paperwork and filing, since we have written this a further thought could be put into setting this up on peer group

standards that the board establishes.

474, Report Requirements. This lays down the types of information that the system will need to comment upon the financial condition of institutions, of hospitals and proposed rates and financial requirements.

It consists of annual financial information which is to be filed 120 days after the close of the institution's fiscal year, and shall consist of detailed balance sheet, as outlined in A. 1. of 474.

This balance sheet definition is consistent with the MHA chart of accounts of hospitals and the AICPA guide for balance sheets.

Income statement, detailed income statement, on page 10, 2., and a statement of expenses by natural classification for the whole institution, as outlined on page 11; an unaudited copy of the hospital's cost report filed with the Medicare intermediary or the Title XVIII Medicare cost report.

We also say that if the institution cannot provide a balance sheet or income statement in the forms suggested here, that they send documentation as to where and in what respects it differs from this format.

The reason we have done this is because we have no specific legislative authority to require uniform accounting or reporting, and we may have a suggestion for the format that the information should take, but if it is different we will accept it but we would like a complete enumeration of those differences.

EXAMINER MIHALCHICK: Comments? Mr. Van Hauer.

MR. VAN HAUER: Mr. Examiner, I would like to make

two suggestions, if we may, please. One would be on page 12 down toward the bottom of the page. We find Paragraph (iv) captioned management services; and Subparagraph (v) collection services, and we draw attention to Subparagraph (d) toward the top of the page carrying the heading, "Other Professional Fees," and (i) under that is "Consulting and Management Services."

This means that management services could be placed in either one of two places. That is bound to cause confusion, lack of comparability. We would suggest that it be deleted from (iv) and left under Paragraph (i) Subparagraph (d), and in similar fashion we would suggest that collection services ought to also be moved to Paragraph (d) because as a matter of fact consulting services often go on to become legal services, which are also part of that same sentence.

Then we would like to bring to your attention the matter in Paragraph 5. on page 14, and I would ask Robert Potts to speak to that point if he would.

MR. POTTS: This Paragraph 5 is a rather dramatic extension of the attest function, and it would seem to require the attest function being performed on projections and on some rather undefined terms, at least in accounting literature, such as reasonableness of resources and necessary resources to maintain hospital solvency.

I don't believe the state of the art as it relates to public accounting at least is in a position where it can yet attest to what is reasonable and adequate without well-defined and generally accepted measurement

criteria.

I would suggest that this form of attestation be held in abeyance until such requirements, if considered necessary, could be established in conjunction with an appropriate body of public accountants, such as the Minnesota Society of CPAs, and this would eliminate the potential problem of a report being deemed incomplete due to another group which is outside of the control of the hospital and not being able to perform under these rules.

MR. SATTLER: We don't object to that. We realize the wording here probably takes the public accountant outside of his normal area.

EXAMINER MIHALCHICK: What should it be changed to, or should it be deleted entirely?

MR. SATTLER: I think that --

EXAMINER MIHALCHICK: Let's ask Mr. Potts. What would the accountant attest to?

MR. POTTS: I would think there would be no objection to requiring an audit by a qualified independent public accountant and the submission of his report. Going beyond that, perhaps laying down the scope of what his services are.

MR. SATTLER: Recognizing that it is not an independent certified public accountant.

Just one note on page 14, on 4., "Attestation by the governing authority of the hospital or its designee -- " we would expect that that language be very similar to the language which is currently included in the Medicare cost report, just to clarify what is intended

and what type of attestation would be necessary.

MR. LAMSON: Fred, you are requiring the institution to file a copy of the unaudited Medicare cost report which contains that attestation?

MR. SATTLER: Right, but in addition to that on the balance sheet and income statement.

MR. LAMSON: But the Medicare attestation covers the reports that are filed therein, which contain the balance sheet and the income and expense statement, so I think that as long as they have filed a copy of the Medicare cost report and have signed it, then you don't need number 4. Right?

MR. SATTLER: Mr. Lamson is an expert on Medicare requirements. If he thinks it is the same purpose --

MR. LAMSON: Well, Mr. Fearing has suggested here that number 4 indicates governing authority to mean a member of the Board.

MR. SATTLER: Or its designee. I would --

MR. LAMSON: Or its designee, which would be the administrator or chief financial officer, which is approved for the Medicare cost report.

MR. SATTLER: Yes.

MR. LAMSON: I submit that if the Medicare cost report is submitted as part of this and it is properly signed, that you don't need number 4.

