



JOHN D. ROCKEFELLER IV
Governor

STATE OF WEST VIRGINIA
HEALTH CARE COST REVIEW AUTHORITY

SALLY K. RICHARDSON
Chairperson
LARRY C. FIZER
Board Member
WILLIAM L. GILLIGAN
Board Member

Certification

Legislative Rules for the Freeze on Hospital Rates and Granting of Temporary Rate Increases, Chapter 16-29B, Series II (1984).

The above titled Legislative rules constitute the official rule promulgated by the West Virginia Health Care Cost Review Authority on the rate freeze provision of West Virginia Code, §16-29B-4 and filed pursuant to law in the Office of the Secretary of State, State of West Virginia.

Sally K. Richardson
Chairperson
West Virginia Health Care Cost
Review Authority

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE

THIS DATE Dec. 19, 1987
Administrative Law Division

Entered



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Notice

Legislative Rules for the Freeze on Hospital Rates and Granting of Temporary Rate Increases, Chapter 16-29B, Series II (1984).

The above titled legislative rules are hereby submitted to the Legislative Rule Making Review Committee.

A handwritten signature in cursive script that reads "Sally K. Richardson".

Sally K. Richardson
Chairperson
West Virginia Health Care
Cost Review Authority

Entered

WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY
RULE ABSTRACT

TITLE: Legislative Rules for the Freeze on Hospital Rates and Granting
of Temporary Rate Increases

TYPE: Legislative Rules

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE 12-19-83
Administrative Law Division

AUTHORITY AND RELATED CODE: West Virginia Code, §16-29B-1 et seq.
(especially §16-29B-4); §16-5F-3; §§29A-2-9,15; and §29B-1-3.

NUMBER: Chapter 16-29B, Series II (1984)

SCOPE: Implements freeze on hospital rates as provided for in West
Virginia Code §16-29B-4, as well as the temporary rate increase
provisions of that section of §16-29B-21Cc).

APPLICATION: West Virginia Code, §16-29B-4, states that "The Board
shall have authority to develop rules and regulations to administer
the provision of this section." These rules administer a portion of
Section 4 and will apply to all acute care hospitals in West Virginia,
except for federal hospitals.

COMMENTS:

Section 4 and these regulations remain under federal injunction issued
in April 1983 by the United States District Court for the Northern District
of West Virginia. Efforts to dissolve that injunction are continuing.
The regulations remain necessary to help hospitals and other intended
third parties plan for the financial functions of our hospitals.

West Virginia Health Care Cost Review Authority
John H. Kozak, General Counsel, 348-2678

DATE: December 12, 1983
TO: Legislative Rule Making Committee
FROM: Sally K. Richardson, Chairperson, WV Health Care Cost Review Authority
SUBJECT: INFORMATION TO BE SUPPLIED TO THE COMMITTEE
RULES: Legislative rules on Hospital Rates and Granting of Temporary
Rate Increases
INFORMATION REQUIRED

1. Please give the citation of the statute which authorizes your promulgation of these rules.

West Virginia Code, §16-29B-4; also, West Virginia Code §16-29B-1
et seq; §16-5F-3; §§29A-2-9,15; and §29B-1-3

2. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:
(29A-3-5)

- a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

- b. Was the hearing held on the date scheduled and were all interested parties permitted to be heard?
-
-

- c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?
-
-

- d. Is the transcript of all evidence received preserved and available for public inspection and copying?
-

3. For all rules promulgated:

- a. When did you file the rules in the state Register together with notice of a hearing time, date and location? (29A-3-5)

August 10, 1983; and October 7, 1983

- b. Did you give at least 30 days notice and no more than 60 days notice? (29A-3-7)

In each instance, yes

- c. What other notice, including advertising, did you give of the hearing? (29A-3-5)

Delivered copies to news media and mailed to Authority's list of interested persons.

- d. Was the hearing held on the scheduled date? If not, why not?

In each instance, yes

- e. Was the opportunity given for all interested parties to submit data, objections, suggested amendments, views, evidence or arguments?

In each instance, yes

- f. List all persons who appeared at the hearing and what type of comment they made about the proposed rules (for, against, suggested and amendments). Please attach a copy of the minutes of the hearing.

See attached copies of persons who attended public hearings,

summaries of comments and staff responses, and copies of

minutes of hearings.

- _____
- _____
- _____
- _____
- g. On what date did you file in the State Register notice of your action on the proposed rules together with the text of such rules?

Proposed rules were filed as emergency rules and

as proposals on August 10, 1983, and on October 7, 1983.

On December 7, 1983, the rules were refiled as emergency
rules and as proposed permanent rules.



Sally K. Richardson
Chairperson
West Virginia Health Care
Cost Review Authority

(Please attach additional sheets if necessary)

PUBLIC HEARINGS
REGISTRATION

DATE 9/13/83

NAME	ADDRESS	DESIRE TO SPEAK	
		YES	NO
J. D. BRADLEY	1707 28 th ST. VIENNA, WV 26105		
Stephen E. Skride	3 Mockingbird Drive Milton WV 25541		
Maire Ward	Cabell Huntington Hospital		X
LYNN HUBBARD	Stonewall Jackson Hys Weston	X	
ELWIN BRESSETTE	Thomas Memorial Hospital		✓
GARY . GOULD	WHEELING HOSPITAL		
William J. Day	WHEELING HOSPITAL		✓
RICHARD HOWE	ERNST & WHINNEY		X
Mary ANN GOFF	ERNST & WHINNEY		X
JAM OURS	ERNST & WHINNEY		✓
P. Paul	P.O. Box 1680		✓
Bl. Champ	Cabell Huntington Hospital		✓
John Hrenko	Roane Gen'l Hospital		✓
Maive Poljan	Council of St. West Virginians		✓
Mark Clement	629 Steady Ave Clarksburg, WV		✓
ALAN RIFDEN	BLUE CROSS		✓
Eleanora Wylie	Coalition on Legislation for the Elderly		✓
Larry E. ROBERTSON	CAMC	✓	
RALPH T. Bowles	11		✓
ROBERT J. HALONEN	11		✓
Robert J. O'Neil	Spelman Thomas Battle & Kleinstenmeyer		✓
HARRY S. MOORE	Young Moore & Company, Inc.	✓	
BROCK J. CHAMBERLAIN	W. V. I. A.	✓	

WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY

Public Hearing Minutes
September 13, 1983

The Authority held a public hearing on the following proposed regulation:

Legislative Rules on Freeze
on Hospital Rates and Granting
of Temporary Rate Increases.

Presiding: Sally K. Richardson, Chairperson

Members Present:

Larry C. Fizer

William L. Gilligan

Staff Present:

Bill Crouch
Mary Ann Johnson
Gary Thompson
Lynne White
Robert Durbin

Larry Arnold
John Bennett
John Kozak
Penny Esworthy
Shirley Jones

Public Present:

See attached list

PUBLIC COMMENTS

Freeze on Hospital Rates and Granting of Temporary Rate
Increases

- A. Lynn Hubbard, Director of Nursing Service, Stonewall Jackson Memorial Hospital and West Virginia Society of Hospital Nursing Service Administrators, provided prepared remarks. She spoke with regard to the wage passthrough section of Senate Bill 320 stating that wage and benefit increases were not addressed in the temporary regulations. She expressed concern that hospitals will be unable to increase their rates to offset costs for salary increases for nurses, and will be at a disadvantage in terms of recruiting and competing for nurses with the rest of the nation. She stated she felt the rate adjustments for emergency facility and major repair are inadequate, and also expressed concern that when hospital boards need to consider cost reduction to maintain operations, they will need to consider an elimination of patient services, which will deprive people of needed services.

- B. Larry E. Robertson, Director of Financial Services at Charleston Area Medical Center, provided prepared remarks. In summary, Mr. Robertson addressed five key issues as follows:
- Accuracy of definitions
 - Weaknesses of formula for determining the reasonableness of increases in patient revenues
 - Return on equity and insolvency snafu
 - Omission of wage passthrough adjustment.
 - Uses and transfers of hospital funds.
- C. Harry Moore, President of Young, Moore and Company, investment bankers specializing in municipal bonds primarily in West Virginia, spoke with regard to Section 6.02.06 - Bond and Loan Covenants. He also presented material which had been prepared by Moody's Investors Service.
- D. Bruce Carter of the West Virginia Hospital Association provided prepared remarks. In summary, Mr. Carter addressed the following issues:
- Accuracy and clarification of definitions.
 - Omission of wage passthrough
 - 3% average return on equity addressed in Section 6.03.03.

Absent further testimony, the hearing was adjourned.

PRESENTED BY: Lynn Hubbard, R.N.
Director of Nursing Service
Stonewall Jackson Memorial Hospital
70 Bed Facility
West Virginia Society for Hospital
Nursing Service Administrators

As hospital nursing administrators, we are responsible for the care W.Va. hospital patients receive. In our hospitals the majority of the care given to these patients is by R.N.'s and L.P.N.'s.

The wage pass through part of Senate Bill 320 is not addressed in the temporary regulations. This means that hospitals will be unable to increase their rates to offset costs for salary increases for nurses. Hospitals in our State will be at a disadvantage in terms of recruiting and competing for nurses with the rest of the nation.

When the Rate Review Commission actually begins to review rates, nursing salaries in our state will continue to be 2 - 3 % behind the rest of the nation. Some hospitals in W.Va. plan no wage increases, while others may be able to give 3 - 6 %. The wage pass through was one of the major selling issues of Senate Bill 320 to the nursing profession. All those who believed the wage pass would be a part of the temporary rate regulations were grossly deceived by the legislators and the rate setting commission.

One of the ways hospitals replace obsolete equipment, repair and update equipment and facilities is to set aside excess revenue over expenses and to fund depreciation. If hospitals use these methods, they will not be allowed rate increases. There will be a considerable time lag - an estimated 2 years between now and the time the Rate Review Commission will have an opportunity to establish rates for hospitals. There is a provision for rate adjustments for emergency facility and major repair, but it is inadequate. When equipment and facilities need repairs there would be too much lag time between change in the rate and the revenue rate increases generated. Nurses may be forced to practice with unsafe equipment or work in unsafe environments until adequate funds can be generated.

There is also a provision that loans may be made by hospitals to handle emergency repair or replacement. However, many hospitals in the State are city or county owned and do not have assets to generate funding without extensive - procedural and legal hassles.

Hospital Boards will need to consider cost reduction to maintain operations. They will need to consider an elimination of patient services that may not produce excess revenue even though the elimination of these services may deprive the people around this hospital area of needed services.

Hospitals will be taking immediate action to compress, freeze, reduce and eliminate professional nurse positions in favor of technical, less costly personnel. Staffing patterns will be changed to meet only minimum requirements of State and accrediting agencies as opposed to the use of optimum staffing patterns.

These recommendations of the society must be considered for the well being and health of the people of West Virginia. I submit these to you as a representative of nurse managers and as a nurse practicing in rural West Virginia.

STATEMENT FOR THE RECORD AND CONSIDERATION OF
THE WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY
REGARDING COMMENTS ON PROPOSED REGULATION FOR
THE FREEZE ON HOSPITAL RATES
DELIVERED BY THE CHARLESTON AREA MEDICAL CENTER
AT THE PUBLIC HEARING HELD SEPTEMBER 13, 1983

Chairperson Richardson, Commissioners Gilligan and Fizer, The Charleston Area Medical Center appreciates the opportunity to appear today and make brief comments regarding the proposed regulations for the freeze on hospital rates and the granting of temporary rate increases.

In the interest of time, I will limit my comments to five key issues that we feel the Authority needs to review in more depth before issuing these regulations for approval as an "emergency filing of legislative rules". These five issues were selected by us for discussion today because of their importance to the operations of hospitals throughout West Virginia. The fact that we have limited our discussion to these five key issues does not, in itself, indicate our approval or concurrence with the remaining sections as published. Also, it does not mean that there are not other issues in these regulations that need to be either clarified or changed.

The five key issues I would like to discuss are as follows:

- o Accuracy of definitions.
- o Weaknesses in the formula for determining the reasonableness of increases in net patient revenues.
- o Return on equity and insolvency snafu.
- o Omission of wage pass through adjustment.
- o Uses and transfers of hospital funds.

In our review of the definitions in the Regulations, we made a number of observations. The regulations define Cost Reimbursements as amounts payable for goods and services rendered to a class of purchasers provided that the amount contracted for is cost-based. Examples of such purchasers included workers compensation and members of health maintenance organizations. In reality, both of these organizations reimburse hospitals their charges and in fact are not cost-based payors.

Third Party Payor is defined as any person, corporation or government entity responsible for payment for patient care services rendered by hospitals. This definition implies that the patient who pays his own bill would be classified as a third party payor. This is not accurate and could create con-

fusion in further calculations involving percentages of payment received by the various actual classes of third party payors.

In reviewing the formulas for determining the reasonableness of increases in net patient revenues, we have a number of major concerns! In all cases, the formulas are based on the accrual method of accounting and do not take into consideration the daily cash flow needs of an institution. A hospital can clearly show a profit on its accrual based financial statements and yet be struggling to obtain the cash flow required to meet its daily operations. It's cash flow that keeps a facility viable and solvent; not the artificial profit that is reported on the bottom line of a financial statement. Slowdowns in the payments from such agencies as the State Welfare Department and the Public Employees Insurance Board, earlier this year, have created a cash crunch for many hospitals in West Virginia. This slowdown, however, is not reflected in the financial statements and therefore, would not be reflected in the Authority's formula for determining the reasonableness of a requested rate hike. The economic environment in which the hospital operates has a large effect on a hospital's cash flow. In many of the communities, in rural West Virginia, unemployment is high and the hospitals

have large amounts in uncollectable accounts and charity write-offs which do not decrease revenue but severely restrict cash flow.

The formula takes into consideration changes in the number of admissions from one period to the next. What about changes in the number of outpatient or emergency room visits from one period to the next? It has become an accepted premise that health care costs are reduced by shifting patient care from the inpatient to the outpatient setting. However, the formula completely ignores outpatient and emergency room visit information. What happens to the hospital whose emergency room and outpatient volume and costs increase rapidly while its admissions remain constant? The regulation also fails to define just what is included in "Admissions". Does this include strictly routine inpatient admissions or are we to assume it includes newborn admissions, transfers from one facility to another, intra-hospital transfers, etc.?