I am wondering now. The only -- no, all hospitals are required to file Medicare cost reports, even a childrens' hospital.

MR. SATTLER: I think though we should probably leave this in for this reason. We could say the Medi-

care cost report would be sufficient attestation. We may not in all cases in the future have every hospital sign a provider agreement.

MR. LAMSON: Well, you could add a sentence to this to identify that if the Medicare Cost report has not been submitted and signed --

MR. SATTLER: Also if Medicare decides to change their format, I think legally we should have our own requirements. I think we could say if you sign the Medicare cost report that suffices. That would be no problem --

MR. LAMSON: Yes.

MR. SATTLER: -- in the administrative sense.

Okay. Rate Revenue and Expense Report, Page 14, B. This particular report is really the heart of the prospective analysis and determination of reasonableness of financial requirements.

We say that each hospital shall submit this report annually. The report shall include both financial and statistical information for three years; what is called the prior year, which is the last year in which you had a full audited statement; the current year, which is the year in which the form is being filled out, which shall contain eight months actual data and four months projected data; and the budget year, which is the forthcoming prospective year or the year in which the rate increase will be taking place.

The Department will develop a set of forms that can be used to guide and help in getting, you know, establishing what kind of information is required and the

appropriate format, and I believe I have a number of amendments, am suggesting a number of amendments on page 15.

They are in 2., statistical information, a. I would like to add the word after "hospital," -- add the words "and each appropriate service center."

The reason or the rationale for adding "and each appropriate service center" is that the rules generally look at information on a total hospital and on a service center basis. We would, therefore, need patient days both on the total hospital and on the service center basis. This is information that the hospitals normally accumulate anyhow, and if they don't we would hope that they would start.

In d., we would like to delete what is there and include the following: "The number of beds (licensed), the number of beds physically present (the statistical mean), and the number of beds actually staffed and set up (the statistical mean) for the hospital and for each appropriate routine service center."

Then e., we would like to delete. The reason is the system can compute that as well as the institution. There is no need for the institution to run that statistic.

That takes us through statistical information. Why don't we take comments on these sections?

EXAMINER MIHALCHICK: We didn't take any comments on the reports, balance sheet, either, so any comments on any of those. Mr. O'Hare.

MR. O'HARE: Is it appropriate to go back to Page 8?

When they are talking at the bottom of the page about "plant capital allowances, including historical cost of, price level increments related to an accumulated depreciation related to:" and it enumerates items there, we have already expressed our feeling about price level depreciation, but in addition I just wonder are we confined here to indicate depreciation for land and construction in progress? Those are two items that are not, to the best of my knowledge, typically depreciable items. Construction in process is depreciated once it is completed and capitalized. Land is not depreciated.

Those are housekeeping items.

MR. EGO: Could I comment on a specific point?

EXAMINER MIHALCHICK: Mr. Ego.

MR. EGO: On the bottom of page 8, that (2) starts out talking about "Plant Capital Allowances, including historical cost of, -- "

Well, you would want to see the historical cost of land and construction in progress even though we don't have depreciation, so I think for that reason you would want to leave it in there.

MR. SATTLER: I don't think this implies depreciated.

MR. O'HARE: That's right.

EXAMINER MIHALCHICK: They are talking about a balance sheet here.

MR. O'HARE: Another housekeeping item on page 10. It says 2. a. "A detailed statement of income and expenses, including:"

Then I think we had eliminated the courtesy discount previously. This has been brought to my attention. Therefore, it should be struck too as well under (3) at the bottom of that page.

MR. SATTLER: Correct.

MR. O'HARE: And I guess on page 15 regarding the statistical information --

MR. LAMSON: To go back to page 10, I don't think you would necessarily strike "courtesy discounts" in this situation. It should be laid out. This is a detailed statement of income and expenses, and if you do have courtesy discounts then it should be identified so that they do not get into the expenses.

MR. SATTLER: Let me possibly suggest non-cost justified discount, which is consistent with at least the proposed language, and depending on what happens with that language we can debate again.

EXAMINER MIHALCHICK: Your point is everything should be disclosed here whether or not it is allowable for determination of reasonableness?

MR. LAMSON: Correct. It should stay in that item (3), either that or the term that Fred suggests.

MR. O'HARE: On page 15 on the statistical information, item h., where it indicates, "The hospital shall select the statistic that best measures the level of activity for a particular function -- " Is it the feeling it is outside the authority of the legislation to require that there be a uniform statistic used to measure this?

I think where I am coming from on that point is

that although, you know, you can't mandate that, what you are talking about here is, you know, really the rules for the voluntary -- guidelines for the voluntary program, and maybe we should question what the authority empowered is there, but it seems like having a variation in statistics could end up striking at the ability to compare.

MR. SATTLER: The drafters, the individuals involved -- when I say "individuals" all those who had input in to the drafting of these rules, you know, were cognizant of the difficulties associated with comparisons of various types of statistics and statistical measurements.

We were also aware that -- Mr. Jackson specifically was aware of the lack of authority, as he pointed out, to mandate uniform accounting. We believe that the mandating of uniform statistics is at the very heart of the uniform accounting question.

Also we have realized that the federal government is developing a uniform accounting and reporting system which we believe will be mandated for Medicare use within the relatively near future. As such, we did not feel it wise to make great changes in the current practices of institutions in the state until we can get a much better handle on what the federal government is planning and what they will do.

MR. O'HARE: If I can respond to that, as far as I know, there is no authority for the federal government to implement a uniform accounting and reporting system. There is authority under Section 1526 -- well, the new

planning legislation, to develop a uniform accounting system, which they are doing, but they had no authority whatsoever to implement that anyway.

MR. SATTLER: Well, I was told -- if you are familiar with the proposed Talmadge Bill, which talks about the form of this Medicare reimbursement system, there is also a requirement within that piece of legislation which talks to uniform accounting. As best as one can "crystal ball" this situation, they are going to pass it sometime next year; and also talking with the people at the Social Security Administration they are not convinced that under existing legislation they do not have the power to mandate uniform accounting.

Off the record.

(At this time a discussion was had off the record.)

EXAMINER MIHALCHICK: On the record. Mr. O'Hare.

MR. O'HARE: There would be substantial opposition to any move on that part by, you know, all providers, led by the American Hospital Association, I am sure.

I just don't see, you know -- well, I am talking here about statistics. I am not talking about uniform accounting, but putting it in the same breath, the power is limited, yes, I guess it is, but somehow using that particular statistic is not really the same as uniform accounting, but I think it is a measure that we have to use really to make adequate comparisons; otherwise, you are ending up making inaccurate or unjustified comparisons between institutions, which is not really

fair to the institutions being compared.

EXAMINER MIHALCHICK: Mr. Lamson.

MR. LAMSON: Yes, the Medicare cost report provides for statistics, and that statistic that they consider, or statistics that they consider, can be used as a measure, and most hospitals would probably be using that statistic for simplicity sake. Some hospitals do not necessarily agree with the statistic bases that the Medicare cost report uses, but, nevertheless, it is one that is used universally.

MR. SATTLER: The system also under the continuing analysis section will be looking at appropriate statistics to be using, and this whole evolution of the system over time in conjunction with the Hospital Association, Blue Cross, HIAA, to determine, I think, the appropriate way to go. There is an awful lot happening in a short period of time. We feel that it is about all we can handle just to get these rules started, reviewing, and we will be investigating this whole area over a period of time and proceeding in what I hope will be an orderly fashion.

MR. VAN HAUER: Mr. Examiner, one small point, if I may, please, on page 15. Paragraph 2. a., as amended, uses the language "each appropriate service center."

b. contains the same language, "each appropriate service center."

d. contains the language "each appropriate routine service center," raising the implication that there is some difference then.

After studying this it is our conclusion that we

are talking about identically the same items in Paragraphs a., b., and d., therefore, we would suggest that the word "routine" be deleted.

MR. SATTLER: We think that is in keeping with what we intended.

Paragraph e. also, if I remember correctly, Paragraph e.

MR. LAMSON: You have deleted that.

EXAMINER MIHALCHICK: We are talking about Paragraph d., aren't we?

MR. SATTLER: Yes.

MR. LAMSON: But the amendment also shows "routine".

MR. SATTLER: Correct. We can strike that.

MR. LAMSON: You want to strike it out?

MR. SATTLER: Yes.

MR. LAMSON: Fine.

EXAMINER MIHALCHICK: Mr. Fearing.

MR. FEARING: Yes, Mr. Examiner. I would like to make one further point on this section on page 14 under the Rate Revenue and Expense Report, Item b., which calls for information with regard to this report, and it states under item b. (1) that "Information for at least the first eight months shall be actual;" (2) "Information for the last four months may be estimated."