We feel that a hospital's revenue from sources other than patient services should not be considered by the Authority in the rate formula! If a hospital is able to generate outside revenues to help subsidize hospital operations, these revenues should not be considered by the Authority in allowing temporary rate increases. This provision will discourage hospitals from seeking

non-health care related revenues in that the more outside revenues they earn, the less revenues they can generate from their actual charge based structure. The rate formula should encourage hospitals to generate revenues from outside sources to supplement its revenue base!

The Authority has presented criteria for determining that a rate change is necessary to prevent undue financial hardship and insolvency. The regulations refer to a declining equity position as a rate of return on equity which averages less than 3% over a five year period. First of all, we feel it is very important that the methodology for calculating return on equity be defined. Our review of current accounting and financial texts revealed no less than five accepted methods of computing return of equity. Secondly, we feel the 3% level is unacceptable. The Medicare return on equity amounts, as permitted under law, have averaged nearly 15% for the past three years. If 15% is acceptable at the Federal level, we see no reason for it not to be accepted at the state level.

The bond and loan covenants stated in these regulations are such that if a hospital is in compliance with them, the facility is probably already in technical insolvency or headed towards bankruptcy proceedings. The covenants are so low (120% of annual debt service) that by the time a hospital reached these

ratios, it may be beyond recovery. These limitations will also serve to reduce the amount of borrowing available to West Virginia hospitals for future replacement of plant and equipment. With these types of restrictions, hospital bond ratings will fall, making it more expensive, maybe even impossible, to obtain tax-exempt funding so necessary to maintain and preserve our health care industry. Also, restrictive covenants such as these will discourage the investment banking community from making loans in West Virginia which will further increase the cost of borrowing to hospitals - rather than decrease costs.

The legislative act clearly called for a wage pass through for hospital employees. Nowhere in the rate freeze proposals or in the rate capping regulations as previously submitted by the Authority, was this pass through mentioned. Is it the purpose of the Authority to ignore this part of the statute or has this avoidance been an oversight on the part of those who prepared the rate freeze regulations?

We would like to see some explanation of how the Authority plans to incorporate this wage pass through into its review mechanism. Or, can we assume that this portion of a rate hike is not subject to review by the Authority and there-

fore, hospitals are at liberty to raise rates in an amount sufficient to cover increases in the labor component of hospital salary costs?

The Authority has restricted the use and transfer of funds by the hospital corporation to or from a parent, sister or subsidiary corporation or related foundation after February 1, 1983. We feel this is a question of corporate law and that the Authority should not have the power to pierce the corporate veil. We feel this question needs to be reviewed at the state and federal levels to determine the legitimacy of this section of the rate freeze regulations. This restriction will create havoc among the religious hospitals in West Virginia which depend on their "mother houses" etc. to maintain their financial stability. Proprietary hospitals owned by chain organizations will also be affected even though they are abiding by the standard corporate regulations in effect under the laws of the State of West Virginia.

It is our opinion that the quality of health care will suffer in the State of West Virginia if these regulations are approved and put into effect. As the regulations are written, cash flow will become an immediate problem that may force drastic cutbacks in the quality and quantity of health care services pro-

vided to the community. Hospitals that are unsuccessful in their requests for a rate increase, will be unable to reward their employees with just compensation, or may have to lay off employees just to survive. These employees may very well seek alternate career patterns or decide to seek employment outside West Virginia in states where industry regulation does not limit their career objectives. Without rate increases, hospitals will be unable to afford the latest innovations in the health care technology necessary to preserve the health and well-being of our citizens. In short, we do not feel that a rate freeze is the answer to cost containment in the health care industry.

We appreciate the opportunity to appear in front of this Authority to render our comments and opinions and offer our resources and assistance in examining the health care cost issue. We will appreciate any consideration to our ideas and alternatives that the Authority may make presently or in the future.

Respectfully submitted,

Larry E. Robertson
Director of Financial Services
Charleston Area Medical Center, Inc.

WEST VIRGINIA HOSPITAL ASSOCIATION
COMMENTS ON "EMERGENCY FILING OF LEGISLATIVE RULES
FOR THE FREEZE ON HOSPITAL RATES
AND GRANTING OF TEMPORARY RATE INCREASES"

MADAM CHAIRMAN, MEMBERS OF THE WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY, MY NAME IS BRUCE CARTER, PRESIDENT OF THE WEST VIRGINIA HOSPITAL ASSOCIATION. WE HAVE REVIEWED THE EMERGENCY FILING OF THE LEGISLATIVE RULES FOR THE FREEZE ON HOSPITAL RATES AND GRANTING OF TEMPORARY RATE INCREASES AND HAVE THE FOLLOWING COMMENTS TO PRESENT.

AGAIN, AS I DID UNDER THE TESTIMONY ON THE PROPOSED REGULATIONS FOR ADJUSTMENT TO GROSS PATIENT REVENUE, I MUST PREFACE MY COMMENTS BY STATING THAT THIS INPUT IS BEING MADE WITHOUT PREJUDICE TO THE POSITION ASSERTED BY THE FOUR (4) HOSPITALS IN THE LITIGATION WHICH IS PRESENTLY PENDING IN THE FEDERAL COURT WHEREIN THE JUDGE HAS ISSUED AN ORDER ENJOINING THE SECTION OF THE LAW DEALING WITH THE GROSS PATIENT REVENUE LIMIT AND FREEZE. ANY COMMENTS MADE BY ME OR ANY OTHER MEMBER OF OUR ASSOCIATION SHOULD NOT BE TAKEN AS AN INDICATION THAT WE ARE ABANDONING THE POSITION ASSERTED BY THE HOSPITALS IN THAT CASE.

THE PENDING LITIGATION AND THESE PROPOSED REGULATIONS CREATE A DILEMMA. THE HOSPITAL ASSOCIATION WOULD BE NEGLIGENT OF ITS DUTIES IF IT LET THE PROPOSED REGULATIONS PROCEED WITHOUT COMMENT AND, THUS, NOT PROVIDE THE AUTHORITY WITH THE BENEFIT OF OUR TECHNICAL INPUT.

FIRST, SOME GENERAL COMMENTS AND THEN WE WILL ADDRESS SOME SPECIFIC ISSUES POINT-BY-POINT IN THE PROPOSED REGULATIONS.

WHILE WE RECOGNIZE MANY OF THE POSITIONS TAKEN BY THE AUTHORITY IN THESE REGULATIONS, ARE DESIGNED TO BE OF BENEFIT TO HOSPITALS, WE ARE CONCERNED THAT THEY ARE, IN FACT, CONTRADICTORY TO THE LANGUAGE IN THE LAW. TYPICALLY, THEY WOULD BE FOUND TO BE EXCESSIVE REGULATION IN THAT THEY DO, IN FACT, CHANGE THE INTENT OF THE LAW. IN OTHER WORDS, IN SEVERAL INSTANCES THROUGHOUT THESE REGULATIONS, THE AUTHORITY IS REDEFINING SPECIFIC LEGISLATIVE LANGUAGE. NORMALLY LEGISLATIVE OVERSIGHT WOULD CHALLENGE REGULATION WHICH CHANGE THE MEANING OF THE LAW.

THE LANGUAGE IN THE REGULATIONS SOUNDS VERY MUCH LIKE LANGUAGE THAT WOULD BE USED IN THE STATE OF MARYLAND WHERE THE AUTHORITY HAS A SYSTEM FOR REVIEWING AND RULING ON HOSPITAL CHARGES. YET, INTERSPERSED THROUGHOUT THESE REGULATIONS ARE COST REIMBURSEMENT TYPE LANGUAGE WHICH IS INCOMPATIBLE WITH CHARGE BASED SYSTEMS AND THE MARYLAND LANGUAGE.

THE REGULATIONS DO NOT ADDRESS WHETHER OUTPATIENT SERVICES AND LONG-TERM CARE SERVICES (HOSPITAL BASED SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES) ARE INCLUDED. THESE DATA AND STATISTICS CAN HAVE A PROFOUND AFFECT ON THE HOSPITALS FINANCIAL POSITION. IN ADDITION, THE REGULATIONS DO NOT TAKE INTO CONSIDERATION THE UNCONTROLLABLE INCREASES IN THE COST OF OPERATING A HOSPITAL THAT HAVE OCCURRED AND WILL OCCUR. THESE TOO CAN HAVE A SIGNIFICANT IMPACT AND ARE NOT UNDER THE CONTROL OF HOSPITAL MANAGEMENT AND BOARDS OF TRUSTEES.

THE REGULATIONS, AND CORRESPONDING FORMULAE, DEAL ONLY WITH ADMISSIONS AND DO NOT TAKE INTO CONSIDERATION PATIENT DAYS, OUTPATIENT SERVICES AND OTHER VOLUME FACTORS. WHILE ADMISSIONS MAY REMAIN AT THE SAME LEVEL OR

EVEN DECLINE, DEPENDING ON THE INTENSITY AND SEVERITY OF THE PATIENTS AND ANY CHANGES THAT MAY HAVE OCCURED IN THE TYPE OF SERVICES PROVIDED BY THE INSTITUTION, THERE MAY BE AN ACTUAL INCREASE IN PATIENT DAYS. THERE ARE VOLUME FACTORS THAT NEED TO BE TAKEN INTO CONSIDERATION IN THESE REGULATIONS TO PROPERLY ADDRESS THE FINANCIAL PROBLEMS OF HOSPITALS.

THE REGULATIONS APPEAR TO EXCLUDE CONSIDERATION OF A NEW HOSPITAL COMING INTO BEING AFTER FEBRUARY 1, 1983. WE ARE AWARE OF AT LEAST ONE (1) HOSPITAL THAT WILL BE CAUGHT BY THIS PROHIBITION UNLESS IT IS PROPERLY ADDRESSED.

BECAUSE OF RECENT CHANGES IN THE MEDICARE LAW AFFECTING PHYSICIANS, HOSPITALS WILL BE RENEGOTIATING MANY CONTRACTS. HOW DO THESE REGULATIONS ADDRESS THESE MEDICARE REQUIREMENTS? MANY HOSPITALS WILL BE REQUIRED TO ABSORB ADDITIONAL COSTS EFFECTIVE OCTOBER 1, 1983.

THE REGULATIONS DO NOT APPEAR TO RECOGNIZE THE WAGE PASSTHROUGH WHICH, IN OUR OPINION, IS CLEARLY INTENDED BY THE LAW. WITH WAGES AND BENEFITS ACCOUNTING FOR APPROXIMATELY 65% OF THE HOSPITALS COST OF OPERATION, THIS WILL BE A SIGNIFICANT FACTOR.

THE REGULATIONS DO NOT APPEAR TO RECOGNIZE THAT A HOSPITAL HAS TO HAVE A REASONABLE AMOUNT OF REVENUE OVER EXPENSE TO INCLUDE DEPRECIATION. IN FACT, THE REGULATIONS APPEAR TO BE SPENDING DOWN ANY FUNDED DEPRECIATION THAT THE HOSPITAL MAY HAVE ACCRUED. BOTH OF THESE ISSUES ARE OF PRIME CONCERN FOR THE LONG TIME FINANCIAL WELFARE OF A HOSPITAL AND

COULD BE VERY COSTLY TO THE PROVISION OF HOSPITAL SERVICES SHOULD A HOSPITAL HAVE TO BORROW FUNDS TO MEET ITS FINANCIAL NEEDS.

THE REGULATIONS AND THE FORMULA ARE SILENT AS TO HOW NEWBORNS WILL BE HANDLED. LIKEWISE, THEY ARE SILENT WITH RESPECT TO REPLACEMENT COSTS OF EQUIPMENT NOT SUBJECT TO C.O.N. LIMITS.

SINCE THE HEALTH CARE FINANCING ADMINISTRATION HAS RULES NOT TO RECOGNIZE COST COMMISSIONS ASSESSMENTS AS ALLOWABLE COSTS UNDER MEDICARE AND MEDICAID, ASSESSMENTS SHOULD BE BUILT INTO THE FORMULAE AS AN AUTOMATIC PASSTHROUGH.

TURNING TO SPECIFIC POINTS IN THE PROPOSED RULES, WE HAVE THE FOLLOWING COMMENTS:

PAGE 2, SECTION 2.01 - ACCREDITATION. THE GENERALLY ACCEPTED DEFINITION OF ACCREDITATION HAS BEEN EXPANDED TO INCLUDE CERTIFICATION FOR MEDICARE AND MEDICAID AND LICENSURE BY THE WEST VIRGINIA DEPARTMENT OF HEALTH. AGAIN, WE RECOGNIZE THIS AS BEING DONE IN AN EFFORT THE HELP HOSPITALS, BUT WE ARE CONCERNED THAT IT IS AN EXPANSION AND REDEFINITION OF THE LAW BY REGULATION THAT WOULD NOT STAND THE TEST OF LEGAL CHALLENGE.

PAGE 2, SECTION 2.02 - AUTHORITY. AGAIN, THE LAW STATES THAT THE DIRECTOR OF THE WV DEPARTMENT OF HEALTH IS DESIGNATED TO CONSIDER AND DECIDE UPON TEMPORARY RATE CHANGES. IN FACT, THESE AND THE PREVIOUS REGULATIONS SHOULD HAVE BEEN PROMULGATED BY THE DEPARTMENT OF HEALTH.

PAGE 3, SECTION 2.04 - COST REIMBURSEMENTS. WORKERS COMPENSATION IS NOT A COST REIMBURSEMENT SYSTEM. THEY PAY HOSPITALS BASED ON CHARGES. IN ADDITION, WE ARE NOT AWARE OF ANY OTHER INSURANCE PROGRAMS OR HEALTH MAINTENANCE ORGANIZATIONS THAT PAY HOSPITALS ON A COST BASIS.

PAGE 3, SECTION 2.07 - PROPORTION OF MEDICARE, MEDICAID OR CHARITY PATIENTS. HOSPITALS UNCOLLECTIBLE ACCOUNTS, BAD DEBT, HAVE NOTHING TO DO WITH MEDICARE, MEDICAID OR CHARITY.

PAGE 4, SECTION 2.10 - THIRD PARTY PAYER. THIS DEFINITION SHOULD BE RESTRUCTURED TO SPECIFY "OTHER THAN THE PATIENT". A PATIENT WHO PAYS HIS OWN HOSPITAL BILLS IS CLEARLY NOT A THIRD PARTY PAYER.