In order to bring this into conformity with Section 474 B.3.a., on page 16, which requires six months of actual and six months of estimated, we think this change should be made here.

Secondly, would the sixty-day filing requirement in advance of these regretable expense reports, it be-

com● virtually impossible for ● hospital to get the complete budget cycled down if they are required to have eight months of actual data and then have to submit their data ahead of time sixty days, which takes them ten months to a year; you have basically two months to get your accounting reports out, it is another fifteen days, and that leaves you forty-five days to provide your entire budgeting cycle.

Even though Mr. Sattler will shake his head, I would like to see him do it in our hospital in forty-five days.

MR. SATTLER: Off the record.

(At this time a discussion was had off the record.)

EXAMINER MIHALCHICK: On the record.

MR. SATTLER: First let me comment there is no necessary relationship between page 14, B.1.b. and page 16, 3.a. There is no necessary relationship between those two sections, and I think to draw a parallel is spurious.

I would suggest though that quite possibly Mr. Fearing might have a point about the eight and four, although I doubt if we can go as far as necessary in meeting the requirements of his hospital. I think that somewhere in the area of seven and five might be considered reasonable.

Now, let me comment on the reason why there is no relationship between Section B.1.b. and 3.a. In 3.a. we are asking for an actual financial statement, and

recognizing that hospitals might only pull financial statements quarterly or semi-annually we are asking for the actual financial statement. The actual information may well be available on a monthly basis even though you don't pull the formal financial statement, so the difference in timing is hopefully to recognize the formal financial statement operation versus just aggregating of data.

We have, by the way, found that that is a very reasonable approach in the Hospital Association's rate review program over the last year and a half, and has worked rather well.

EXAMINER MIHALCHICK: Mr. Fearing.

MR. FEARING: I think I will disagree with Mr. Sattler in that when you are putting together the information required in the rate revenue and expense report there is no way that you can legitimately put it together accurately without pulling a balance sheet for a base period, base period starting point, if you will, to project future periods, so I would suggest that in order to just make the simplest change in the language source that all the working capital requirements, etc., do not have to be changed in the light of this particular provision, that if we could settle with my original suggestion of six months and six months, it might save us all a lot of headaches, particularly in the administration of this program once it is started because I really think that in order to validate the information in the Rate Revenue and Expense Report, it is necessary to have actual balance sheets, which Mr.

Sattler is correct in saying a lot of hospitals don't have, particularly on a month-to-month basis, but perhaps only on a quarterly basis.

EXAMINER MIHALCHICK: Is six and six unreasonable?

(No response.)

MR. FEARING: One other point I would like to make, just to make it so it is at least six months and that the remaining months be estimated so that if a hospital does have more information and wish to use that period of information that it can.

EXAMINER MIHALCHICK: Do you want to consider it?

MR. SATTLER: We will consider it.

EXAMINER MIHALCHICK: Did you talk about number 3?

MR. SATTLER: Number 3, Financial Information. Basically this talks about financial information, and I have an amendment on page 17 in d., top of page 17.

I am suggesting we remove the words "step-down," and strictly talk about "an" allocation, and again for the same reasons I deleted it earlier.

Also in number 4 we are asking that the Rate Revenue and Expense Report contain a statement of the pricing policy of the institution.

This is something that the American Hospital Association itself suggests that the hospitals do engage in, undertake, so we are also suggesting that.

We again ask for attestation by the hospital's governing authority or its designee that the rates are set equitably and without discrimination among insurers.

c., we are asking that if the hospital expands facilities that they do provide the report; that if that expansion does require a certificate of need, that the certificate of need application be filed along with the regular Rate Revenue and Expense Report.

MR. LAMSON: In reference to that item, Fred, there is a list that is published by Mr. Gilley's (phonetics) office. It should be available and really I think it would be unnecessary. I mean, it is all right, but --

MR. SATTLER: The only problem is we would like that report. I am sure if Mr. Gilley's office has that report --

MR. LAMSON: Okay.

MR. SATTLER: -- I don't know why they wouldn't, but as long as the report is available; I am sure there are multiple copies of that report at the institution, so we are asking for a copy. I don't see that as a problem.

MR. LAMSON: Okay.

EXAMINER MIHALCHICK: Mr. Ego.

MR. EGO: This Section b. that deals with the Rate Revenue and Expense Report leaves a certain amount of uncertainty on one issue.

There have been a lot of hints about rate increases in the budget year, and we have the involvement of the interim increase report, and nowhere in this discussion of the Rate Revenue and Expense Report is anything said about the fact that the hospital in preparing its budget will incur such charge or rate increases as it deems appropriate under the system.

It does say that it will lay out the pricing policy, but it kind of leaves us a little uncertain as to -- first of all, we aren't really positively clear on the point that the budget would be prepared with these increases in it; and, secondly, we are not at all clear as to how detailed the information would be.

Are we just talking about the overall rates of the institution, or are we talking about the individual charge numbers for every test, or just what? I would like some clarification of this if Fred could give it.

MR. SATTLER: We do not see this going to individual charges or really asking that you send those in. We would think that a number of your points would be handled in the forms and instructions themselves and, yes, it would be -- if I could draw an analogy to the forms that the Hospital Association currently uses, I think that would give you an idea of the kind of thing we had in mind for forms and the way it would include the budget year projections, both prior to charge increases and after charge increases and things of that nature, so, yes, we would be specifically covering that.

We thought that was somewhat implied in this. We do have to -- we get into it later -- but we do have to develop forms, and some of these are technical questions that appear to be handled by the forms themselves.

MR. EGO: Thank you.

MR. SATTLER: Okay. Page 17, C. Interim Increase Reports. Each hospital who desires to modify a rate

during the budget year shall submit an interim increase report if the rate would exceed the interim increase limit, and we have talked about the interim increase already so I think we have a fairly good case of the rationale behind the limit and then the form submission.

The interim increase report, if filed, will take the form of the rate revenue and expense report essentially, and the same types of information required on the rate revenue and expense report would be required on the interim increase report; all the statistics, all the budgets, actual, projected, this kind of thing.

Okay. Is there any question on the interim increase report?

(No response.)

I guess not.

Next we move into Section MHD 481, which sets forth administrative procedures. Here we talk under A. that the system shall develop a set of forms. Forms, I think are generally implied by the reporting requirements set forth in the proposed rules, and I would certainly expect, just to anticipate comments, that we would be concurring with all of the interested parties in developing a set of forms, whether they be HIAA, Blue Cross, the Hospital Association, public accounting firms, anyone who we think would have some positive input.

With that are there any specific comments about this form?

(No response.)

Next, all documents must be filed with the Health Department. I think it is self-evident, that we don't have to justify that.

The reports will be available and open to public inspection, as meeting the intent of the legislation. We will do that.

No report required by these rules shall be deemed to be filed until the system has ascertained the completeness of the report.

MR. LAMSON: You say the reports shall be open to public inspection during business hours. What about somebody that comes in and wants copies of the reports? There is no provision here for charging for making copies.

MR. BREVIU: The Health Department, and the Board of Health specifically, has already promulgated the rule already to xerox copies of any public documents, so that would be covered.

MR. LAMSON: Thank you.

MR. SATTLER: Okay. The one thing to note here is that no report under this -- no report required by these rules shall be deemed to be filed until the system has ascertained the completeness of the report.

This means that no rate increases can occur until sixty days after the report has been filed, subject to the comments and the rules we went over earlier, and I don't know exactly what the citation was, but I think

487 C.1.

Any comments then on those particular points?

MR. FEARING: Let me back up a minute. Let me make comment on page 17, which I think we missed before.

On Page 17, Item e. where it says, "A statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of patients days outstanding -- " I think that was supposed to read "The average aggregate number of days charges outstanding at the end of each period."

MR. SATTLER: Yes, thank you.

Okay. The filing of the reports of annual financial information, they must be filed within 120 days of the end of the institution's fiscal year, except for the Medicare cost report, which we recognize may not be filed with the intermediary within 120 days, so that at the time the report is filed with the intermediary it should be filed with the system if it is in excess of 120 days.

We will also consider the filing to be quote, "temporarily" complete, subject to submission of Medicare's cost report and will not affect additional other filing requirements.

Failure to file, on page 21. Any hospital which fails to file may be subject to a fine as a misdemeanor, or the Board may consider this a violation to revoke or suspend the institution's license, the only legal recourse, I think, the Department has with regard to meeting the requirements of this particular Act.

MR. VAN HAUER: Mr. Examiner, the Association is

deeply concerned about the possibility that because of an administrative detail their license might be revoked, suspended or its reissuance denied, depending on the time.

This seems to us to be far too punitive for what is involved. The exacting of a fine is reasonable. We would submit that the proposal to revoke, suspend or deny is not reasonable, and would take strong issue with it. As a matter of fact, I would go so far as to wonder whether the state could even enforce that.