PAGE 6, SECTION 4.03 - RELATIONSHIP OF TEMPORARY RATE CHANGE TO GROSS PATIENT REVENUE LIMIT. THIS SECTION CLEARLY CREATES A VERY SERIOUS PROBLEM FOR HOSPITALS AND IN OUR OPINION IS NOT THE INTENT OF THE LAW. ANY HOSPITAL FILING FOR A TEMPORARY RATE INCREASE, BECAUSE OF INSOLVENCY OR FINANCIAL HARDSHIP, WILL VERY PROBABLY BE IN VIOLATION OF THE GROSS PATIENT REVENUE LIMIT IF SUCH INCREASES ARE GRANTED BY THE DIRECTOR OF HEALTH. THIS WILL BE A PARTICULARLY SEVERE PROBLEM FOR SMALL HOSPITALS WHO EXPERIENCE GREATER FLUCTUATIONS IN VOLUME THAN DO LARGE HOSPITALS. WHAT GOOD IS IT GOING TO DO FOR A HOSPITAL TO BE GRANTED A TEMPORARY RATE INCREASE WHEN A PORTION OR POSSIBLY ALL OF THE INCREASED REVENUE TO THE HOSPITAL HAS TO BE TURNED OVER TO THE STATE BECAUSE IT IS IN VIOLATION OF THE GROSS PATIENT REVENUE LIMIT?

PAGE 6, SECTION 5.01.01 - CERTAIN APPLICATIONS ISSUED ORDER OF APPROVAL WITHOUT REVIEW. WE ASSUME SUBSECTION (B) AUTOMATICALLY APPROVES ANY RATE INCREASE THAT A HOSPITAL PUTS IN PLACE BECAUSE OF A CHANGE IN A PAYMENT AGREEMENT WITH A THIRD PARTY PAYER WHEN, IN FACT, THOSE CHANGES SHOULD BE SCRUTINIZED JUST AS CAREFULLY AS ANY OTHER RATE CHANGE. FOR INSTANCE, SHOULD A HOSPITAL NEGOTIATE A NEW CONTRACT WITH BLUE CROSS, WHEREIN BLUE CROSS PAYS HOSPITALS AT A RATE LOWER THAN THEY HAD PAID HISTORICALLY, THE HOSPITAL, BY NECESSITY, WILL HAVE TO SHIFT THAT LOSS OF REVENUE AND INCREASE CHARGES TO OTHER THIRD PARTY PAYERS AND SELF-PAYING PATIENTS. THE AUTHORITY SHOULD SCRUTINIZE THOSE RATE CHANGES CAREFULLY TO DETERMINE WHETHER 1) THE INCREASE IN CHARGES PROPOSED BY THE HOSPITAL TO COVER THAT LOSS OF REVENUE ARE APPROPRIATE, AND 2) TO BE CERTAIN THAT THE AUTHORITY IS PHILOSOPHICALLY IN AGREEMENT WITH CONTINUING AND, IN THIS CASE, EXPANDING THE CONCEPT OF COST SHIFTING.

PAGE 8, SECTION 5.02.01(G) - THE FIRST FOUR (4) ITEMS, "STATEMENT OF INCOME AND EXPENSE; BALANCE SHEET; STATEMENT OF CHARGES AND CHANGES IN FINANCIAL POSITION; AND CURRENT AND SUCCEEDING YEAR PROJECTIONS OF REVENUE AND EXPENSES" ARE ON FILE WITH THE AUTHORITY AND SHOULD BE USED. IN AN EFFORT TO REDUCE PAPERWORK, THE AUTHORITY SHOULD NOT ASK FOR INFORMATION THEY ALREADY HAVE.

PAGE 9, SECTION 5.03.01 - NOTIFICATION OF REVIEW. WE ASSUME THAT THIS SECTION SPEAKS OF PUBLIC NOTICE BY THE AUTHORITY. WE WOULD ALSO LIKE TO HAVE CLARIFICATION AS TO WHO THE AUTHORITY CONSIDERS TO BE "INTERESTED PERSONS".

PAGE 14, SECTION 6.02.04 - REVENUE OTHER THAN PATIENTS SERVICE REVENUE. WHAT IF NON-PATIENT REVENUE IS LESS? WHAT IF INTEREST INCOME IS LOWER? WE DON'T UNDERSTAND WHY THE REGULATIONS ONLY SPEAK TO ONE SIDE OF THE ISSUE.

PAGE 14, SECTION 6.02.05 - USES AND TRANSFER OF HOSPITAL FUNDS. SECTION (2) COULD BE A SIGNIFICANT PROBLEM TO BOTH PROFIT AND NONPROFIT CORPORATE CHAINS. FOR INSTANCE, THE APPALACHIAN REGIONAL HOSPITAL SYSTEM FREQUENTLY SUBSIDIZES UNPROFITABLE HOSPITAL WITH REVENUE FROM A PROFITABLE HOSPITAL IN ORDER TO KEEP THE WHOLE SYSTEM FINANCIALLY SOUND. THE NO TRANSFER REQUIREMENT COULD SEVERELY HARM PATIENT CARE IN A SPECIFIC AREA OF THE STATE.

PAGE 15, SECTION 6.02.05(B) - PROHIBITS TRANSFER OF ASSETS TO BOARD DESIGNATED FUNDS ACCEPT FOR BOND AND LOAN COVENANTS. THERE ARE A NUMBER OF OTHER RESTRICTED FUNDS WHICH A HOSPITAL MUST LEGALLY MAINTAIN, SUCH AS PENSION PLANS AND SELF-INSURANCE FUNDS.

PAGE 15, SECTION 6.02.06 - BOND AND LOAN COVENANTS. THIS SECTION SHOULD BE REVIEWED IN DETAIL BY EXPERTS IN THE FIELD. THOSE EXPERTS THAT HAVE DISCUSSED THIS SECTION WITH US DO NOT BELIEVE THAT 120% IS ADEQUATE AND WOULD EXCLUDE HOSPITALS FROM THE CAPITAL MARKET.

PAGE 16, SECTION 6.02.08(A) - EXPENSES ASSOCIATED WITH AN ACCREDITATION REQUIREMENT. THIS SECTION IS MUCH TOO LIMITED SINCE HOSPITALS HAVE APPROXIMATELY 100 DIFFERENT AGENCIES WHICH REGULATE THE ACTIVITIES WITHIN A HOSPITAL. TO TOUCH JUST A FEW, THERE ARE STRICT INSPECTION

STANDARDS AND REQUIREMENTS FOR LABORATORIES, X-RAY DEPARTMENTS, PSYCHIATRIC DEPARTMENTS, AND OSHA.

PAGE 18, SECTION 6.03.03 - CRITERIA FOR DETERMINING THAT A RATE CHANGE IS NECESSARY TO PREVENT UNDUE FINANCIAL HARDSHIP. SUBSECTION (2) USES A 3% AVERAGE RETURN ON EQUITY. ON AN ACCURAL BASIS OF ACCOUNTING, A 3% RETURN ON EQUITY DOESN'T ASSURE THAT THE HOSPITAL WILL HAVE CASH TO MEET ITS CURRENT OPERATING EXPENSES. IN FACT, A NUMBER OF HOSPITALS HAVE, IN RECENT RECESSION YEARS, MET THAT MARGIN AND STILL HAD TO GO TO THE BANK TO BORROW MONEY TO MEET PAYROLL.

THE WEST VIRGINIA HOSPITAL ASSOCIATION ASKED MEMBER HOSPITALS TO RUN THEIR FINANCIAL INFORMATION THROUGH THE FORMULAE CONTAINED IN THESE PROPOSED REGULATIONS. UNFORTUNATELY, WE ARE NOT ABLE TO PROVIDE YOU WITH ANY FEEDBACK ON THE RESULTS OF THESE STUDIES, SINCE THE HOSPITALS ARE NOT ABLE TO DETERMINE HOW TO APPLY THEIR DATA TO THE FORMULAE BECAUSE OF A LACK OF CLEAR DEFINITIONS IN THESE REGULATIONS. THESE REGULATIONS NEED MORE EXTENSIVE REVIEW AND CLARIFICATION BEFORE THE FORMULAE CAN BE MEANINGFULLY APPLIED.

AGAIN, THE LAW MANDATES THAT ISSUES BEFORE THE AUTHORITY BE REVIEWED BY THE ADVISORY COUNCIL PRIOR TO ANY FORMAL ACTION. NOW THAT THE ADVISORY COUNCIL HAS BEEN APPOINTED, WE STRONGLY RECOMMEND THAT THESE PROPOSED REGULATIONS BE REVIEWED BY THAT BODY BEFORE PROMULGATION.

SINCE THESE REGULATIONS ARE DESIGNED TO COVER A TEMPORARY PERIOD OF TIME AND PECULIAR CIRCUMSTANCES OF INSTITUTIONS, WE FEEL THAT THE AUTHORITY

WOULD BETTER SERVE THE PUBLIC BY TAKING THE APPROACH OF BUDGET REVIEW, BY ESTABLISHING A PROSPECTIVE PAYMENT SYSTEM, THAT CAN BE ADJUSTED UP OR DOWN WHEN THE AUTHORITY ESTABLISHES ITS RATE SETTING SYSTEM AND ESTABLISHES THE HOSPITALS FIRST SET OF RATES, YOU ALLEVIATE A LOT OF COMPLEXITY AND PAPERWORK. THESE REGULATIONS APPEAR TO BE MUCH TOO PRECISE, TRYING TO COVER EVERY POSSIBLE CIRCUMSTANCE. IF SUCH A SYSTEM WERE POSSIBLE TO CREATE, IT WOULD HAVE BEEN IMPLEMENTED YEARS AGO BY THE FEDERAL GOVERNMENT AND OTHERS. BY THE TIME THE AUTHORITY COULD APPLY ALL THE DETAILS IN THESE REGULATIONS, THE START UP PERIOD WOULD EXPIRE.

I STAND READY TO ATTEMPT TO ANSWER ANY QUESTIONS THAT MAY HAVE BEEN RAISED BY THIS TESTIMONY.

Moody's Investors Service

99 Church Street, New York, N.Y. 10007
212-553-0300

February 2, 1983

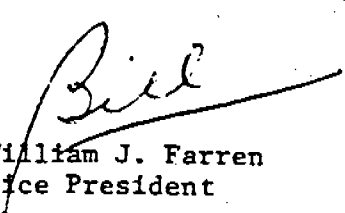
To: Municipal Credit Report Subscribers

I am pleased to enclose a copy of

- ✓1) State Medians
- ✓2) Range of Overall and Net Debt
Cities & Counties
- ✓3) Revenue Enterprise Medians
Electric - Water - Sewer - Airport - Bridge
Tunnel - Expressway and Turnpikes
- ✓4) Hospital Medians

We believe this kind of information will be of assistance to you in your day-to-day analysis of municipal credits. Your comments would be appreciated.

WJF/sc


William J. Farren
Vice President

MOODY'S INVESTORS SERVICE
MUNICIPAL DEPARTMENT

CURRENT HOSPITAL ENTERPRISE MEDIANS

The following represents the medians calculated on 167 hospital enterprises which have been rated by Moody's for the calendar year 1982. The medians convey various measures of performance and earning capabilities of hospitals which have used tax-exempt bonds for their capital financing program. The medians represent ratios and indices common to revenue-producing enterprises, as well as several which are unique to the health care enterprises. The current medians are as follows:

Operating ratio (%)	91.0
Net take-down (%)	11.0
Peak debt service coverage by historical net revenues	0.98
Peak debt service coverage by estimated net revenues in first full year after project completion	2.26
Debt ratio (%)	32.5
Projected debt ratio (%)	52.3
Bed occupancy (%)	81.7
Number of beds	314
Average length of stay (days)	7.4
Debt svc. safety margin	7.9

(Please refer to other side for definitions)

CURRENT HOSPITAL ENTERPRISE MEDIANS

DEFINITIONS:

Income Statement Definitions and Ratios:

Gross revenue and income	:	Operating revenue plus non-operating revenue.
Operating expenses	:	Operating expenses, excluding depreciation, amortization and interest.
Net revenues	:	"Gross revenue and income" minus "operating expenses."
Operating ratio (%)	:	"Operating expenses" divided by total operating revenues.
Net take-down (%)	:	"Net revenues" divided by "gross revenue and income."
Peak debt service coverage by historical net revenues	:	"Net revenues" divided by the estimated maximum annual principal and interest on all outstanding bonds and the bonds to be issued.
Peak debt service coverage by projected net revenues	:	Estimated "net revenues" for the hospital during the first full fiscal year following the completion of the capital project financed from the new bonds, divided by the estimated maximum annual principal and interest on all outstanding bonds and the bonds to be issued.
Debt service safety margin	:	Net revenues less current debt service divided by gross revenues.

Balance Sheet Definitions and Ratios:

Net fixed assets	:	Fixed assets minus accumulated depreciation.
Long term debt	:	Gross long-term debt plus the current portion of long-term debt.
Net long-term debt	:	"Long-term debt" minus the bond reserve funds/accounts for the payment of bond principal.
Debt Ratios (%)	:	"Net long-term debt" divided by the sum of "net fixed assets" plus net working capital.
Projected Debt Ratio (%)	:	Proforma "Net long-term debt" divided by the sum of "net fixed assets" plus "net working capital" for the first full fiscal year following issuance of the bonds. Figures are derived from feasibility studies.

Utilization Results Definitions and Ratios:

Number of beds	:	Represents the average bed complement.
Average daily census	:	Total patient days divided by the days in the year (365).
Bed occupancy (%)	:	Average occupancy of the hospital's patient beds during the year. This ratio is computed by dividing "average daily census" by the hospital's average beds available for that year.
Average length of stay	:	Average stay for inpatients, as reported by the hospital for that year. It is computed by taking the total patient days divided by number of admissions or discharges.

Blue Cross
and
Blue Shield
of West Virginia, Inc.