MR. BREVIU: Mr. Hearing Examiner, I believe this is simply a statement of law. Section 144.55 gives the Board of Health the authority to revoke, suspend or fail to renew the license of any hospital which is in violation of the Board rules; however, first there must be a hearing and, obviously, that is where the arguments Mr. Van Hauer has raised could be raised if the Board were ever to attempt to do such a thing.

In regard to the statement about a fine being reasonable, the statute does not confer upon the Board the authority to fine a hospital under these circumstances. They can, however, file a complaint with the County Attorney, alleging that the hospital is accused of a misdemeanor pursuant to 147.49.

EXAMINER MIHALCHICK: This is just, I think, a restatement of what is available. It is not likely that any of it would be used, I would think.

MR. LAMSON: It is my understanding that this is the only thing really that is available as a punitive measure.

MR. VAN HAUER: Too strong.

EXAMINER MIHALCHICK: That provision on the Board's authority to revoke or suspend is not only for this set of rules, is it? It is for any of its rules?

MR. BREVIU: That is correct. Any licensed health facility may have its license revoked or suspended for failure to comply with Board of Health rules.

EXAMINER MIHALCHICK: It seems to me you are putting it in because there is nothing else to put in here.

MR. BREVIU: It is simply an expression of the statutory authority and serves further to put the facility on notice, I believe.

MR. VAN HAUER: Mr. Examiner, we are familiar with the fact that the Board of Health could suspend the license where the Board of Health rules are being disobeyed by the hospital. This is intended to protect the public's health. The Board has rules of certain sanitary measures, other provisions, safety precautions, where a long list of things bearing on patient care are involved, and where the institution after due notice continues to violate those rules, then certainly one would not question the authority of the state to terminate it by the only means they can.

I would refer to my earlier comments that this is an administrative detail, and failure to satisfy the parties concerned on an administrative detail is not sufficient grounds to put the institution out of business. It doesn't bear on the institution's ability to provide adequate care, which is its function.

EXAMINER MIHALCHICK: Okay. Thank you.

MR. SATTLER: C. Filing of Report of Rate Revenue and Expense. Hospitals shall annually file such a report. The reason for this is so that the system can review financial requirements and rates, and see to it that the legislative intent is carried out on an annual basis. About failure to file once again.

We go now to page 22 D. Filing of Interim Increase Reports.

MR. VAN HAUER: One moment, if you please, Mr. Sattler. May I comment on Paragraph C.1?

Here we have a statement that the hospital shall file a report of rate revenue and expense sixty days prior to commencement of any accounting period of the hospital.

The Association would like to suggest the addition to that sentence of this language: "or sixty days prior to the effective date of a proposed rate increase," and the reason for this, Mr. Examiner, is this entire task of accumulating the financial data necessary to file these reports and their attendant schedules, and so on, if a hospital would prefer to do that during the last sixty days of the fiscal year, and most of us would, we would not object to postponing the effective rate increases until sixty days after the start of our year, and I think that is the essential towards which this is addressed; namely, that there be a sixty-day period between filing and the effective date of the beginning of the new rates, and to insist that the hospital must do all this number work at a time not particularly convenient, and causing the hospital to redo much of it

again for its own purposes, and instead refuse to offer the hospital the alternative of saying, "we would rather do it the last sixty days in our fiscal year. We don't mind putting off our rate increase for sixty days to comply with the processing period," -- I would think this would be a proper extension of cooperation between the Department and its constituent hospitals.

MR. SATTLER: Let me ask a question. Would it be a great burden if we changed the language to say that sixty days prior to the commencement of any accounting period or on the last or first day of its fiscal year?

The reason I suggest that is I think we have a responsibility to review annually the relationship of cost and charges. For administrative purposes we have some control so that we know fiscal years, so we can line up fiscal years and file them, and keep track of who should file when. If we get into the middle of the year and sixty days prior to a rate increase, which may occur sometime during the second quarter of the year, we would never really know when a filing is due. It would be a great administrative help for us if we could keep track of the fiscal year.

Also filing on fiscal year can also include a projected rate increase that may not take effect until six months down the road, so that we would have that covered also.

I would think the fiscal year time is very consistent with the gathering of other information.

MR. VAN HAUER: We would agree.

EXAMINER MIHALCHICK: Mr. Ego.

MR. EGO: We were discussing a point here; I think it could probably be cleared up as kind of a detail and not take the time today.

MR. SATTLER: Okay. We do have another failure on page 21, 2.a., failure to file, which is similar to the failure to file we came across previously, and the whole failure to file section -- rate revenue and expense follows the same failure to file as the financial information.

Do you want to say anything about the failure to file on this?

MR. VAN HAUER: Pass.

MR. SATTLER: On page 22, D. Filing of Interim Increase Reports. We state the basis upon which interim increase reports have to be filed, and I think we have discussed the whole question of interim increases and interim increase reports prior, and I think if the hospitals are sufficiently comfortable with our justification -- do you have any comments?

MR. VAN HAUER: No comment.

MR. SATTLER: We also --

MR. EGO: Excuse me. I lost track of where you are at the moment, because I do have a question.

MR. SATTLER: We are on the bottom of page 23.

MR. EGO: That is where I have the question. Thank you.

The bottom of page 23, Subparagraph D. talks about a retrospective assessment of a hospital's compliance.

We made reference to this earlier when we were discussing the other subject of adjustments between fiscal

years for exceeding or failing to achieve budgeted volume, and suggested then there might be some either conflict or doubling up of penalties as a result of both of these sections.

Again I would draw the attention of everybody to the fact that when it says, "the system shall recognize that actual rates -- " we are again talking about a big lump composite average for the whole hospital, and we do not charge our patients that way. This is the result of how we charge our patients and a result of what kind of patients come in and what kind of services they get, so that we can be actually placed in the position of having changed none of our original plans and yet retrospectively finding out that this actual rate did creep up beyond some reasonable amount.

You go on to define reasonable amount, and if I interpret this correctly -- let me give an example. If the system judged that the allowable increase limit for the four quarters was 6%, I would infer from this that the reasonable amount by which you could exceed the projected rate would be 1.1 times 6%, which is 6.6%.

I am not sure I have interpreted it correctly, but that is the way I have interpreted it. Is that correct?

MR. SATTLER: I believe so.

MR. EGO: Thank you.

Then while again talking about this same section, if we refer back to D.1. on the preceding page, it says, "A hospital shall file an interim increase report sixty days prior to the effective date of any amendments or

modification to rates -- "

Well, when you take that in conjunction with this Subparagraph d. that would suggest that the hospitals have to be able to predict by at least sixty days when they are going to be running over their actual rate for the budget year, which is a very difficult thing to do at best. I don't see how this can be made to be workable.

Being in a position of exceeding the projected rates can be completely beyond our control even though we have submitted a budget; we have done all our work to the best of our ability, and then we must predict sixty days ahead of when it is going to happen that it is going to happen, and I don't see how we can comply with this requirement.

MR. SATTLER: The rationale of allowing this excess, which I think you understand that it -- the interim increase report has to be filed, and it is possible that you don't believe you are going to exceed the budgeted rate, and so retrospectively we wanted to leave some sort of a corridor or a gap between the actual interim increase limit and what you might actually experience before you are said to be out of compliance with the system.

I think during the earlier discussions that Steve did talk with accountants and controllers about what kind of margin of error is reasonable and should be allowed, and I think that he came up with, after discussion, a tenth of one percent of that increase limit, and saying if you are within that or close to it -- you

know, I think we are all going to use some degree of reason here -- you are really not out of compliance with the system. It is really a protective measure for the hospital.

MR. EGO: I appreciate what you are saying, but that still puts us in a difficult position of having to predict sixty days ahead of time when we are going to be more than 1.1 times our projected rate.

MR. SATTLER: Well, if your projected rate exceeds the interim increase limit going into the year there is really no problem because any change as such would require -- okay, I think I see what your problem is.

Any change in current rates, in the rate as we calculated, would be assessed at the end of the year through that volume variance. If your increase was less than the limit and you are deciding -- let's say it was 6%; you raise it 4%, have 2% to play with, you say, "Okay, I will raise my rates 1.8% and I will be underneath sometime in the middle of the year." You raise it 1.8% and you really come out instead of 6%, you come out at 6.09 -- okay.

We would say you are really within the bounds of the system and you didn't violate any of the terms of the system, and, therefore, you didn't have to file an interim increase report.

MR. EGO: Let's suppose a different circumstance, I think, which would be quite typical, that when the rate revenue and expense report is filed you are already going in with a rate increase in excess of this allowable increase limit of say 6%, for example.

MR. SATTLER: Fine.