City Center West
P. O. Box 1353
Charleston, WV 25325

Writer's Direct Dial Number

(304) 232-4550

September 8, 1983

Ms. Sally K. Richardson, Chairperson
Health Care Cost Review Authority
State Capitol Building
Charleston, West Virginia 25305

Dear Ms. Richardson:

Attached is a series of comments and suggested changes relative to the emergency filing of legislative rules for the freeze on hospital rates and granting of temporary rate increases, Chapter 16-29 B, Series 2 (1983). In general, the emergency regulations seem to be a valid effort to use the exception process provided for in the legislation to prevent permanent harm from befalling hospitals, which conduct themselves in a responsible manner.

The regulations note in their preamble that the intent is to deal with the short-term problems created by a blanket freeze on hospital rates; and quite properly note that the criteria for rate changes should not be construed as establishing a precedent for the authority's future design of hospital rate regulation. Many of the items which are contained in these regulations would not be appropriate as long-range policy and should be viewed strictly as a stop-gap to prevent permanent damage to the state's health care system resulting from the freeze on hospital rates and the cap on hospital revenues which was applied to all facilities in the state.

Thank you very much for the opportunity to comment on these regulations.

Sincerely,

A handwritten signature in cursive script that reads "William E. Gavin".

W. E. Gavin
Vice President

F:2:hb

Enclosure

BLUE CROSS AND BLUE SHIELD OF WEST VIRGINIA, INC.

Comments

The following are some specific comments relative to sections of the proposed regulations implementing the exception process to the hospital rate freeze.

§ 4.03 and § 5.02.01e

These sections indicate that there is some relationship between the granting of a temporary rate increase and a change in the hospital's gross patient revenue limit. While there may be a relationship relative to the addition of services, and there may be instances in which an exception to the 12% gross patient revenue limitation would be necessary to prevent insolvency or undue financial hardship, the precise intent of the wording "may result in an adjustment to the amount of gross patient revenue otherwise allowed in hospitals," should be clarified within the body of a regulation. Would a separate finding be required by the authority to permit a hospital an increase in gross patient revenue in excess of 12%?

§ 5.01.02

Provides that the authority will immediately determine the application's eligibility for expedited review. The use of the word immediately may prove to be unfeasible replacement with a precise time frame, such as, within three working days, may avoid legal complications.

§ 5.02.01g

Should be modified to assure that the information submitted by the hospital is the information required for analysis and that the information is based based upon traditional accounting, possible modified wording would be as follows:

§ g The following financial statements prepared in accordance with generally accepted accounting principles for the hospital's current, one succeeding, and ~~four~~ three preceding fiscal years, certified as being true for the preceding ~~four~~ three fiscal years, and the best estimates for the current and one succeeding year projections:

- (1) Statement of income and expense;
- (2) Balance sheet;
- (3) Statement of changes in financial position;
- (4) Current and succeeding projections of Schedule of Departmental Revenues and Expenses; and
- (5) Schedule of Assumptions for Projections; and

§ 6.02.05a

Speaks to the transfer of funds to or from a parent, sister or subsidiary corporation. While the intent seems clear that the transfer of funds to a related organization in order to avoid these regulations will not be tolerated; it is not clear why hospitals projections for transfers of funds from a related organization should not be taken into consideration. Would suggest that the "or from" language be deleted from this section.

§ 6.03.02b

Speaks to hospital expenses for emergency repairs. The cash nature of the accounting principles that are contemplated in the section could be emphasized by having the section read "hospital evidences that expenses expenditures required for emergency repairs"

§ 6.03.02c and § 7.02

The term "funds available from other sources" should be defined and guidelines provided as to the minimum amount of funds which are necessary for a hospital to meet its current obligations in the normal course of business. A possible approach may be to reference data on financial ratios for the hospital industry published by the Financial Analysis Service Division of the Hospital Financial Management Association and provide that the authority will determine an amount of "funds" which must be maintained as a minimum liquidity position for the hospital to efficiently carry on its business. In the accounting literature "funds" is often used to mean Working Capital vs. Cash and Marketable Securities. An ideal analysis of "funds available from other sources" should take into consideration the hospital's level of working capital and the major components of working capital such as cash (and equivalents), Accounts Receivable and Accounts Payable.

As an alternative to defining "funds available from other sources," consideration should be given to a revised formula which also considers -

- 1) Non-cash Expenses as a source of funds;
- 2) Principle Payments and mandatory sinking fund deposits as uses of funds; and

such that the projected return on equity [net income divided by (total assets minus total liabilities)] for the year does not exceed the lower of 1) three percent plus any amounts determined to be necessary to meet cash expenditures for emergency repairs which are not utilized in the determination of net income, or 2) and amount which will bring the hospital's return on equity over the five-year period to an average of three percent.

Such a provision would be intended to:

- 1) Recognize that in an inflationary economy, a non-for-profit hospital must show an accounting "bottom line" if they are to maintain their current real financial position. The use of a three percent ROE is well below the rate of inflation over the past few years and thus would require a significant shrinkage in the real value of the hospital's equity before the facility would qualify for a hardship exception.
- 2) Preclude hospital from requesting a "catch up" during the freeze period if their ROE has averaged less than three percent over past years.
- 3) Minimize the level of financial deterioration in hospitals which have maintained responsible profit margins so that a large "bump" in hospital charges will not be necessary when the authority establish as the hospitals' permanent rates. The need of third-party payors and purchasers for both a reduction in the rate of increase in hospital rates and increased predictability in the rate of change in total hospital cost should be kept in mind. A flattening of the hospital cost curve followed by a sharp escalation in rates would be very disruptive.

- 3) A minimum "funds level," which is based upon a specified number of days operating expense. The number of days operating expense which would constitute a minimum working capital level should be based upon an analysis of hospital data.

In establishing any "funds level," flexibility should be allowed to permit further analysis of the components of working capital.

§ 6.03.02d

An additional standard dealing with rate changes necessary to prevent insolvency may be useful which provides an exception to the freeze for a hospital which evidences that it is in imminent danger of insolvency as defined in federal bankruptcy laws. The general bankruptcy laws may provide a series of detailed test for defining this aspect of insolvency.

§ 6.03.03a

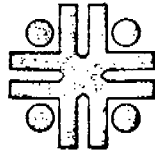
It may be desirable to modify the first sentence to read: "The hospital evidences a significantly declining equity position. A significant decline in." In addition, the fourth line should be modified to read: "The rate of return on equity projected for"

§ 7.01a

The definition of the term V_m may work better if changed to read "Projected average annual volume over life of service." As written, the use of volume at maturity would not give recognition to the build up of the service to the maturity level. Use of average would preclude the establishment of a rate for a new service based upon the projected volume during the first year which would not result in a reasonable rate for the service.

§ 7.03

The formula for determining the amount necessary to prevent undue financial hardship due to a significant decline in hospital's equity position should be reconsidered. The formula could possibly be replaced with a sentence such as; "When a rate change is found necessary to prevent undue financial hardship as a result of the hospital experiencing a significant decline in its equity position over a five-year period, the amount of the rate change shall be determined as an amount



CABELL HUNTINGTON HOSPITAL

August 19, 1983

AUG 19 1983

Sally K. Richardson, Chairperson
Health Care Cost Review Authority
State Capitol Building
Charleston, West Virginia 25305

Dear Mrs. Richardson:

I have reviewed the regulations recently filed with the Secretary of State regarding the granting of temporary rate increases under the recently passed Cost Containment Legislation. Since you will undoubtedly receive lengthy responses to the temporary regulations, I plan to keep my comments concise and to the point.

First, the formula for insolvency addresses future gain or loss. I see insolvency as being a condition of the present which does not permit you to meet your obligations in terms of payroll and vendors. I would see allowing a reasonable number of days in operating cash as being a more realistic formula for insolvency than a projection into the future.

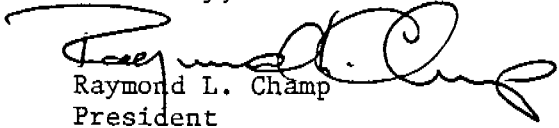
Second, the formula indicated on page 17 is basically a break-even formula and thus ignores the question of legitimate need for a reasonable amount of revenue over expense. Also, the definition of "r" gives rise to my suspicion that you are including funded depreciation as being available. I have detected from the beginning of our discussions as I sat with the temporary rate increase committee that there was a lack of understanding of the hospital's need for a reasonable amount of funded depreciation. Simply stated, this need is based upon the fact that depreciation is based upon historical dollars (what you paid rather than what you will have to pay to replace the item) and that the expense of replacement will far exceed the original purchase price. I strongly suggest that the long-term interest of hospitals will be served if the commission begins to recognize the need for funded depreciation and for a reasonable amount of excess of revenue over expense.

Having made these two quick points let me move then to that part of my response I feel most strongly about. The temporary regulations ignore completely the intent of legislation to pass through legitimate granted or bargained for wages and benefits to non-supervisory employees. As you well know, this

language is crystal clear and is contained in the Section 16-20B-20 paragraph 4 d). For those of us who would like to bargain in an unrestrained environment and have the ability to recover the costs of these increases, the unwillingness of the commission to recognize the intent of the legislation places us in a very difficult situation. I understand that the language of the legislation specifies reasonable increases and it would certainly be our intent to arrive at a figure that is consistent with the needs of our employees as well as cost concerns of the public. The commission, in my judgment, has an obligation to address directly this question in its temporary regulations rather than leaving both employers and employees hanging as to what your disposition will be.

I appreciate the opportunity to have served on the temporary commission and I am hopeful that my comments will be of some assistance.

Sincerely,



Raymond L. Champ
President

RLC/dmo

cc: Board of Trustees

WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY
October 7, 1983

The meeting of the West Virginia Health Care Cost Review Authority Board of Directors was held Friday, October 7, 1983 convening at 9:30 AM in Conference Room 522 of the West Virginia Department of Health.

Presiding: Sally K. Richardson, Chairperson

Members Present

Larry C. Fizer
William L. Gilligan

Staff Present

Bill J. Crouch, Executive Secretary, HCCRA
John Kozak, General Counsel, HCCRA
Lynne White, Senior Analyst, HCCRA
Penny Esworthy, Financial Analyst, HCCRA
Rob Durbin, Rate Analyst, HCCRA
John Bennett, Jr., Rate Analyst, HCCRA
Gary Thompson, Statistician, HCCRA
Cathie Gamber, Program Analyst, HCCRA
Mary Ann Johnson, Secretary, HCCRA
Shirley Jones, Administrative Assistant, HCCRA
Connie Atkins, Secretary, HCCRA
Larry Arnold, General Counsel, OHPE

MINUTES - The minutes of the August 8, 1983 meeting were approved without change.

OLD BUSINESS

1. Staff recommendations concerning the Series II Rules and Regulations

Bill Crouch stated that the staff had made significant changes in the regulations after receiving comments at a public hearing which was held September 13, 1983, and that the staff was recommending that these regulations be refiled as emergency regulations.

The significant changes recommended in the regulations by staff members were as follows:

Sections 4.03, 5.02.01(e) and 6.03.01

Public Comments: Sections 4.03, 5.02.01(e), and 6.03.01 of the draft of the legislative rules filed with the Secretary of State on August 8, 1983, are incorrectly premised upon an interpretation of West Virginia Code, §1629B4, which would prohibit any changes in a hospital's gross patient revenue to not more than a 12% increase except for certificate of need adjustments to the gross patient revenue base and certain payor mix adjustments.

The Act in §1629B3(h) defines "Rates" as "all value given or money payable to hospitals for health care services, including fees, charges and cost reimbursements." The term "charges" is defined in section §1629B3(a) as "the economic value established for accounting purposes of the goods and services a hospital provides for all classes of purchasers." Further, it should be noted that the term "gross patient revenue" is not defined but is accepted to be the aggregation of charges over a particular period of time, normally a year.

Section 1629B4 provides that the Board has the power to adjust a hospital's rates during the interim period until permanent rates are set. The temporary rate change mechanism is premised upon certain factors which go towards monitoring the financial viability of a particular hospital. Indeed, in its statement of purpose, §1629B1, the Legislature states its intent to not only control the cost of acute care hospital services, but also "to ensure the continuation of appropriate acute care hospital services." A review of the entirety of the Act reinforces the motion that the Legislature is concerned that the hospitals of this state not be injured by actions taken under the Act.

Staff Response: Accordingly, staff recommends that the Board adopt a construction of Section 1629B4 which provides that the temporary rate change mechanism applies to all rates, including charges, whether individually or in the aggregate, so that adjustments to a hospital's gross patient revenue base can be made where necessary to afford the provision of appropriate health care and where necessary to allow for relief from the factors set forth in the Act in section 4 and 21(c) including, inter alia, financial hardship and impending insolvency.

This construction would cause the rewriting of section 4.03 as set forth in the staff's proposed draft. Also, section 5.02.01(e) of the initial draft would be deleted as no longer necessary, and section 6.03.01 is changed and reappears as section 7.01 to permit reasonable increases in the gross patient revenue base.

Section 6.02.03 Operating Expenses

Public Comments: There were several comments concerning the Authority's interpretation of the legislation regarding 16-29B-20(d) pertaining to wage and benefit increases to non-supervisory personnel. It was felt by several individuals that this section of the legislation was intended to allow an automatic increase in rates (i.e.: wage passthrough) equal to any increase in salaries or fringe benefits given to non-supervisory personnel.

Staff Response: Staff carefully reviewed the language under the West Virginia Code, Section 16-29B-20(d) which states that wages, salaries and benefits paid to or on behalf of non-supervisory employees of hospitals subject to this article, shall not be subject to review unless the Board first determines that such wages, salaries and benefits may be unreasonably or uncustomarily high or low. It is staff's interpretation that this section of the legislation does not specifically authorize hospitals to automatically raise rates when they raise salaries. Staff has treated wages, salaries and fringe benefits, as a legitimate operating expense. If the hospital has other revenue or funds sufficient to absorb the salary increase without a rate increase, then a rate increase would not be permitted. If the hospital has sufficient revenue or funds to cover a portion of the increase, then the hospital, in all likelihood would be permitted a rate increase to cover the excess portion of the increase. In summary, the staff recommends, based on Section 16-29B-21 of Senate Bill 320, that a hospital demonstrate that a temporary rate change is in the public interest, and is necessary to prevent insolvency, to maintain accreditation or for emergency repairs or to relieve undue financial hardship.

Section 1.05 Designation of Responsibility

Modify to be more consistent with the law which states that the Director of the State Department of Health does have the responsibility to decide upon rate changes until HCCRA chooses to undertake the responsibility itself.

Section 2. Definitions

Added:

2.08 Interested Persons: Persons on the Authority's mailing list and persons who have requested to be notified of the review of an application.

2.09 Operating Expenses: Defined by the American Hospital Association Chart of Accounts for hospitals.

2.11 Return on Equity: Revenues minus Expenses divided by Assets minus Liabilities.

2.02 Admissions - Inpatient: Formal acceptance by a hospital of a patient who is to receive physician, dental or allied services while lodged in a hospital (excluding newborn and adding neo-natal).

Fees: Definition of fees should be omitted.

Section 2.07 Cost Reimbursements

Public Comment: That Cost Reimbursements, as defined under Section 2.04, includes amounts payable for hospital goods and services from purchasers whose payments are not cost-based (worker's compensation and health maintenance organizations).

Staff Response: Recommend that the definition for Cost Reimbursements be changed to read as follows:

Cost Reimbursements means the negotiated or contracted amount payable to a hospital for goods and services rendered to a designated class of purchasers provided that the amount negotiated or contracted for is cost-based. Examples of classes of purchasers are Medicare beneficiaries, Medicaid beneficiaries, subscribers of specific cost-based insurance programs, some health maintenance organizations and other groups as defined by the Authority or the Director.

Section 2.07 Proportion of Medicare, Medicaid or Charity Care Patients

Public Comment: Medicare, Medicaid or charity are not related to uncollectable accounts or bad debts.

Staff Response: Staff is recommending changing Section 2.07 to Deductions from Gross Patient Revenue rather than the Proportion of Medicare, Medicaid or Charity Care Patients.

Section 2.13 Third Party Payor

Public Comment: That Third Party Payor as defined under Section 2.10 (payor) could be construed to include the patient who pays his own bill.

Staff Response: The definition for Third Party Payor comes directly from Senate Bill 320. An individual consumer of hospital services who pays his own bills falls under the definition "Purchaser" as described in Senate Bill 320; therefore, no change is recommended.

Section 4.01 Public Notice of a Temporary Rate Change Application

Public Comment: It is assumed subsection (b) automatically approves any rate increase that a hospital puts in place because of a change in payment agreement with a third party payor when, in fact, those changes should be scrutinized just as carefully as any other rate change.

Staff Response: Although the Board has decided that it is without jurisdiction to review Medicare or Medicaid contracts, it was determined after considerable discussion that the Authority may wish to review contracts or agreements other than Medicare or Medicaid, therefore, staff is suggesting that the wording be changed from "the Authority shall assume".... to "the Authority may assume".....

Section 5.05.02 (g). Application for a Temporary Rate Change

Public Comment: Modify contents of Application for a Temporary Rate Change to include information required for financial analysis and state that this information adheres to traditional accounting practices.

Staff Response: Financial statements should be prepared according to generally accepted accounting principles. Financial statements should be those required for complete analysis. The financial statements were expanded to include the appropriate number of years needed and the proper statements. These financial statements should be prepared in accordance with generally accepted accounting principles.

Section 5.02.02 (c) Contents of Application for
Expedited or Regular Review

Public Comment: The Authority should not request financial statements for prior years since this information is already on file.

Staff Response: The required financial statements will be part of a total "package" for review in a format specified by the Authority. No change is recommended.

Section 6.02.02 Net Patient Revenue

Public Comment: The regulations and corresponding formula deal only with admissions and do not take into consideration patient days, outpatient services and other volume factors.

Staff Response: The use of the term "equivalent admissions" will more accurately account for the volume, therefore, delete "admissions" and use the term "equivalent admissions".

Section 6.02.02 Determination of Standards of Reasonableness

Public Comment: That the standard of reasonableness for the required key projection Net Patient Revenue as defined in Section 6.02.02 does not take into consideration the daily cash flow needs of an institution.

Staff Response: An increase in rates isn't necessarily going to solve the cash flow problems of a hospital. The Net Patient Revenue Standard of Reasonableness is intended to look at the amount of projected revenues for the next fiscal year, not expenditures or cash flow for the next fiscal year.

Section 6.02.02 Net Patient Revenue

Public Comment: Suggested that the Authority should add projection of net patient revenue for the next year (N₃).

Staff Response: Staff agreed with recommendation, therefore, N₃ projection was added.

Section 6.02.04. Revenue Other Than Patient Services Revenue

Public Comment: What happens when other income is lower?

Staff Response: In such a situation, an explanation would be required explaining why those revenues were lower.

Section 6.02.05 Uses and Transfers of Hospital Funds

Public Comment: The no transfer requirement could severely harm patient care in such organizations as the Appalachian Regional Hospital system.

Staff Response: Staff is recommending eliminating uses and transfers of funds as a screening standard. Information requirement can be met from the financial statements.

Section 6.02.06 Bond and Loan Covenant

Public Comment: Hospital Association feels that 120% is not adequate and would exclude hospitals from the capital market.

Staff Response: The 120% figure is a screening standard, so a hospital may have a higher rate covenant but must explain why it is so high. The section was rewritten to deal more clearly with debt service requirements.

Section 6.02.07 Expenses Associated with an Accreditation Requirement

Public Comment: The requiring of having a letter of certification from architect or professional engineer adds cost to the hospital.

Staff Response: Staff agreed with this and suggests changing the requirements of having a letter from an architect or professional engineer to a letter from the governing board certifying the necessity of the expense.

Section 6.02.08(b) Expenses Associated with an Accreditation Requirement

Public Comment: The requiring of having a letter of certification from architect or professional engineer adds cost to the hospital.

Staff Response: Staff agreed with this and suggests changing the requirements of having a letter from an architect or professional engineer to a letter from the governing board certifying the necessity of the expense.

6.03.02 Criteria for Determining that a Rate Change is Necessary to Prevent Insolvency

Public Comment: Add projection for next year N₃ based on current fiscal year.

Staff Response: Staff agreed, therefore, the addition of a projection for N₃ is recommended. Staff also recommends adding projections for other operating and non-operating expenses for the next fiscal year. Also revenues from other sources should be considered.

Section 6.03.03 Criteria for Determining that a Rate Change is Necessary to Prevent Undue Financial Hardship

Public Comment: Reconsider formula to prevent undue financial hardship due to a significant decline in hospitals equity position. Allows for a 3% return on equity in formula.

Staff Response: A 3% return on equity would insure profit and these regulations are only considering a short term period. The break even return on equity remains as the basis for determining undue financial hardship due to inadequate rate of return. Return on equity will be addressed in the permanent regulations, therefore, no change recommended.

Section 7.01 (b) Amount Necessary to Prevent Insolvency Due to Establishment of New Services

Staff Recommendation: Original wording: In establishing rates at a facility with no Gross Patient Revenue prior to February 1, 1983 initial rates for individual services shall be established by the facility provided that charge per patient day does not exceed projections contained in a Certificate of Need application.

New wording: Initial rates for individual services shall be established by the facility provided that if the new service was subject to a Certificate of Need review and if any of the charges for the new service exceed those in the Certificate of Need application then the hospital must submit to the Authority evidence to justify the increased charges. The Authority shall either approve or disapprove the increase in charges.

Section 6.03.02 Amount Necessary to Prevent Insolvency Due to Inadequate Revenue

Public Comment: "Funds from other sources" should be defined and guidelines provided as to the minimum amount of funds necessary for a hospital to meet its current obligations in the normal course of business.

Staff Response: Variable "s" has been redefined and clarified. "Funds from other sources" are those which are not legally restricted and can be reasonably utilized to offset current operating expenses. This allows flexibility in determining those funds.

Section 7.03 Amount Necessary to Prevent Undue Financial
Hardship Due to Inadequate Rate of Return

Public Comment: Change "z" which is other operating and non-operating revenue to "r" from Section 7.02 which is revenues and funds from other sources.

Staff Response: Staff recommends changing the lettering from "z" to "r", but use the same wording.

Bill Crouch pointed out typographical errors to the Board and recommended to the Board that these regulations be refiled as emergency regulations which would allow another public hearing and review of the regulations.

Authority members expressed concern with regard to Section 4.01, rate changes associated with Diagnostically Related Groups being exempt from the public notice requirement. Language was changed to read:

"Rate changes associated with the Medicare Diagnostic-Related Group reimbursement and methodology are exempt from the requirement of publishing the schedule of rates stated above in their public notice. The hospitals will be required to submit an application to the Authority as outlined in Section 5.05.01."

MOTION: Larry Fizer moved that the "Legislative Rules for the Freeze on Hospital Rates and Granting of Temporary Rate Increases" be amended in accordance with the post-hearing draft prepared by staff, and that the additional changes made this date be accepted. Motion seconded by Mr. Gilligan and it was carried unanimously.

MOTION: William Gilligan moved that the amended "Legislative Rules for the Freeze on Hospital Rates and Granting of Temporary Rate Increases" be readopted for emergency filing. Motion seconded by Mr. Fizer and carried unanimously.

Mrs. Richardson announced that there will be a public hearing and Authority meeting on November 8, 1983 in Room 607 of Building 6, Department of Human Services Conference Room at 9:30 AM.

NEW BUSINESS

1. Approval of Budget

Motion: William Gilligan moved that the budget as prepared by the staff be adopted and submitted to the Governor, Department of Finance and Administration and the Legislature. Motion seconded by Sally Richardson and carried unanimously.

2. Regular Meetings of the Authority

Mrs. Richardson announced that the Authority is submitting notice today to the Secretary of State's Office that it will begin to hold regular meetings on the first and third Mondays of every month at 9:30 AM beginning on the 5th of December for the conduct of routine business at its headquarters at 1591 Washington Street, East.

ADJOURNMENT - There being no further business, the meeting adjourned at 10:35 AM.

PUBLIC HEARINGS
REGISTRATION

DATE 9/13/73

NAME	ADDRESS	DESIRE TO SPEAK YES NO
J. D. BRADLEY	1707 28 th ST. VIENNA, WV 26105	
Stephen E. Skride	3 Mockingbird Drive Milton, WV 25541	
Maite Ward	Cabell Huntington Hospital	X
Lynn HUBBARD	Stonewall Jackson Hys Weston	X
ELWIN BRESSETTE	Thomas Memorial Hospital	✓
GARY GOULD	WHEELING HOSPITAL	
William J. Day	WHEELING HOSPITAL	✓
RICHARD FENCE	ERNST & WHINNEY	X
Mary ANN GOFF	ERNST & WHINNEY	X
SAM OURS	ERNST & WHINNEY	✓
P. Paul	P.O. Box 1680	✓
R. L. Champ	Cabell Huntington Hospital	✓
John Hrenko	Roane Gen'l Hospital	✓
Klaire Polym	Council of St. West Virginians	✓
Mike Clement	629 Steady Ave Clarksburg, WV	✓
ALAN RIGDEN	BLUE CROSS	✓
Eleanora Wylie	Coalition on Legislation for the Elderly	✓
Larry E. ROBERTSON	CAMC	✓
RALPH T. Bowles	"	✓
ROBERT J. HALONEN	"	✓
Robert J. O'Neil	Spelman Thomas Battle & Klestermeyer	✓
HARRY S. MOORE	YOUNG MOORE & COMPANY, INC.	✓
BROCK J. CARTER	W. V. I. A.	✓

WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY

Public Hearing Minutes
September 13, 1983

The Authority held a public hearing on the following proposed regulation:

Legislative Rules on Freeze
on Hospital Rates and Granting
of Temporary Rate Increases.

Presiding: Sally K. Richardson, Chairperson

Members Present:

Larry C. Fizer

William L. Gilligan

Staff Present:

Bill Crouch
Mary Ann Johnson
Gary Thompson
Lynne White
Robert Durbin

Larry Arnold
John Bennett
John Kozak
Penny Esworthy
Shirley Jones

Public Present:

See attached list

PUBLIC COMMENTS

Freeze on Hospital Rates and Granting of Temporary Rate
Increases

- A. Lynn Hubbard, Director of Nursing Service, Stonewall Jackson Memorial Hospital and West Virginia Society of Hospital Nursing Service Administrators, provided prepared remarks. She spoke with regard to the wage passthrough section of Senate Bill 320 stating that wage and benefit increases were not addressed in the temporary regulations. She expressed concern that hospitals will be unable to increase their rates to offset costs for salary increases for nurses, and will be at a disadvantage in terms of recruiting and competing for nurses with the rest of the nation. She stated she felt the rate adjustments for emergency facility and major repair are inadequate, and also expressed concern that when hospital boards need to consider cost reduction to maintain operations, they will need to consider an elimination of patient services, which will deprive people of needed services.

- B. Larry E. Robertson, Director of Financial Services at Charleston Area Medical Center, provided prepared remarks. In summary, Mr. Robertson addressed five key issues as follows:
- Accuracy of definitions
 - Weaknesses of formula for determining the reasonableness of increases in patient revenues
 - Return on equity and insolvency snafu
 - Omission of wage passthrough adjustment.
 - Uses and transfers of hospital funds.
- C. Harry Moore, President of Young, Moore and Company, investment bankers specializing in municipal bonds primarily in West Virginia, spoke with regard to Section 6.02.06 - Bond and Loan Covenants. He also presented material which had been prepared by Moody's Investors Service.
- D. Bruce Carter of the West Virginia Hospital Association provided prepared remarks. In summary, Mr. Carter addressed the following issues:
- Accuracy and clarification of definitions.
 - Omission of wage passthrough
 - 3% average return on equity addressed in Section 6.03.03.

Absent further testimony, the hearing was adjourned. //

PRESENTED BY: Lynn Hubbard, R.N.
Director of Nursing Service
Stonewall Jackson Memorial Hospital
70 Bed Facility
West Virginia Society for Hospital
Nursing Service Administrators

As hospital nursing administrators, we are responsible for the care W.Va. hospital patients receive. In our hospitals the majority of the care given to these patients is by R.N.'s and L.P.N.'s.

The wage pass through part of Senate Bill 320 is not addressed in the temporary regulations. This means that hospitals will be unable to increase their rates to off set costs for salary increases for nurses. Hospitals in our State will be at a disadvantage in terms of recruiting and competing for nurses with the rest of the nation.

When the Rate Review Commission actually begins to review rates, nursing salaries in our state will continue to be 2 - 3 % behind the rest of the nation. Some hospitals in W.Va. plan no wage increases, while others may be able to give 3 - 6 %. The wage pass through was one of the major selling issues of Senate Bill 320 to the nursing profession. All those who believed the wage pass would be a part of the temporary rate regulations were grossly deceived by the legislators and the rate setting commission.

One of the ways hospitals replace obsolete equipment, repair and update equipment and facilities is to set aside excess revenue over expenses and to fund depreciation. If hospitals use these methods, they will not be allowed rate increases. There will be a considerable time lag - an estimated 2 years between now and the time the Rate Review Commission will have an opportunity to establish rates for hospitals. There is a provision for rate adjustments for emergency facility and major repair, but it is inadequate. When equipment and facilities need repairs there would be too much lag time between change in the rate and the revenue rate increases generate. Nurses may be forced to practice with unsafe equipment or work in unsafe environments until adequate funds can be generated.

There is also a provision that loans may be made by hospitals to handle emergency repair or replacement. However, many hospitals in the State are city or county owned and do not have assets to generate funding without extensive - procedural and legal hassles.

Hospital Boards will need to consider cost reduction to maintain operations. They will need to consider an elimination of patient services that may not produce excess revenue even though the elimination of these services may deprive the people around this hospital area of needed services.

Hospitals will be taking immediate action to compress, freeze, reduce and eliminate professional nurse positions in favor of technical, less costly personnel. Staffing patterns will be changed to meet only minimum requirements of State and accrediting agencies as opposed to the use of optimum staffing patterns.

These recommendations of the society must be considered for the well being and health of the people of West Virginia. I submit these to you as a representative of nurse managers and as a nurse practicing in rural West Virginia.

STATEMENT FOR THE RECORD AND CONSIDERATION OF
THE WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY
REGARDING COMMENTS ON PROPOSED REGULATION FOR
THE FREEZE ON HOSPITAL RATES
DELIVERED BY THE CHARLESTON AREA MEDICAL CENTER
AT THE PUBLIC HEARING HELD SEPTEMBER 13, 1983

Chairperson Richardson, Commissioners Gilligan and Fizer, The Charleston Area Medical Center appreciates the opportunity to appear today and make brief comments regarding the proposed regulations for the freeze on hospital rates and the granting of temporary rate increases.

In the interest of time, I will limit my comments to five key issues that we feel the Authority needs to review in more depth before issuing these regulations for approval as an "emergency filing of legislative rules". These five issues were selected by us for discussion today because of their importance to the operations of hospitals throughout West Virginia. The fact that we have limited our discussion to these five key issues does not, in itself, indicate our approval or concurrence with the remaining sections as published. Also, it does not mean that there are not other issues in these regulations that need to be either clarified or changed.

The five key issues I would like to discuss are as follows:

- o Accuracy of definitions.
- o Weaknesses in the formula for determining the reasonableness of increases in net patient revenues.
- o Return on equity and insolvency snafu.
- o Omission of wage pass through adjustment.
- o Uses and transfers of hospital funds.

In our review of the definitions in the Regulations, we made a number of observations. The regulations define Cost Reimbursements as amounts payable for goods and services rendered to a class of purchasers provided that the amount contracted for is cost-based. Examples of such purchasers included workers compensation and members of health maintenance organizations. In reality, both of these organizations reimburse hospitals their charges and in fact are not cost-based payors.

Third Party Payor is defined as any person, corporation or government entity responsible for payment for patient care services rendered by hospitals. This definition implies that the patient who pays his own bill would be classified as a third party payor. This is not accurate and could create con-

fusion in further calculations involving percentages of payment received by the various actual classes of third party payors.

In reviewing the formulas for determining the reasonableness of increases in net patient revenues, we have a number of major concerns! In all cases, the formulas are based on the accrual method of accounting and do not take into consideration the daily cash flow needs of an institution. A hospital can clearly show a profit on its accrual based financial statements and yet be struggling to obtain the cash flow required to meet its daily operations. It's cash flow that keeps a facility viable and solvent; not the artificial profit that is reported on the bottom line of a financial statement. Slowdowns in the payments from such agencies as the State Welfare Department and the Public Employees Insurance Board, earlier this year, have created a cash crunch for many hospitals in West Virginia. This slowdown, however, is not reflected in the financial statements and therefore, would not be reflected in the Authority's formula for determining the reasonableness of a requested rate hike. The economic environment in which the hospital operates has a large effect on a hospital's cash flow. In many of the communities, in rural West Virginia, unemployment is high and the hospitals

have large amounts in uncollectable accounts and charity write-offs which do not decrease revenue but severely restrict cash flow.

The formula takes into consideration changes in the number of admissions from one period to the next. What about changes in the number of outpatient or emergency room visits from one period to the next? It has become an accepted premise that health care costs are reduced by shifting patient care from the inpatient to the outpatient setting. However, the formula completely ignores outpatient and emergency room visit information. What happens to the hospital whose emergency room and outpatient volume and costs increase rapidly while its admissions remain constant? The regulation also fails to define just what is included in "Admissions". Does this include strictly routine inpatient admissions or are we to assume it includes newborn admissions, transfers from one facility to another, intra-hospital transfers, etc.?

We feel that a hospital's revenue from sources other than patient services should not be considered by the Authority in the rate formula! If a hospital is able to generate outside revenues to help subsidize hospital operations, these revenues should not be considered by the Authority in allowing temporary rate increases. This provision will discourage hospitals from seeking

non-health care related revenues in that the more outside revenues they earn, the less revenues they can generate from their actual charge based structure. The rate formula should encourage hospitals to generate revenues from outside sources to supplement its revenue base!

The Authority has presented criteria for determining that a rate change is necessary to prevent undue financial hardship and insolvency. The regulations refer to a declining equity position as a rate of return on equity which averages less than 3% over a five year period. First of all, we feel it is very important that the methodology for calculating return on equity be defined. Our review of current accounting and financial texts revealed no less than five accepted methods of computing return of equity. Secondly, we feel the 3% level is unacceptable. The Medicare return on equity amounts, as permitted under law, have averaged nearly 15% for the past three years. If 15% is acceptable at the Federal level, we see no reason for it not to be accepted at the state level.

The bond and loan covenants stated in these regulations are such that if a hospital is in compliance with them, the facility is probably already in technical insolvency or headed towards bankruptcy proceedings. The covenants are so low (120% of annual debt service) that by the time a hospital reached these

ratios, it may be beyond recovery. These limitations will also serve to reduce the amount of borrowing available to West Virginia hospitals for future replacement of plant and equipment. With these types of restrictions, hospital bond ratings will fall, making it more expensive, maybe even impossible, to obtain tax-exempt funding so necessary to maintain and preserve our health care industry. Also, restrictive covenants such as these will discourage the investment banking community from making loans in West Virginia which will further increase the cost of borrowing to hospitals - rather than decrease costs.

The legislative act clearly called for a wage pass through for hospital employees. Nowhere in the rate freeze proposals or in the rate capping regulations as previously submitted by the Authority, was this pass through mentioned. Is it the purpose of the Authority to ignore this part of the statute or has this avoidance been an oversight on the part of those who prepared the rate freeze regulations?

We would like to see some explanation of how the Authority plans to incorporate this wage pass through into its review mechanism. Or, can we assume that this portion of a rate hike is not subject to review by the Authority and there-

fore, hospitals are at liberty to raise rates in an amount sufficient to cover increases in the labor component of hospital salary costs?

The Authority has restricted the use and transfer of funds by the hospital corporation to or from a parent, sister or subsidiary corporation or related foundation after February 1, 1983. We feel this is a question of corporate law and that the Authority should not have the power to pierce the corporate veil. We feel this question needs to be reviewed at the state and federal levels to determine the legitimacy of this section of the rate freeze regulations. This restriction will create havoc among the religious hospitals in West Virginia which depend on their "mother houses" etc. to maintain their financial stability. Proprietary hospitals owned by chain organizations will also be affected even though they are abiding by the standard corporate regulations in effect under the laws of the State of West Virginia.

It is our opinion that the quality of health care will suffer in the State of West Virginia if these regulations are approved and put into effect. As the regulations are written, cash flow will become an immediate problem that may force drastic cutbacks in the quality and quantity of health care services pro-

vided to the community. Hospitals that are unsuccessful in their requests for a rate increase, will be unable to reward their employees with just compensation, or may have to lay off employees just to survive. These employees may very well seek alternate career patterns or decide to seek employment outside West Virginia in states where industry regulation does not limit their career objectives. Without rate increases, hospitals will be unable to afford the latest innovations in the health care technology necessary to preserve the health and well-being of our citizens. In short, we do not feel that a rate freeze is the answer to cost containment in the health care industry.

We appreciate the opportunity to appear in front of this Authority to render our comments and opinions and offer our resources and assistance in examining the health care cost issue. We will appreciate any consideration to our ideas and alternatives that the Authority may make presently or in the future.

Respectfully submitted,

Larry E. Robertson
Director of Financial Services
Charleston Area Medical Center, Inc.

WEST VIRGINIA HOSPITAL ASSOCIATION
COMMENTS ON "EMERGENCY FILING OF LEGISLATIVE RULES
FOR THE FREEZE ON HOSPITAL RATES
AND GRANTING OF TEMPORARY RATE INCREASES"

MADAM CHAIRMAN, MEMBERS OF THE WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY, MY NAME IS BRUCE CARTER, PRESIDENT OF THE WEST VIRGINIA HOSPITAL ASSOCIATION. WE HAVE REVIEWED THE EMERGENCY FILING OF THE LEGISLATIVE RULES FOR THE FREEZE ON HOSPITAL RATES AND GRANTING OF TEMPORARY RATE INCREASES AND HAVE THE FOLLOWING COMMENTS TO PRESENT.

AGAIN, AS I DID UNDER THE TESTIMONY ON THE PROPOSED REGULATIONS FOR ADJUSTMENT TO GROSS PATIENT REVENUE, I MUST PREFACE MY COMMENTS BY STATING THAT THIS INPUT IS BEING MADE WITHOUT PREJUDICE TO THE POSITION ASSERTED BY THE FOUR (4) HOSPITALS IN THE LITIGATION WHICH IS PRESENTLY PENDING IN THE FEDERAL COURT WHEREIN THE JUDGE HAS ISSUED AN ORDER ENJOINING THE SECTION OF THE LAW DEALING WITH THE GROSS PATIENT REVENUE LIMIT AND FREEZE. ANY COMMENTS MADE BY ME OR ANY OTHER MEMBER OF OUR ASSOCIATION SHOULD NOT BE TAKEN AS AN INDICATION THAT WE ARE ABANDONING THE POSITION ASSERTED BY THE HOSPITALS IN THAT CASE.

THE PENDING LITIGATION AND THESE PROPOSED REGULATIONS CREATE A DILEMMA. THE HOSPITAL ASSOCIATION WOULD BE NEGLIGENT OF ITS DUTIES IF IT LET THE PROPOSED REGULATIONS PROCEED WITHOUT COMMENT AND, THUS, NOT PROVIDE THE AUTHORITY WITH THE BENEFIT OF OUR TECHNICAL INPUT.

FIRST, SOME GENERAL COMMENTS AND THEN WE WILL ADDRESS SOME SPECIFIC ISSUES POINT-BY-POINT IN THE PROPOSED REGULATIONS.

WHILE WE RECOGNIZE MANY OF THE POSITIONS TAKEN BY THE AUTHORITY IN THESE REGULATIONS, ARE DESIGNED TO BE OF BENEFIT TO HOSPITALS, WE ARE CONCERNED THAT THEY ARE, IN FACT, CONTRADICTORY TO THE LANGUAGE IN THE LAW. TYPICALLY, THEY WOULD BE FOUND TO BE EXCESSIVE REGULATION IN THAT THEY DO, IN FACT, CHANGE THE INTENT OF THE LAW. IN OTHER WORDS, IN SEVERAL INSTANCES THROUGHOUT THESE REGULATIONS, THE AUTHORITY IS REDEFINING SPECIFIC LEGISLATIVE LANGUAGE. NORMALLY LEGISLATIVE OVERSIGHT WOULD CHALLENGE REGULATION WHICH CHANGE THE MEANING OF THE LAW.

THE LANGUAGE IN THE REGULATIONS SOUNDS VERY MUCH LIKE LANGUAGE THAT WOULD BE USED IN THE STATE OF MARYLAND WHERE THE AUTHORITY HAS A SYSTEM FOR REVIEWING AND RULING ON HOSPITAL CHARGES. YET, INTERSPERSED THROUGHOUT THESE REGULATIONS ARE COST REIMBURSEMENT TYPE LANGUAGE WHICH IS INCOMPATIBLE WITH CHARGE BASED SYSTEMS AND THE MARYLAND LANGUAGE.

THE REGULATIONS DO NOT ADDRESS WHETHER OUTPATIENT SERVICES AND LONG-TERM CARE SERVICES (HOSPITAL BASED SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES) ARE INCLUDED. THESE DATA AND STATISTICS CAN HAVE A PROFOUND AFFECT ON THE HOSPITALS FINANCIAL POSITION. IN ADDITION, THE REGULATIONS DO NOT TAKE INTO CONSIDERATION THE UNCONTROLLABLE INCREASES IN THE COST OF OPERATING A HOSPITAL THAT HAVE OCCURRED AND WILL OCCUR. THESE TOO CAN HAVE A SIGNIFICANT IMPACT AND ARE NOT UNDER THE CONTROL OF HOSPITAL MANAGEMENT AND BOARDS OF TRUSTEES.

THE REGULATIONS, AND CORRESPONDING FORMULAE, DEAL ONLY WITH ADMISSIONS AND DO NOT TAKE INTO CONSIDERATION PATIENT DAYS, OUTPATIENT SERVICES AND OTHER VOLUME FACTORS. WHILE ADMISSIONS MAY REMAIN AT THE SAME LEVEL OR

EVEN DECLINE, DEPENDING ON THE INTENSITY AND SEVERITY OF THE PATIENTS AND ANY CHANGES THAT MAY HAVE OCCURED IN THE TYPE OF SERVICES PROVIDED BY THE INSTITUTION, THERE MAY BE AN ACTUAL INCREASE IN PATIENT DAYS. THERE ARE VOLUME FACTORS THAT NEED TO BE TAKEN INTO CONSIDERATION IN THESE REGULATIONS TO PROPERLY ADDRESS THE FINANCIAL PROBLEMS OF HOSPITALS.

THE REGULATIONS APPEAR TO EXCLUDE CONSIDERATION OF A NEW HOSPITAL COMING INTO BEING AFTER FEBRUARY 1, 1983. WE ARE AWARE OF AT LEAST ONE (1) HOSPITAL THAT WILL BE CAUGHT BY THIS PROHIBITION UNLESS IT IS PROPERLY ADDRESSED.

BECAUSE OF RECENT CHANGES IN THE MEDICARE LAW AFFECTING PHYSICIANS, HOSPITALS WILL BE RENEGOTIATING MANY CONTRACTS. HOW DO THESE REGULATIONS ADDRESS THESE MEDICARE REQUIREMENTS? MANY HOSPITALS WILL BE REQUIRED TO ABSORB ADDITIONAL COSTS EFFECTIVE OCTOBER 1, 1983.

THE REGULATIONS DO NOT APPEAR TO RECOGNIZE THE WAGE PASSTHROUGH WHICH, IN OUR OPINION, IS CLEARLY INTENDED BY THE LAW. WITH WAGES AND BENEFITS ACCOUNTING FOR APPROXIMATELY 65% OF THE HOSPITALS COST OF OPERATION, THIS WILL BE A SIGNIFICANT FACTOR.

THE REGULATIONS DO NOT APPEAR TO RECOGNIZE THAT A HOSPITAL HAS TO HAVE A REASONABLE AMOUNT OF REVENUE OVER EXPENSE TO INCLUDE DEPRECIATION. IN FACT, THE REGULATIONS APPEAR TO BE SPENDING DOWN ANY FUNDED DEPRECIATION THAT THE HOSPITAL MAY HAVE ACCRUED. BOTH OF THESE ISSUES ARE OF PRIME CONCERN FOR THE LONG TIME FINANCIAL WELFARE OF A HOSPITAL AND

COULD BE VERY COSTLY TO THE PROVISION OF HOSPITAL SERVICES SHOULD A HOSPITAL HAVE TO BORROW FUNDS TO MEET ITS FINANCIAL NEEDS.

THE REGULATIONS AND THE FORMULA ARE SILENT AS TO HOW NEWBORNS WILL BE HANDLED. LIKEWISE, THEY ARE SILENT WITH RESPECT TO REPLACEMENT COSTS OF EQUIPMENT NOT SUBJECT TO C.O.N. LIMITS.

SINCE THE HEALTH CARE FINANCING ADMINISTRATION HAS RULES NOT TO RECOGNIZE COST COMMISSIONS ASSESSMENTS AS ALLOWABLE COSTS UNDER MEDICARE AND MEDICAID, ASSESSMENTS SHOULD BE BUILT INTO THE FORMULAE AS AN AUTOMATIC PASSTHROUGH.

TURNING TO SPECIFIC POINTS IN THE PROPOSED RULES, WE HAVE THE FOLLOWING COMMENTS:

PAGE 2, SECTION 2.01 - ACCREDITATION. THE GENERALLY ACCEPTED DEFINITION OF ACCREDITATION HAS BEEN EXPANDED TO INCLUDE CERTIFICATION FOR MEDICARE AND MEDICAID AND LICENSURE BY THE WEST VIRGINIA DEPARTMENT OF HEALTH. AGAIN, WE RECOGNIZE THIS AS BEING DONE IN AN EFFORT THE HELP HOSPITALS, BUT WE ARE CONCERNED THAT IT IS AN EXPANSION AND REDEFINITION OF THE LAW BY REGULATION THAT WOULD NOT STAND THE TEST OF LEGAL CHALLENGE.

PAGE 2, SECTION 2.02 - AUTHORITY. AGAIN, THE LAW STATES THAT THE DIRECTOR OF THE WV DEPARTMENT OF HEALTH IS DESIGNATED TO CONSIDER AND DECIDE UPON TEMPORARY RATE CHANGES. IN FACT, THESE AND THE PREVIOUS REGULATIONS SHOULD HAVE BEEN PROMULGATED BY THE DEPARTMENT OF HEALTH.

PAGE 3, SECTION 2.04 - COST REIMBURSEMENTS. WORKERS COMPENSATION IS NOT A COST REIMBURSEMENT SYSTEM. THEY PAY HOSPITALS BASED ON CHARGES. IN ADDITION, WE ARE NOT AWARE OF ANY OTHER INSURANCE PROGRAMS OR HEALTH MAINTENANCE ORGANIZATIONS THAT PAY HOSPITALS ON A COST BASIS.

PAGE 3, SECTION 2.07 - PROPORTION OF MEDICARE, MEDICAID OR CHARITY PATIENTS. HOSPITALS UNCOLLECTIBLE ACCOUNTS, BAD DEBT, HAVE NOTHING TO DO WITH MEDICARE, MEDICAID OR CHARITY.

PAGE 4, SECTION 2.10 - THIRD PARTY PAYER. THIS DEFINITION SHOULD BE RESTRUCTURED TO SPECIFY "OTHER THAN THE PATIENT". A PATIENT WHO PAYS HIS OWN HOSPITAL BILLS IS CLEARLY NOT A THIRD PARTY PAYER.

PAGE 6, SECTION 4.03 - RELATIONSHIP OF TEMPORARY RATE CHANGE TO GROSS PATIENT REVENUE LIMIT. THIS SECTION CLEARLY CREATES A VERY SERIOUS PROBLEM FOR HOSPITALS AND IN OUR OPINION IS NOT THE INTENT OF THE LAW. ANY HOSPITAL FILING FOR A TEMPORARY RATE INCREASE, BECAUSE OF INSOLVENCY OR FINANCIAL HARDSHIP, WILL VERY PROBABLY BE IN VIOLATION OF THE GROSS PATIENT REVENUE LIMIT IF SUCH INCREASES ARE GRANTED BY THE DIRECTOR OF HEALTH. THIS WILL BE A PARTICULARLY SEVERE PROBLEM FOR SMALL HOSPITALS WHO EXPERIENCE GREATER FLUCTUATIONS IN VOLUME THAN DO LARGE HOSPITALS. WHAT GOOD IS IT GOING TO DO FOR A HOSPITAL TO BE GRANTED A TEMPORARY RATE INCREASE WHEN A PORTION OR POSSIBLY ALL OF THE INCREASED REVENUE TO THE HOSPITAL HAS TO BE TURNED OVER TO THE STATE BECAUSE IT IS IN VIOLATION OF THE GROSS PATIENT REVENUE LIMIT?

PAGE 6, SECTION 5.01.01 - CERTAIN APPLICATIONS ISSUED ORDER OF APPROVAL WITHOUT REVIEW. WE ASSUME SUBSECTION (B) AUTOMATICALLY APPROVES ANY RATE INCREASE THAT A HOSPITAL PUTS IN PLACE BECAUSE OF A CHANGE IN A PAYMENT AGREEMENT WITH A THIRD PARTY PAYER WHEN, IN FACT, THOSE CHANGES SHOULD BE SCRUTINIZED JUST AS CAREFULLY AS ANY OTHER RATE CHANGE. FOR INSTANCE, SHOULD A HOSPITAL NEGOTIATE A NEW CONTRACT WITH BLUE CROSS, WHEREIN BLUE CROSS PAYS HOSPITALS AT A RATE LOWER THAN THEY HAD PAID HISTORICALLY, THE HOSPITAL, BY NECESSITY, WILL HAVE TO SHIFT THAT LOSS OF REVENUE AND INCREASE CHARGES TO OTHER THIRD PARTY PAYERS AND SELF-PAYING PATIENTS. THE AUTHORITY SHOULD SCRUTINIZE THOSE RATE CHANGES CAREFULLY TO DETERMINE WHETHER 1) THE INCREASE IN CHARGES PROPOSED BY THE HOSPITAL TO COVER THAT LOSS OF REVENUE ARE APPROPRIATE, AND 2) TO BE CERTAIN THAT THE AUTHORITY IS PHILOSOPHICALLY IN AGREEMENT WITH CONTINUING AND, IN THIS CASE, EXPANDING THE CONCEPT OF COST SHIFTING.

PAGE 8, SECTION 5.02.01(g) - THE FIRST FOUR (4) ITEMS, "STATEMENT OF INCOME AND EXPENSE; BALANCE SHEET; STATEMENT OF CHARGES AND CHANGES IN FINANCIAL POSITION; AND CURRENT AND SUCCEEDING YEAR PROJECTIONS OF REVENUE AND EXPENSES" ARE ON FILE WITH THE AUTHORITY AND SHOULD BE USED. IN AN EFFORT TO REDUCE PAPERWORK, THE AUTHORITY SHOULD NOT ASK FOR INFORMATION THEY ALREADY HAVE.

PAGE 9, SECTION 5.03.01 - NOTIFICATION OF REVIEW. WE ASSUME THAT THIS SECTION SPEAKS OF PUBLIC NOTICE BY THE AUTHORITY. WE WOULD ALSO LIKE TO HAVE CLARIFICATION AS TO WHO THE AUTHORITY CONSIDERS TO BE "INTERESTED PERSONS".

PAGE 14, SECTION 6.02.04 - REVENUE OTHER THAN PATIENTS SERVICE REVENUE. WHAT IF NON-PATIENT REVENUE IS LESS? WHAT IF INTEREST INCOME IS LOWER? WE DON'T UNDERSTAND WHY THE REGULATIONS ONLY SPEAK TO ONE SIDE OF THE ISSUE.

PAGE 14, SECTION 6.02.05 - USES AND TRANSFER OF HOSPITAL FUNDS. SECTION (2) COULD BE A SIGNIFICANT PROBLEM TO BOTH PROFIT AND NONPROFIT CORPORATE CHAINS. FOR INSTANCE, THE APPALACHIAN REGIONAL HOSPITAL SYSTEM FREQUENTLY SUBSIDIZES UNPROFITABLE HOSPITAL WITH REVENUE FROM A PROFITABLE HOSPITAL IN ORDER TO KEEP THE WHOLE SYSTEM FINANCIALLY SOUND. THE NO TRANSFER REQUIREMENT COULD SEVERELY HARM PATIENT CARE IN A SPECIFIC AREA OF THE STATE.

PAGE 15, SECTION 6.02.05(B) - PROHIBITS TRANSFER OF ASSETS TO BOARD DESIGNATED FUNDS ACCEPT FOR BOND AND LOAN COVENANTS. THERE ARE A NUMBER OF OTHER RESTRICTED FUNDS WHICH A HOSPITAL MUST LEGALLY MAINTAIN, SUCH AS PENSION PLANS AND SELF-INSURANCE FUNDS.

PAGE 15, SECTION 6.02.06 - BOND AND LOAN COVENANTS. THIS SECTION SHOULD BE REVIEWED IN DETAIL BY EXPERTS IN THE FIELD. THOSE EXPERTS THAT HAVE DISCUSSED THIS SECTION WITH US DO NOT BELIEVE THAT 120% IS ADEQUATE AND WOULD EXCLUDE HOSPITALS FROM THE CAPITAL MARKET.

PAGE 16, SECTION 6.02.08(A) - EXPENSES ASSOCIATED WITH AN ACCREDITATION REQUIREMENT. THIS SECTION IS MUCH TOO LIMITED SINCE HOSPITALS HAVE APPROXIMATELY 100 DIFFERENT AGENCIES WHICH REGULATE THE ACTIVITIES WITHIN A HOSPITAL. TO TOUCH JUST A FEW, THERE ARE STRICT INSPECTION

STANDARDS AND REQUIREMENTS FOR LABORATORIES, X-RAY DEPARTMENTS, PSYCHIATRIC DEPARTMENTS, AND OSHA.

PAGE 18, SECTION 6.03.03 - CRITERIA FOR DETERMINING THAT A RATE CHANGE IS NECESSARY TO PREVENT UNDUE FINANCIAL HARDSHIP. SUBSECTION (2) USES A 3% AVERAGE RETURN ON EQUITY. ON AN ACCURAL BASIS OF ACCOUNTING, A 3% RETURN ON EQUITY DOESN'T ASSURE THAT THE HOSPITAL WILL HAVE CASH TO MEET ITS CURRENT OPERATING EXPENSES. IN FACT, A NUMBER OF HOSPITALS HAVE, IN RECENT RECESSION YEARS, MET THAT MARGIN AND STILL HAD TO GO TO THE BANK TO BORROW MONEY TO MEET PAYROLL.

THE WEST VIRGINIA HOSPITAL ASSOCIATION ASKED MEMBER HOSPITALS TO RUN THEIR FINANCIAL INFORMATION THROUGH THE FORMULAE CONTAINED IN THESE PROPOSED REGULATIONS. UNFORTUNATELY, WE ARE NOT ABLE TO PROVIDE YOU WITH ANY FEEDBACK ON THE RESULTS OF THESE STUDIES, SINCE THE HOSPITALS ARE NOT ABLE TO DETERMINE HOW TO APPLY THEIR DATA TO THE FORMULAE BECAUSE OF A LACK OF CLEAR DEFINITIONS IN THESE REGULATIONS. THESE REGULATIONS NEED MORE EXTENSIVE REVIEW AND CLARIFICATION BEFORE THE FORMULAE CAN BE MEANINGFULLY APPLIED.

AGAIN, THE LAW MANDATES THAT ISSUES BEFORE THE AUTHORITY BE REVIEWED BY THE ADVISORY COUNCIL PRIOR TO ANY FORMAL ACTION. NOW THAT THE ADVISORY COUNCIL HAS BEEN APPOINTED, WE STRONGLY RECOMMEND THAT THESE PROPOSED REGULATIONS BE REVIEWED BY THAT BODY BEFORE PROMULGATION.

SINCE THESE REGULATIONS ARE DESIGNED TO COVER A TEMPORARY PERIOD OF TIME AND PECULIAR CIRCUMSTANCES OF INSTITUTIONS, WE FEEL THAT THE AUTHORITY

WOULD BETTER SERVE THE PUBLIC BY TAKING THE APPROACH OF BUDGET REVIEW. BY ESTABLISHING A PROSPECTIVE PAYMENT SYSTEM, THAT CAN BE ADJUSTED UP OR DOWN WHEN THE AUTHORITY ESTABLISHES ITS RATE SETTING SYSTEM AND ESTABLISHES THE HOSPITALS FIRST SET OF RATES, YOU ALLEVIATE A LOT OF COMPLEXITY AND PAPERWORK. THESE REGULATIONS APPEAR TO BE MUCH TOO PRECISE, TRYING TO COVER EVERY POSSIBLE CIRCUMSTANCE. IF SUCH A SYSTEM WERE POSSIBLE TO CREATE, IT WOULD HAVE BEEN IMPLEMENTED YEARS AGO BY THE FEDERAL GOVERNMENT AND OTHERS. BY THE TIME THE AUTHORITY COULD APPLY ALL THE DETAILS IN THESE REGULATIONS, THE START UP PERIOD WOULD EXPIRE.

I STAND READY TO ATTEMPT TO ANSWER ANY QUESTIONS THAT MAY HAVE BEEN RAISED BY THIS TESTIMONY.

Moody's Investors Service

99 Church Street, New York, N.Y. 10007
212-553-0300

February 2, 1983

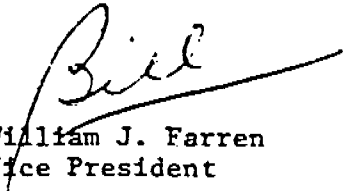
To: Municipal Credit Report Subscribers

I am pleased to enclose a copy of

- 1) State Medians
- 2) Range of Overall and Net Debt
Cities & Counties
- 3) Revenue Enterprise Medians
Electric - Water - Sewer - Airport - Bridge
Tunnel - Expressway and Turnpikes
- 4) Hospital Medians

We believe this kind of information will be of assistance to you in your day-to-day analysis of municipal credits. Your comments would be appreciated.

WJF/sc


William J. Farren
Vice President

MOODY'S INVESTORS SERVICE
MUNICIPAL DEPARTMENT

CURRENT HOSPITAL ENTERPRISE MEDIANS

The following represents the medians calculated on 167 hospital enterprises which have been rated by Moody's for the calendar year 1982. The medians convey various measures of performance and earning capabilities of hospitals which have used tax-exempt bonds for their capital financing program. The medians represent ratios and indices common to revenue-producing enterprises, as well as several which are unique to the health care enterprises. The current medians are as follows:

Operating ratio (%)	91.0
Net take-down (%)	11.0
Peak debt service coverage by historical net revenues	0.98
Peak debt service coverage by estimated net revenues in first full year after project completion	2.26
Debt ratio (%)	32.5
Projected debt ratio (%)	52.3
Bed occupancy (%)	81.7
Number of beds	314
Average length of stay (days)	7.4
Debt svc. safety margin	7.9

(Please refer to other side for definitions)

CURRENT HOSPITAL ENTERPRISE MEDIANS

DEFINITIONS:

Income Statement Definitions and Ratios:

Gross revenue and income	:	Operating revenue plus non-operating revenue.
Operating expenses	:	Operating expenses, excluding depreciation, amortization and interest.
Net revenues	:	"Gross revenue and income" minus "operating expenses."
Operating ratio (%)	:	"Operating expenses" divided by total operating revenues.
Net take-down (%)	:	"Net revenues" divided by "gross revenue and income."
Peak debt service coverage by historical net revenues	:	"Net revenues" divided by the estimated maximum annual principal and interest on all outstanding bonds and the bonds to be issued.
Peak debt service coverage by projected net revenues	:	Estimated "net revenues" for the hospital during the first full fiscal year following the completion of the capital project financed from the new bonds, divided by the estimated maximum annual principal and interest on all outstanding bonds and the bonds to be issued.
Debt service safety margin	:	Net revenues less current debt service divided by gross revenues.

Balance Sheet Definitions and Ratios:

Net fixed assets	:	Fixed assets minus accumulated depreciation.
Long term debt	:	Gross long-term debt plus the current portion of long-term debt.
Net long-term debt	:	"Long-term debt" minus the bond reserve funds/accounts for the payment of bond principal.
Debt Ratios (%)	:	"Net long-term debt" divided by the sum of "net fixed assets" plus net working capital.
Projected Debt Ratio (%)	:	Proforma "Net long-term debt" divided by the sum of "net fixed assets" plus "net working capital" for the first full fiscal year following issuance of the bonds. Figures are derived from feasibility studies.

Utilization Results Definitions and Ratios:

Number of beds	:	Represents the average bed complement.
Average daily census	:	Total patient days divided by the days in the year (365).
Bed occupancy (%)	:	Average occupancy of the hospital's patient beds during the year. This ratio is computed by dividing "average daily census" by the hospital's average beds available for that year.
Average length of stay	:	Average stay for inpatients, as reported by the hospital for that year. It is computed by taking the total patient days divided by number of admissions or discharges.

Blue Cross
and
Blue Shield
of West Virginia, Inc.



City Center West
P. O. Box 1353
Charleston, WV 25325

Writer's Direct Dial Number

(304) 232-4550

September 8, 1983

Ms. Sally K. Richardson, Chairperson
Health Care Cost Review Authority
State Capitol Building
Charleston, West Virginia 25305

Dear Ms. Richardson:

Attached is a series of comments and suggested changes relative to the emergency filing of legislative rules for the freeze on hospital rates and granting of temporary rate increases, Chapter 16-29 B, Series 2 (1983). In general, the emergency regulations seem to be a valid effort to use the exception process provided for in the legislation to prevent permanent harm from befalling hospitals, which conduct themselves in a responsible manner.

The regulations note in their preamble that the intent is to deal with the short-term problems created by a blanket freeze on hospital rates; and quite properly note that the criteria for rate changes should not be construed as establishing a precedent for the authority's future design of hospital rate regulation. Many of the items which are contained in these regulations would not be appropriate as long-range policy and should be viewed strictly as a stop-gap to prevent permanent damage to the state's health care system resulting from the freeze on hospital rates and the cap on hospital revenues which was applied to all facilities in the state.

Thank you very much for the opportunity to comment on these regulations.

Sincerely,

A handwritten signature in cursive script that reads "William E. Gavin".

W. E. Gavin
Vice President

F:2:hb

Enclosure

BLUE CROSS AND BLUE SHIELD OF WEST VIRGINIA, INC.

Comments

The following are some specific comments relative to sections of the proposed regulations implementing the exception process to the hospital rate freeze.

§ 4.03 and § 5.02.01e

These sections indicate that there is some relationship between the granting of a temporary rate increase and a change in the hospital's gross patient revenue limit. While there may be a relationship relative to the addition of services, and there may be instances in which an exception to the 12% gross patient revenue limitation would be necessary to prevent insolvency or undue financial hardship, the precise intent of the wording "may result in an adjustment to the amount of gross patient revenue otherwise allowed in hospitals," should be clarified within the body of a regulation. Would a separate finding be required by the authority to permit a hospital an increase in gross patient revenue in excess of 12%?

§ 5.01.02

Provides that the authority will immediately determine the application's eligibility for expedited review. The use of the word immediately may prove to be unfeasible replacement with a precise time frame, such as, within three working days, may avoid legal complications.

§ 5.02.01g

Should be modified to assure that the information submitted by the hospital is the information required for analysis and that the information is based based upon traditional accounting, possible modified wording would be as follows:

§ g The following financial statements prepared in accordance with generally accepted accounting principles for the hospital's current, one succeeding, and ~~four~~ three preceding fiscal years, certified as being true for the preceding ~~four~~ three fiscal years, and the best estimates for the current and one succeeding year projections:

- (1) Statement of income and expense;
- (2) Balance sheet;
- (3) Statement of changes in financial position;
- (4) Current and succeeding projections of Schedule of Departmental Revenues and Expenses; and
- (5) Schedule of Assumptions for Projections; and

§ 6.02.05a

Speaks to the transfer of funds to or from a parent, sister or subsidiary corporation. While the intent seems clear that the transfer of funds to a related organization in order to avoid these regulations will not be tolerated; it is not clear why hospitals projections for transfers of funds from a related organization should not be taken into consideration. Would suggest that the "or from" language be deleted from this section.

§ 6.03.02b

Speaks to hospital expenses for emergency repairs. The cash nature of the accounting principles that are contemplated in the section could be emphasized by having the section read "hospital evidences that ~~expenses~~ expenditures required for emergency repairs"

§ 6.03.02c and § 7.02

The term "funds available from other sources" should be defined and guidelines provided as to the minimum amount of funds which are necessary for a hospital to meet its current obligations in the normal course of business. A possible approach may be to reference data on financial ratios for the hospital industry published by the Financial Analysis Service Division of the Hospital Financial Management Association and provide that the authority will determine an amount of "funds" which must be maintained as a minimum liquidity position for the hospital to efficiently carry on its business. In the accounting literature "funds" is often used to mean Working Capital vs. Cash and Marketable Securities. An ideal analysis of "funds available from other sources" should take into consideration the hospital's level of working capital and the major components of working capital such as cash (and equivalents), Accounts Receivable and Accounts Payable.

As an alternative to defining "funds available from other sources," consideration should be given to a revised formula which also considers -

- 1) Non-cash Expenses as a source of funds;
- 2) Principle Payments and mandatory sinking fund deposits as uses of funds; and

such that the projected return on equity [net income divided by (total assets minus total liabilities)] for the year does not exceed the lower of 1) three percent plus any amounts determined to be necessary to meet cash expenditures for emergency repairs which are not utilized in the determination of net income, or 2) and amount which will bring the hospital's return on equity over the five-year period to an average of three percent.

Such a provision would be intended to:

- 1) Recognize that in an inflationary economy, a non-for-profit hospital must show an accounting "bottom line" if they are to maintain their current real financial position. The use of a three percent ROE is well below the rate of inflation over the past few years and thus would require a significant shrinkage in the real value of the hospital's equity before the facility would qualify for a hardship exception.
- 2) Preclude hospital from requesting a "catch up" during the freeze period if their ROE has averaged less than three percent over past years.
- 3) Minimize the level of financial deterioration in hospitals which have maintained responsible profit margins so that a large "bump" in hospital charges will not be necessary when the authority establish as the hospitals' permanent rates. The need of third-party payors and purchasers for both a reduction in the rate of increase in hospital rates and increased predictability in the rate of change in total hospital cost should be kept in mind. A flattening of the hospital cost curve followed by a sharp escalation in rates would be very disruptive.

- 3) A minimum "funds level," which is based upon a specified number of days operating expense. The number of days operating expense which would constitute a minimum working capital level should be based upon an analysis of hospital data.

In establishing any "funds level," flexibility should be allowed to permit further analysis of the components of working capital.

§ 6.03.02d

An additional standard dealing with rate changes necessary to prevent insolvency may be useful which provides an exception to the freeze for a hospital which evidences that it is in imminent danger of insolvency as defined in federal bankruptcy laws. The general bankruptcy laws may provide a series of detailed test for defining this aspect of insolvency.

§ 6.03.03a

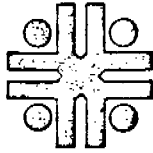
It may be desirable to modify the first sentence to read: "The hospital evidences a significantly declining equity position. A significant decline in." In addition, the fourth line should be modified to read: "The rate of return on equity projected for"

§ 7.01a

The definition of the term V_m may work better if changed to read "Projected average annual volume over life of service." As written, the use of volume at maturity would not give recognition to the build up of the service to the maturity level. Use of average would preclude the establishment of a rate for a new service based upon the projected volume during the first year which would not result in a reasonable rate for the service.

§ 7.03

The formula for determining the amount necessary to prevent undue financial hardship due to a significant decline in hospital's equity position should be reconsidered. The formula could possibly be replaced with a sentence such as; "When a rate change is found necessary to prevent undue financial hardship as a result of the hospital experiencing a significant decline in its equity position over a five-year period, the amount of the rate change shall be determined as an amount



CABELL HUNTINGTON HOSPITAL

August 19, 1983

AUG 19 1983

Sally K. Richardson, Chairperson
Health Care Cost Review Authority
State Capitol Building
Charleston, West Virginia 25305

Dear Mrs. Richardson:

I have reviewed the regulations recently filed with the Secretary of State regarding the granting of temporary rate increases under the recently passed Cost Containment Legislation. Since you will undoubtedly receive lengthy responses to the temporary regulations, I plan to keep my comments concise and to the point.

First, the formula for insolvency addresses future gain or loss. I see insolvency as being a condition of the present which does not permit you to meet your obligations in terms of payroll and vendors. I would see allowing a reasonable number of days in operating cash as being a more realistic formula for insolvency than a projection into the future.

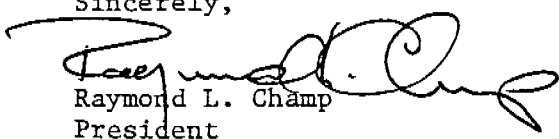
Second, the formula indicated on page 17 is basically a break-even formula and thus ignores the question of legitimate need for a reasonable amount of revenue over expense. Also, the definition of "r" gives rise to my suspicion that you are including funded depreciation as being available. I have detected from the beginning of our discussions as I sat with the temporary rate increase committee that there was a lack of understanding of the hospital's need for a reasonable amount of funded depreciation. Simply stated, this need is based upon the fact that depreciation is based upon historical dollars (what you paid rather than what you will have to pay to replace the item) and that the expense of replacement will far exceed the original purchase price. I strongly suggest that the long-term interest of hospitals will be served if the commission begins to recognize the need for funded depreciation and for a reasonable amount of excess of revenue over expense.

Having made these two quick points let me move then to that part of my response I feel most strongly about. The temporary regulations ignore completely the intent of legislation to pass through legitimate granted or bargained for wages and benefits to non-supervisory employees. As you well know, this

language is crystal clear and is contained in the Section 16-20B-20 paragraph 4 d). For those of us who would like to bargain in an unrestrained environment and have the ability to recover the costs of these increases, the unwillingness of the commission to recognize the intent of the legislation places us in a very difficult situation. I understand that the language of the legislation specifies reasonable increases and it would certainly be our intent to arrive at a figure that is consistent with the needs of our employees as well as cost concerns of the public. The commission, in my judgment, has an obligation to address directly this question in its temporary regulations rather than leaving both employers and employees hanging as to what your disposition will be.

I appreciate the opportunity to have served on the temporary commission and I am hopeful that my comments will be of some assistance.

Sincerely,



Raymond L. Champ
President

RLC/dmo

cc: Board of Trustees