MR. EGO: Then at that point, if that is approved at that point we are already over that limit.

MR. SATTLER: Fine.

MR. EGO: Then how do these things work on it for that year?

MR. SATTLER: If you do not change your rate base yourself, in other words actually ask for additional revenues through an increase in charges, as we normally talk of charges, you would not have to worry about this provision at all. It would not apply.

MR. EGO: I wish it would say that.

MR. SATTLER: Okay. The intent is only if you were to go about raising your charges yourself, would this apply.

MR. EGO: On that basis, no objection.

MR. SATTLER: I think if we get into a definition of charge -- of rate, I think it might solve this problem. That is why we have this end of year adjustment business.

MR. EGO: Okay.

MR. SATTLER: We are almost finished.

Page 24, 3. Allowable Increase Limits. Basically this sets forth the language the hospital shall determine what that limit is, and it hinges upon the way the Board will promulgate the quarterly estimates and the hospital just adds these quarterly estimates together and that will be its annual increase limit, and we discuss how the Board will handle that.

Are there any questions with 3. Allowable Increase

Limits?

(No response.)

I have an amendment on Page 25, C., and after the word "designee," in the fourth line I would like to add the words, "notice of these amendments or modifications at the time they become effective shall be given to the Board," meaning that you don't have to fill out a full report obviously, but by letter so it is on file in case anyone asks was the system cognizant of the fact that rates were changed; this is to say yes it was, and I think it is in with our public disclosure mandate.

Are there any problems with that amendment?

(No response.)

Application for Variance in Rate Determination, E. Here also we are suggesting that we amend this by deleting the entire paragraph.

Does anybody have any problem with that?

MR. VAN HAUER: We support both those amendments.

MR. SATTLER: Mr. O'Hare?

MR. O'HARE: Fine.

MR. SATTLER: Also Filing of Reports for Multi-Hospital Corporations, F., the idea is that we have a number of multi-hospital corporations in the state and we would like to know what each specific individual institution is doing financially and statistically, not

the whole conglomerate. That is the rationale for that, so we can see that rates are set equitably for each institution.

Okay. Filing of Reports, the top of page 26. Extensions are allowable. The system can get together with the hospital and work out a reasonable way to handle filings if there is a problem.

I suggest that we have completed the rules.

MR. VAN HAUER: Mr. Examiner, before you close the record, on behalf of all the participants I want to thank you and the members of the panel for the effective, efficient way in which this hearing was conducted. Thank you.

EXAMINER MIHALCHICK: Thank you. I would appreciate your written comments, which will be due by the 26th at my office.

Okay. The hearing is adjourned.

* * *

REPORTER'S CERTIFICATE

I, Alice C. Nelson, do hereby certify that I recorded in Stenotypy the Hearing of the Board of Health before Steve M. Mihalchick, State Hearing Examiners Office on the 5th and 6th days of January, 1977, at the Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota;

I further certify that thereafter I transcribed into typewriting under my direction the foregoing transcript of said recorded hearing, which transcript consists of the preceding 288 typewritten pages;

I further certify that said transcript of such hearing is true and correct to the best of my ability.

Alice C. Nelson

Dated this 19th day
of January, 1977.

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE BOARD OF HEALTH

IN THE MATTER OF THE PROPOSED)
RULES OF THE BOARD OF HEALTH)
GOVERNING THE HOSPITAL RATE)
REVIEW SYSTEM.)

REPORT OF THE
CHIEF HEARING EXAMINER

WHEREAS, hearings were held on January 5 and 6, 1977, before Steve M. Mihalchick, a Hearing Examiner of the State Office of Hearing Examiners, on the above-entitled matter in compliance with Minn. Stat. §15.0412, Subd. 4; and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. §15.052, Subd. 3, was issued to the Board of Health on February 25, 1977; and

WHEREAS, the Board of Health has now determined to adopt rules prusuant to Minn. Stat. §15.0412, Subd. 4; and

WHEREAS, the Board of Health has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. §15.052, Subd. 4, and Rule HE 107; and

WHEREAS, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing and that the Board of Health has met all requirements of Minn. Stat. §15.0412, Subd. 4.

NOW, THEREFORE, upon receipt of this Report, the Board of Health has the responsibility of submitting the complete hearing record and the rules as adopted by the Board to the Attorney General and to publish in the State Register, all pursuant to Minn. Stat. §15.0412, Subd. 4.

Dated this 28th day
of April, 1977.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner