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

Double Reg. Filing 8-15-84 (Emerg. Reg.)

Emergency Both Emerg. Filings

June 8, 1984

The Honorable A. James Manchin
Secretary of State
State of West Virginia
State Capitol Complex
Charleston, WV 25305

Dear Mr. Manchin:

Re: Emergency filing of Procedural and Legislative Rules

A public hearing was held on the "Statement of Policy: Hospital Cost Containment Methodology: and the "Procedural Rules for the Projection of Gross Revenues for Hospitals, Setting the Amount of Net Revenue Over Expenditures for Hospitals, and Setting Schedules of Rates for Hospitals, Chapter 16-29B, Series III (1984)", which were heretofore filed with your office on April 16, 1984, and as a result of those hearings, certain changes were made. Therefore, pursuant to West Virginia Code, §29A-3-15(e), please file the enclosed "Statement of Policy: Hospital Cost Containment Methodology" and "Procedural Rules for the Projecting of Gross Revenues for Hospitals, Setting the Amount of Net Revenue Over Expenditures for Hospitals, and Setting Schedules of Rates for Hospitals, Chapter 16-29B, Series III (1984)" both dated June 8, 1984, as substitute emergency rules. Both sets of rules are effective upon filing; however, the expiration date of the rules remains as one hundred and eighty days (180) following the original filing on April 16, 1984.

Sincerely,

Sally K. Richardson

Sally K. Richardson
Chairperson

SKR/maj

FILED IN THE OFFICE OF
A. JAMES MANCHIN
SECRETARY OF STATE
THIS DATE June 8, 1984
Administrative Law Division

STATE CAPITOL BUILDING
CHARLESTON, WEST VIRGINIA 25305
TELEPHONE (304) 348-2678

343-370

June 8, 1984

Emergency Filing

PROCEDURAL RULES

WEST VIRGINIA
HEALTH CARE COST REVIEW AUTHORITY

Procedural Rules for the Projecting of Gross Revenues for Hospitals, Setting the Amount of Net Revenue Over Expenditures for Hospitals, and Setting Schedules of Rates for Hospitals

Chapter 16-29B
Series III
(1984)

WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY

Emergency Filing

PROCEDURAL RULES

Procedural Rules for the Projecting of Gross Revenues for Hospitals, Setting the Amount of Net Revenue Over Expenditures for Hospitals, and Setting Schedules of Rates for Hospitals

Chapter 16-29B
Series III
(1984)

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Emergency Filing

PROCEDURAL RULES

WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY

Chapter 16-29B
Series III
(1984)

Subject: Procedural Rules for the Projecting of Gross Revenues for Hospitals, Setting the Amount of Net Revenue Over Expenditures for Hospitals, and Setting Schedules of Rates for Hospitals

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Section 1. General.

1.01. Scope. These procedural rules set the procedure to be used to ascertain appropriate projections of gross revenues for hospitals, to set the amount of net revenue over expenditures that is appropriate for the effective operation of each hospital, and to set initial and later rate schedules for each hospital. The procedural rules also set forth time periods for the submission of applications by hospitals pertaining to rate schedules, increases therein, and for subsequent actions on the applications including hearings in contested cases. These procedural rules supplement the Health Care Cost Review Authority Act, West Virginia Code, §16-29B-1 et seq., and the West Virginia Administrative Procedures Act, West Virginia Code, §29A-1-1 et seq., and must be read in conjunction with those Acts.

1.02. Authority. These procedural rules are issued under the Authority of the Health Care Cost Review Authority Act, West Virginia Code, §16-29B-1 et seq., the Administrative Procedures Act, West Virginia Code, §§29A-2-9, 15, and the Freedom of Information Act, West Virginia Code, §29B-1-3.

1.03. Filing Date. These procedural rules were promulgated on June 8, 1984, and were filed in the Office of the Secretary of State on June 8, 1984.

1.04. Effective Date. These rules become effective upon filing under the emergency provisions of West Virginia Code, §29A-3-15, and shall remain in effect for a period of one hundred and eighty days from April 16, 1984, and each rule may be renewed for another one-hundred-and-eighty-day period pursuant to the provisions of that statute.

Section 2. Definitions. As used in these rules, all terms have the same meaning as provided in the definition section of the Health Care Cost Review Authority Act, West Virginia Code, §16-29B-3. Definitions of additional terms are set forth below and whenever those terms are used, the following definitions apply, except where the context may expressly otherwise require.

2.01. Act means the West Virginia Health Care Cost Review Authority Act, West Virginia Code, §16-29B-1 et seq.

2.02. Authority means the West Virginia Health Care Cost Review Authority, an autonomous division within the State Department of Health.

2.03. Gross Revenue means a hospital's gross patient revenue plus all operating and non-operating revenues from whatever source.

2.04. Hospital means:

(a) a facility subject to licensure as such under the provisions of West Virginia Code, §16-5B-1 et seq.; or

(b) any acute care facility operated by the state government which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons;

but, in either event, does not include state mental health facilities, facilities primarily engaged in rendering psychiatric diagnosis, treatment, and care, or state long-term care facilities.

2.05. Methodology means the Hospital Cost Containment Methodology, together with all of its appendices. The Methodology is a statement of policy by which the Board will make its decisions in rate-setting matters and is being filed concurrently with these procedural rules as a legislative rule pursuant to West Virginia Code, §§29A-1-2(d), (i) and §29A-3-15.

Section 3. Revenues Paid by and Rates Set for Federal Medicare and Medicaid Programs. Until such time as agreements are entered into by the Board with the Secretary of the United States Department of Health and Human Services so that department and affected state agencies allow reimbursement to hospitals subject to the provisions of this article in accordance with rates approved by the Board for services provided for by that department, nothing in these rules shall be interpreted or construed so as to allow the Board to affect revenues paid by or rates set for the Federal Medicare and Medicaid programs. Rather, until such agreements

are entered into, the Board shall set rates of payments only for all other payors.

Section 4. Initial Schedule of Rates.

4.01. Commencing Reviews. The Authority shall commence review activities for hospitals in accordance with the beginning of each hospital's fiscal year. Appendix "A", contains a chart which group the various hospitals by their fiscal year beginning dates. Appendix "B" contains charts listing the dates for each group to have completed certain tasks in order to obtain an initial schedule of rates. A hospital's review commences upon receipt of a notice from the board informing it that the hospital's review process has begun or upon sixty (60) days prior to the start of its fiscal year, whichever is later. Upon commencement of its review, a hospital may not change the rates it charges for its services to non-medicare or non-medicaid patients without the prior approval of the board.

4.02. Time Periods for Filing of Applications. At least thirty (30) days prior to the beginning date of each hospital's next fiscal year following the emergency effective date of these rules, such hospital shall file its application and a proposed budget for that fiscal year. The application shall contain the information specified in Section 5.

The application and proposed budget must be received by the Authority on or before the thirtieth day in order for there to be an effective filing.

4.03. Authority's Approval of Gross Revenue Limit. Upon receipt of the hospital's application and proposed budget, the Authority's staff shall submit to the Board a proposed gross revenue limit for that hospital. The Board shall, within fifteen (15) days after the start of the hospital's fiscal year, issue a final order setting the hospital's gross revenue limit; except that, if the application and proposed budget are received less than thirty (30) days before the start of the hospital's fiscal year, the Authority may extend the review process and the issuance of the final order to forty-five (45) days from the date the application is received. The hospital's community shall be notified by the Authority of the final order through an announcement in the media. Upon the Authority's staff's request, a conference may be held among the hospital's officials, the staff, and any interested persons at any time prior to issuance of the order.

4.04. Revised Proposed Budget and Schedule of Rates. The final order setting the gross revenue limit shall be sent to the hospital by registered mail, return receipt requested. The hospital may implement a new schedule of rates based on the gross revenue limit after receiving the final order setting such limit. Within forty-five (45) days of receipt of the final

order, the hospital shall file a revised proposed budget which takes into account the gross revenue limit set by the Board and shall also file a schedule of rates which is predicated upon that gross revenue limit. To be effectively filed, the revised proposed budget and schedule of rates must be actually received by the Board on or before the aforesaid forty-fifth day. Within thirty (30) days of receipt of the revised proposed budget and the schedule of rates, the Board shall issue a final order accepting, rejecting, or modifying the hospital's budget and schedule of rates for the impending fiscal year. The final order shall be sent to the hospital by registered mail. The hospital's community shall be notified by the Authority of the final order through an announcement in the media.

4.05. Priority of Gross Revenue Limit. Should a conflict arise between the gross revenue limit set by the board and the revenue generated or anticipated by the schedule of rates, the gross revenue limit shall take precedence and the hospital shall take actions to reduce its schedule of rates. The hospital must notify the board of the reductions made by the hospital. Nothing in this subsection is intended to apply to a situation where greater utilization than was anticipated results in the generation or anticipation of the excess gross revenue. Moreover, the board reserves the right to review the hospital's compliance with its final orders and to direct changes in the schedule of rates, following notice and an opportunity for hearing, if such action is warranted.

4.06. Notice of Contest. Should the hospital or an interested party claiming to be an affected party wish to contest a final order, the hospital or the interested party must file a written notice with the Board within twenty (20) days of the hospital's receipt of the final order. The written notice must be received by the Authority on or before the twentieth day in order for there to be an effective filing. The written notice must specifically state the basis for the hospital's or interested party's disagreement with the Board's final order. The written notice shall also set forth with specificity the facts upon which the hospital or interested party will rely to prove its case. If no written notice is timely filed, the proposed schedule of rates and gross revenue limit shall go into effect sixty (60) days from the date of issuance of the final order or earlier if the hospital wishes.

4.07. Hearing on Notice of Contest. Upon receipt of a written notice of contest, the Board shall schedule a hearing upon the matters in disagreement. The hearing shall be held no earlier than ten (10) days after receipt by the Board of the written notice of contest. The hearing shall be conducted pursuant to the provisions of West Virginia Code, §16-29B-12 and §29A-5-1 et seq. In addition, the

Rules of Procedure for Contested Case Hearings and Declaratory Rulings, Chapter 16-1, Series I (1983) heretofore promulgated by the West Virginia Board of Health on December 30, 1982, are incorporated herein by reference and shall supplement the aforesaid code provisions. The board or the hearing examiner may schedule and require attendance at a pre-hearing conference to be conducted by an officer appointed for that purpose by the board. The purposes of the pre-hearing conference shall be similar to the purposes of Rule 16, West Virginia Rules of Civil Procedure. Within ninety (90) days after the Board first submitted the contested final order, the Board shall issue a final order on the matters which were in disagreement at the hearing.

4.08. Appeals from Board's Final Order Following Hearing. Should the hospital or interested party wish to further contest the Board's final order following a hearing, the hospital or interested party shall file its appeal pursuant to the provisions of West Virginia Code, §16-29B-13.

4.09. Rates During Hearings and Appeals. In the event the Board modifies the request of a hospital for a change in its rates so that the hospital obtains only a partial increase in its rate schedule,

the hospital shall have the right to accept the benefits of the partial increase in rates and charge its purchasers accordingly without in any way adversely affecting or waiving its right to contest or appeal that portion of the decision and final order of the Board which denied the remainder of the requested rate increase. Similarly, if an interested party contests or appeals the decision and final order of the Board, the hospital may charge its purchasers in accordance with the Board's decision and final order until the final order is subsequently modified by the Board or other appellate agency.

4.10. Notice to the Community. Contemporaneously with the filing of the application and proposed budget pursuant to Section 4.02, the hospital shall also cause to be published in a newspaper of general circulation in the county in which the hospital is located a legal advertisement setting forth the fact that the hospital is applying to the Board for the setting of its initial rate schedule. The legal advertisement shall summarize the effect of the requested relief and shall further state that any person desiring to inspect the application and proposed budget may do so at the hospital during the hospital's regular business hours. Also, the legal advertisement shall advise the public that any person who claims to be an interested person in the

proceedings for the setting of the initial rate schedule must file, prior to the start of the hospital's fiscal year, with the Authority a written notice setting forth the interested person's name, address, and the facts relied upon to establish his or her interest. The Authority will then send notices of all proceedings and copies of all orders to those persons deemed to be interested in the matter.

Section 5. Applications. Each hospital which must file an application pursuant to Section 4.02 shall include in that application the forms appended to these rules. The forms are to be completed pursuant to their instructions. Any additional information which the hospital believes will be useful to the Board may be submitted to the Board together with the application. The proposed budget must contain not only all usual information under generally accepted accounting principles for a budget, but must also contain a full and specific statement of all assumptions relied upon in preparing the budget.

Section 6. Changes in the Schedule of Rates. Pursuant to West Virginia Code, §16-29B-21(b), in the event that a hospital wishes to change or amend its schedule of rates after the initial schedule of rates is set pursuant to Section 4 of these rules (including any rate changes desired

prior to the start of the hospital's second fiscal year following the effective date of these rules), the hospital must file an application and proposed budget with the Authority.

6.01. Application and Proposed Budget. The application shall contain information requested on forms provided by the Authority. In addition, the hospital must provide, in a written report, the information described in West Virginia Code, §16-29B-21(b)(2). The proposed budget must contain not only all usual information under generally accepted accounting principles for a budget, but must also contain a full and specific statement of all assumptions relied upon in preparing the budget. The hospital may also submit such additional information as it wishes.

6.02. Public Hearing. Upon receipt of the application and proposed budget, the Board, if it considers necessary, may hold a public hearing on any proposed change or amendment. Such hearing shall be held no later than forty-five (45) days after receipt of the application and proposed budget.

6.03. Review by the Board. Upon receipt of the hospital's application and proposed budget, the Authority's staff shall submit to the Board a

proposed gross revenue limit for that hospital. The Authority's staff may also request a conference with the hospital's officials and any interested persons. Thereafter, the Board shall issue a final order setting the hospital's gross revenue limit. The order shall be sent by certified mail, return receipt requested, to the hospital. Within forty-five (45) days of receiving the final order, the hospital shall file with the Board a revised proposed budget and a proposed schedule of rates, each of which shall be drafted in accordance with the gross revenue limit set by the Board. Thereafter, the Board shall issue a final order setting the hospital's budget and schedule of rates. The final order shall specify the effective date of any proposed changes. The final order shall be sent by certified mail, return receipt requested, to the hospital. The hospital's community shall be notified of the final order through an announcement in the local media.

The final order on any proposed change or amendment shall not be issued more than one hundred and eighty days from the date of filing of the application and proposed budget with the Board. If the Board fails to complete its review of the proposed change within the time period specified for the review, the proposed change shall be deemed to have been approved by the Board.

6.04. Notice of Contest. Should the hospital or an interested party claiming to be an affected party wish to contest a final order, the hospital or the interested party must file a written notice with the Board within twenty (20) days of the hospital's receipt of the final order. The written notice must be received by the Authority on or before the twentieth day in order for there to be an effective filing. The written notice must specifically state the basis for the hospital's or interested party's disagreement with the Board's final order. The written notice shall also set forth with specificity the facts upon which the hospital or interested party will rely to prove its case. If no written notice is timely filed, the final order shall be effective on the date specified within the final order.

6.05. Hearing on Notice of Contest. Upon receipt of a written notice of contest, the Board shall schedule a hearing upon the matters in disagreement. The hearing shall be held no earlier than ten (10) days after receipt by the Board of the written notice of contest. The hearing shall be conducted pursuant to the provisions of West Virginia Code, §16-29B-12 and §29A-5-1 et seq. In addition, the Rules of Procedure for Contested Case Hearings and Declaratory Rulings,

Chapter 16-1, Series I (1983) heretofore promulgated by the West Virginia Board of Health on December 30, 1982, are incorporated herein by reference and shall supplement the aforesaid code provisions. The board or the hearing examiner may schedule and require attendance at a pre-hearing conference to be conducted by an officer appointed for that purpose by the board. The purposes of the pre-hearing conference shall be similar to the purposes of Rule 16, West Virginia Rules of Civil Procedure. Within ninety (90) days after the hospital's receipt of the contested final order, the Board shall issue a final order on the matters which were in disagreement at the hearing.

6.06. Appeals from Board's Final Order Following Hearing. Should the hospital or interested party wish to further contest the Board's final order following a hearing, the hospital or interested party shall file its appeal pursuant to the provisions of West Virginia Code, §16-29B-13.

6.07. Rates During Hearings and Appeals. In the event the Board modifies the request of a hospital for a change in its rates so that the hospital obtains only a partial increase in its rate schedule, the hospital shall have the right to accept the benefits of the partial

increase in rates and charge its purchasers accordingly without in any way adversely affecting or waiving its right to contest or appeal that portion of the decision and final order of the Board which denied the remainder of the requested rate increase. Similarly, if an interested party contests or appeals the decision and final order of the Board, the hospital may charge its purchasers in accordance with the Board's decision and final order until the final order is subsequently modified by the Board or other appellate agency.

6.08. Notice to the Community. Contemporaneously with the filing of the application and proposed budget pursuant to Section 6, the hospital shall also cause to be published in a newspaper of general circulation in the county in which the hospital is located a legal advertisement setting forth the fact that the hospital is applying to the Board for a change or amendment to its schedule of rates. The legal advertisement shall summarize the effect of the requested relief and shall further state that any person desiring to inspect the application and proposed budget may do so at the hospital during the hospital's regular business hours. Also, the legal advertisement shall advise the public that any person who claims to be an interested person in the proceedings for the changing or amending of the schedule of rates must file with the Authority a written notice setting forth the interested person's name, address, and the facts relied upon to establish his or

interest. The legal advertisement must inform the public that interested persons must file this notice within thirty (30) days of the hospital's filing of its application with the Authority or else the Authority will, except for good cause shown, deny the interested party's notice. The Authority will then send notices of all proceedings and copies of all orders to those persons deemed to be interested in the matter.

Section 7. Temporary Changes in a Hospital's Rates. The Legislative Rules for the Freeze on Hospital Rates and Granting of Temporary Rate Increases, Chapter 16-29B, Series II (1983), were drafted to implement Section 4 of the Act and to implement Section 21(c) of the Act insofar as it pertained to Section 4 of the Act. Those rules do not have applicability to the implementation of the hospital's initial rate schedule or to subsequent changes or amendments to that initial rate schedule.

7.01. Application for Temporary Rate Change. In the event a hospital desires to obtain a temporary change in its schedule of rates, the hospital shall submit an application to the Authority which addresses the criteria set forth in Section 21(c) of the Act. The application must state the facts in support of the temporary rate change with specificity and not in a conclusory fashion.

7.02. Immediate Effectiveness of Application. Upon receipt of the application for a temporary rate change, the Board shall review the application and decide whether or not to issue an order making the change effective immediately upon filing and in advance of review procedures. The board's decision may be treated as a final order and a hearing requested by the hospital or an interested party pursuant to Section 6.04, 6.05, and 6.06.

7.03. Preferential Review of Application. After receipt of the application for a temporary rate change, the Board shall extend preference to hospitals demonstrating immediate risk of insolvency, or demonstrating substantial financial hardship, to maintain accreditation or for emergency repairs which in the discretion of the Board justify temporary rate changes prior to the commencement of full review of the proposed rate change.

7.04. Full Review of Application. All applications for a temporary change in a hospital's schedule of rates shall be subject to full review by the Board in accordance with the principles stated in Section 6 et seq., of these rules; except that, the hospital shall cause the required legal advertisement to be published within seven (7) days of filing of the application for a temporary rate change and the hospital need not submit the information normally contained in a Section 6.01

application and proposed budget, unless such information is subsequently requested by the Board.

Section 8. Failure to Comply with Rules. Failure by a hospital or an interested party to comply with any of the requirements of these rules shall subject the hospital or the interested party to sanctions including the possibility of denial of all requested relief in an appropriate case. Failure by a hospital or an interested party to comply with the time limits set forth in these rules may also, in the discretion of the Board, cause the time limits to be extended and the failing party shall be deemed to have waived the time periods set forth in the Act and these rules or the Board may impose another appropriate sanction.

Section 9. Additional Information. Should the Board require additional information from a hospital or an interested party, then, in the discretion of the Board, the various time limits imposed by these rules shall be tolled until the information is received by the Board.

Section 10. Time Periods. In each instance in these rules where a time period is stated, the period is intended to be a maximum period.

In the event a given task is completed sooner than the stated period by the Authority, the Board, a hospital, or an interested party, then the next time period, if any, shall begin to elapse upon the actual completion date.

10.01. Calculation of Time Periods. Whenever in these rules the date by which some action is directed to be taken or accomplished would fall on a Saturday, Sunday, or a State Holiday, then the time for taking or accomplishing the action shall be extended to the next day which is not a Saturday, Sunday, or a State Holiday.

Section 11. Decisions and Records Available. Decisions and records of the Authority may be inspected in accordance with West Virginia Code, §29B-1-3, and may be copied at a charge of 25 cents per page.

Section 12. Compliance Reports. The board may require compliance reports from a hospital midway and three-quarters of the way through the hospital's fiscal year. The information requested for the compliance report shall be listed on forms to be provided by the board.

Section 13. Severability. If any provisions of these rules or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or applications of these rules which can be given effect without the invalid provisions or application and to this end the provisions of these rules are declared to be severable.

APPENDIX A

APPENDIX A

GROUP 1 HOSPITALS (FISCAL YEAR BEGINS JULY 1)

1. Beckley Appalachian Regional Hospital
2. Bluefield Community Hospital
3. Boone Memorial Hospital
4. Calhoun General Hospital
5. Camden-Clark Memorial Hospital
6. Grafton City Hospital
7. Grant Memorial Hospital
8. Hampshire Memorial Hospital
9. Man Appalachian Regional Hospital
10. Monongalia General Hospital
11. Morgan County War Memorial Hospital
12. Pocahontas Memorial Hospital
13. Potomac Valley Hospital
14. Preston Memorial Hospital
15. Princeton Community Hospital
16. Summers County Hospital
17. Webster County Memorial Hospital
18. Weirton Medical Center
19. Welch Emergency Hospital
20. Wetzel County Hospital

GROUP 2 HOSPITALS (FISCAL YEAR BEGINS SEPTEMBER 1)

1. Greenbrier Valley Hospital
2. St. Luke's Hospital

GROUP 3 HOSPITALS (FISCAL YEAR BEGINS OCTOBER 1)

1. Cabell-Huntington Hospital
2. Davis Memorial Hospital
3. Herbert J. Thomas Memorial Hospital
4. Huntington Hospital
5. Jackson General Hospital
6. Jefferson Memorial Hospital
7. Kanawha Valley Memorial Hospital
8. Memorial General Hospital
9. Ohio Valley Medical Center
10. Pleasant Valley Hospital
11. Putnam General Hospital
12. Reynolds Memorial Hospital
13. Roane General Hospital
14. Sacred Heart Hospital
15. St. Joseph's Hospital (Buckhannon)
16. St. Mary's Hospital
17. Stonewall Jackson Memorial Hospital
18. United Hospital Center
19. Wheeling Hospital
20. Williamson Memorial Hospital
21. Wyoming General Hospital

GROUP 4 HOSPITALS (FISCAL YEAR BEGINS NOVEMBER 1)

1. Guyan Valley Hospital

GROUP 5 HOSPITALS (FISCAL YEAR BEGINS JANUARY 1)

1. Beckley Hospital, Inc.
2. Braxton County Memorial Hospital
3. Broaddus Hospital
4. Charleston Area Medical Center
5. City Hospital
6. E. C. Leonard Memorial Hospital
7. Eye and Ear Clinic of Charleston
8. Fairmont General Hospital
9. Frank E. Pick Memorial Hospital
10. Guthrie Memorial Hospital
11. Holden Hospital
12. Logan General Hospital
13. Montgomery General Hospital
14. Plateau Medical Center
15. Raleigh General Hospital
16. St. Francis Hospital
17. St. Joseph's Hospital (Parkersburg)
18. Sistersville General Hospital
19. Summersville Memorial Hospital
20. Tucker County Hospital
21. Weirton Osteopathic Hospital
22. West Virginia University Hospital

GROUP 6 HOSPITALS (FISCAL YEAR BEGINS APRIL 1)

1. Stevens Clinic Hospital

APPENDIX B

APPENDIX B

April 1, 1984

(a) HCCRA requests information from Group 1 hospitals.

June 1, 1984

(a) Group 1 hospitals submit requested information to HCCRA.

(b) HCCRA requests information from Group 2 hospitals.

July 1, 1984

(a) Group 1 hospitals begin reporting on the uniform reporting system.

(b) HCCRA requests information from Group 3 hospitals.

July 16, 1984

(a) HCCRA sets revenue limit for Group 1 hospitals.

August 1, 1984

(a) Group 2 hospitals submit requested information to HCCRA.

(b) HCCRA requests information from Group 4 hospitals.

August 30, 1984

(a) Group 1 hospitals submit a final budget and rate schedule to meet revenue limit.

September 1, 1984

(a) Group 2 hospitals begin reporting on the uniform reporting system.

(b) Group 3 hospitals submit requested information to HCCRA.

September 17, 1984

(a) HCCRA sets revenue limit for Group 2 hospitals.

September 30, 1984

(a) HCCRA approves final budget and rate schedule for Group 1 hospitals.

October 1, 1984

(a) Group 3 hospitals begin reporting on the uniform reporting system.

(b) Group 4 hospitals provide HCCRA with requested information.

(c) HCCRA requests information from Group 5 hospitals.

October 15, 1984

(a) HCCRA sets revenue limit for Group 3 hospitals.

November 1, 1984

(a) Group 2 hospitals submit a final budget and rate schedule to meet revenue limit.

(b) Group 4 hospitals begin reporting on the uniform reporting system.

November 15, 1984

(a) HCCRA sets revenue limit for Group 4 hospitals.

November 29, 1984

(a) Group 3 hospitals submit a final budget and rate schedule based on revenue limit.

December 1, 1984

(a) HCCRA approves final budget and rate schedule for Group 2 hospitals.

(b) Group 5 hospitals submit requested information to HCCRA.

December 31, 1984

(a) HCCRA approves final budget and rate schedule for Group 3 hospitals.

(b) Group 4 hospitals submit a final budget and rate schedule based on revenue limit.

January 1, 1985

(a) Group 5 hospitals begin reporting on the uniform reporting system.

(b) HCCRA requests information from Group 6 hospitals.

January 15, 1985

(a) HCCRA sets revenue limit for Group 5 hospitals.

January 30, 1985

(a) HCCRA approves final budget and rate schedule for Group 4 hospitals.

March 1, 1985

(a) Group 5 hospitals submit a final budget and rate schedule to meet revenue limit.

(b) Group 6 hospitals submit requested information to HCCRA.

April 1, 1985

(a) HCCRA approves final budget and rate schedule for Group 5 hospitals.

(b) Group 6 hospitals begin reporting on the uniform reporting system.

April 15, 1985

(a) HCCRA sets revenue limit for Group 6 hospitals.

May 30, 1985

(a) Group 6 hospitals submit a final budget and rate schedule to meet revenue limit.

July 1, 1985

(a) Authority approves final budget and rate schedule for Group 6 hospitals.

WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY

Emergency Filing

PROCEDURAL RULES

Procedural Rules for the Projecting of Gross Revenues for Hospitals, Setting the Amount of Net Revenue Over Expenditures for Hospitals, and Setting Schedules of Rates for Hospitals

INDEX

INDEX (Continued)

IMPLEMENTATION SCHEDULE FOR PHASE ONE METHODOLOGY

	1984																1985							
	APR 1	JUN 1	JUL 1	JUL 16	AUG 1	AUG 30	SEPT 1	SEPT 17	SEPT 30	OCT 1	OCT 15	NOV 1	NOV 15	NOV 29	DEC 1	DEC 31	JAN 1	JAN 15	JAN 30	MAR 1	APR 1	APR 15	MAY 30	JUL 1
HCCRA Requests Information From Hospitals	1	2	3		4					5							6							
Hospitals Submit Requested Information		1			2	3				4					5					6				
Hospitals Begin Reporting on The Uniform Reporting System			1				2			3		4					5				6			
HCCRA Establishes Allowed Revenue Limit				1				2			3		4					5				6		
Hospitals Submit Budget and Rate Schedule Based on Allowed Revenue Limit						1						2		3		4				5			6	
HCCRA Approves Budget and Rate Schedule									1						2	3			4		5			6

APPENDIX C

INPATIENT DAYS

Institution Name _____ Fiscal Year _____

Institution Number _____ Budget Year _____

Check if Fourth Quarter Projection _____

	INPATIENT DAYS	SOURCE	PAYOR CLASSIFICATION			
			MEDICARE	MEDICAID	ALL OTHER	TOTAL
	NUMBER OF PATIENTS					
A	Fiscal Year Discharges	Records				
B	Projected Change	Budget				
C	Budget Year Discharges	A + B				
	PATIENT DAYS					
D	Fiscal Year Patient Days	Records				
E	Budget Year Patient Days	C x G				
	AVERAGE LENGTH OF STAY					
F	Fiscal Year Length of Stay	D ÷ A				
G	Budget Year Length of Stay	Estimate				
	BEDS AND OCCUPANCY					
H	Licensed Beds - Fiscal Year	Records				
I	Licensed Beds - Budget Year	Budget				
J	Beds Set Up - Fiscal Year	Records				
K	Beds Set Up - Budget Year	Budget				
L	% Occupancy - Fiscal Year	D÷(Hx365)				
M	% Occupancy - Budget Year	E÷(Ix365)				

INPATIENT DAYS

INSTRUCTIONS:

Utilization data must be provided for three years. For each of the two previous years, complete Lines A, D, F, H, J, and L entering the appropriate numbers by payor classification. For Lines H - M, complete only the column labeled "TOTAL."

For the third year (FY-84), complete two copies of R-1. On one copy, use three quarters of actual data with projections for the fourth quarter. Complete a separate form with fourth-quarter projections only. For Lines A - G, enter the appropriate number by payor classification. For Lines H - M, complete only the column labeled "TOTAL."

NUMBER OF PATIENTS

Line A — Enter the number of discharges for the fiscal year.

Line B — Estimate budget year increase (decrease) in annual number of inpatient discharges.

Line C — Compute budget year discharges by adding the amounts in Lines A and B.

PATIENT DAYS

Line D — Enter the fiscal year patient days.

Line E — Multiply Line C (budget year discharges) by Line G (budget year length of stay).

AVERAGE LENGTH OF STAY

Line F — Compute the fiscal year average length of stay by dividing Line D (fiscal year patient days), by Line A, (fiscal year discharges).

Line G — Enter the projected budget average year length of stay based on historic utilization trends.

BEDS AND OCCUPANCY

Line H — Enter the number of average licensed beds for the fiscal year. In determining the average number of licensed beds, add the number of licensed beds at the beginning of each month and divide by twelve.

INPATIENT DAYS
(continued)

Line I — Enter the projected budget year average number of licensed beds.

Line J — Enter the number of beds set up for the fiscal year.

Line K — Enter the number of beds set up for the budget year.

Line L — Compute percent occupancy for fiscal year by dividing Line D, fiscal year patients, by the product of Line H, average licensed beds - fiscal year, multiplied by 365 days (Line D) - (Line H x 365).

Line M — Compute percent occupancy for budget year by dividing Line E, budget year patient days, by the product of Line I, average licensed beds - budget year, multiplied by 365 days (Line E) - (Line I x 365).

OUTPATIENT VISITS

Institution Name _____ Fiscal Year _____

Institution Number _____ Budget Year _____

Check if Fourth Quarter Projection _____

	OUTPATIENT VISITS	SOURCE	PAYOR CLASSIFICATION			
			MEDICARE	MEDICAID	ALL OTHER	TOTAL
	EMERGENCY ROOM					
A	Base Year	Records				
B	Projected Change	Budget				
C	Total Visits	A + B				
	CLINIC VISITS					
D	Base Year	Records				
E	Projected Change	Budget				
F	Total Visits	D + E				
	OTHER (specify)					
G	Base Year	Records				
H	Projected Change	Budget				
I	Total Visits	G + H				
J	TOTAL	C + F + I				

OUTPATIENT VISITS

INSTRUCTIONS:

In accumulating data, provide visits not occasions of service. Data must be provided for three years. Complete Lines A, D, and G on Form R-2 for each of the two previous years. For the third year, complete two copies of Form R-2. On one copy, use three quarters of actual data with projections for the fourth quarter. Complete a separate form with fourth-quarter projections only.

Line A — Enter the number of Emergency Room visits by payor classification and the total number of these visits for the previous fiscal year.

Line B — Enter the projected change in Emergency Room visits for the next fiscal year by payor classification and enter the projected total change in the number of visits in the total column (last column).

Line C — Calculate the sum of Lines A and B and enter the total number of Emergency Room visits by payor classification. Next add the sum of Medicare, Medicaid, and all other payors and enter the result in the total column (last column).

Line D — Enter the number of clinic visits by payor classification and the total number of these visits for the previous fiscal year.

Line E — Enter the projected change in clinic visits for the next fiscal year by payor classification and enter the projected total change in the number of visits in the total column (last column).

Line F — Calculate the sum of Lines A and B and enter the total number of clinic visits by payor classification. Next add the sum of Medicare, Medicaid, and all other payors and enter the result in the total column (last column).

Line G — Enter the number of other visits by payor classification and the total number of these visits for the previous fiscal year.

Line H — Enter the projected change in other visits for the next fiscal year by payor classification and enter the projected total change in the number of visits in the total column (last column).

Line I — Calculate the sum of Lines A and B and enter the total number of other visits by payor classification. Next add the sums of Medicare, Medicaid, and all other payors and enter the result.

Line J — Total Lines C, F and I by payor classification. Next total Line J and enter the result in the total column (last column).

R-3
Modified

NON-SUPERVISORY
WAGE AND SALARY SUMMARY

Institution Name _____ Fiscal Year _____

Institution Number _____ Budget Year _____

	FISCAL YEAR	TOTAL WAGES	NUMBER OF FTE'S	AVERAGE SALARY PER FTE
A	FY - 1982			
B	FY - 1983			
C	FY - 1984 (12 months)			
D	FY - 1984 (4th quarter)			

R-3
Modified

NON-SUPERVISORY
WAGE AND SALARY SUMMARY

INSTRUCTIONS:

Summary data must be provided for three years. For each of the two previous years, complete lines A and B using audited data (if available). For the third year, FY-84, complete two lines: On line C, provide one full year of data using three quarters of actual data and projections for the fourth quarter. On line D, provide fourth-quarter projections only.

FRINGE BENEFITS CALCULATION

Institution Name _____ Fiscal Year _____

Institution Number _____ Budget Year _____

Check if Fourth Quarter Projection _____

	TYPE OF FRINGE BENEFIT	NON-SUPERVISORY	SUPERVISORY
A	FICA		
B	Unemployment Insurance Compensation (SUI & FUI)		
C	Workers' Compensation		
D	Group Health and Life Insurance and Union Health and Welfare		
E	Pension and Retirement		
F	Other Employee Benefits		
G	Sub-Total (A + B + C + D + E + F)		
H	Cafeteria, Parking, Etc., Loss		
I	Employee Benefits Included In Cafeteria, Parking, Etc., Loss		
J	Sub-Total (H + I)		
K	Holiday Pay		
L	Vacation Pay		
M	Sick Pay		
N	Total Fringe Benefits (G + J + K + L + M)		

INSTRUCTIONS:

The Fringe Benefits Calculation form allocates the cost of fringe benefits between non-supervisory and supervisory employees. For each line, separate the costs attributable to each group under its particular heading.

In completing Lines A-M, use actual amounts for supervisory and non-supervisory (if available). Where these records are not maintained, calculate by using proportions.

Calculation of non-supervisory proportion of fringe benefits: Calculate non-supervisory wages divided by total wages. Multiply by total dollar amount of each type of fringe benefit.

Calculation of supervisory proportion of fringe benefits: Calculate supervisory wages divided by total wages. Multiply by total dollar amount of each type of fringe benefit.

Data must be provided for three years. For each of the two previous years, complete the form using audited data (if available). For the third year (FY-84), complete two copies. On one copy use three quarters of actual data with projections for the fourth quarter. Complete a separate form with fourth-quarter projections only.

STATEMENT OF REVENUE AND EXPENSES

R-5A

Institution Name _____ Fiscal Year _____

Institution Number _____ Budget Year _____

Check if Fourth Quarter Projection _____

CLASSIFICATION		MEDICARE	MEDICAID		OTHER	TOTAL
			INPATIENT	OUTPATIENT		
1.	Gross Patient Revenue	L	O	R	V	A
2.	Contractual Allowances	M	P	S	W	B
3.	Uncollectable Accounts					C
4.	Charity Care					D
5.	Net Patient Revenue			T		E
6.	Operating Expenses	N	Q	U	X	F
7.	Other Operating Revenue					G
8.	Non-Operating Revenue Interest					H
9.	Non-Operating Revenue Gifts					I
10.	Non-Operating Revenue Other					J
11.	Excess Revenue Over Expense					K

INSTRUCTIONS:

Data must be provided for three years. For each of the two previous years, complete the forms using audited data (if available). For the third year (FY-84), complete two copies. On one copy, provide one full year of data using three quarters of actual data and projections for the fourth quarter. Complete a separate form with fourth-quarter projections only.

A - E Enter all data requested from the Statement of Revenue and Expenses, source documents or hospital records.

F Enter total operating expenses. This figure should include all taxes except State and Federal income tax. All data should come from the Statement of Revenue and Expenses, source documents or hospital records.

G - K Enter all data requested from the Statement of Revenue and Expenses, source documents or hospital records.

L Calculate and enter total gross patient charges from Medicare patients. Use Medicare Cost Report, Worksheet E, Part II, line titled "Total customary charges." Add inpatient charges, Part A, plus outpatient charges, Part B, 80%, (column 1 plus column 3).

M Calculate contractual allowance associated with Medicare patients. Use Medicare Cost Report, Worksheet E, Part II. Add line titled "Excess of aggregate cost over aggregate charges" minus column 1 and column 3 from line titled "allowable return on equity capital."

N Calculate operating expense associated with Medicare patients. Use Medicare Cost Report, Worksheet E, Part II, line titled "Cost of services." Add inpatient charges, Part A, plus outpatient charges, Part B, 80%, (column 1 plus column 3). Do not include allowable return on equity capital.

O Enter total gross patient charges from Medicaid patients. Use Medicare Cost Report, Worksheet E-5, Part II, line titled "Total customary charges."

P Calculate contractual allowance associated with Medicaid patients. Use Medicare Cost Report, Worksheet E-5, Part II. Add the line titled "Excess of customary charges over reasonable cost" minus the line titled "Allowable return on equity capital."

Q Enter operating expense associated with Medicare patients. Use Medicare Cost Report, Worksheet E-5, Part II, line titled "Cost of services." Do not include allowable return on equity capital.

R Enter amount of gross patient revenue for Medicaid outpatient services from hospital records.

S Enter amount of contractual allowance associated with Medicaid outpatient service from hospital records.

T Enter amount of reimbursement associated with Medicaid outpatient service from hospital records.

U Calculate amount of operating expense associated with Medicaid outpatient service. 1) Calculate ratio of cost to charges for outpatient services. Use Medicare Cost Report, Worksheet C, lines titled "Outpatient Service Cost Centers - clinic and emergency." Using column 1, add the quantity (clinic costs plus emergency costs) divide by the quantity (clinic charges plus emergency charges). 2) Multiply the resulting cost to charge ratio by line R and enter the result.

V Calculate gross patient revenue for all other payors (V=A-(L+O+R)).

W Calculate contractual allowance for all other payors (W=B-(M+P+S)).

X Calculate operating expense for all other payors (X=F-(N+Q+U)).

DISTRIBUTION OF OPERATING EXPENSE

R-5B

Institution Name _____ Fiscal Year _____

Institution Number _____ Budget Year _____

Check if Fourth Quarter Projection _____

CLASSIFICATION OF PAYOR	TOTAL	SUPERVISORY	NON-SUPERVISORY	ALL OTHER
Total	1)	6)	7)	8)
Medicare	2)	9)	10)	11)
Medicaid - Inpatient	3)	12)	13)	14)
Medicaid - Outpatient	4)	15)	16)	17)
All Other Payors	5)	18)	19)	20)

DISTRIBUTION OF OPERATING EXPENSE

INSTRUCTIONS:

Data must be provided for three years. For each of the two previous years, complete the form using audited data (if available). For the third year (FY-84), complete two copies. On one copy use three quarters of actual data with projections for the fourth quarter. Complete a separate form with fourth quarter projections only. Ratios used for calculations should be rounded to four decimal places.

	TOTAL OPERATING EXPENSE	SOURCE
1	Total operating expense	WVHCCRA R-5A, Line F
2	Total Medicare expense	WVHCCRA R-5A, Line N
3	Total Medicaid inpatient expense	WVHCCRA R-5A, Line Q
4	Total Medicaid outpatient expense	WVHCCRA R-5A, Line U
5	Total Non-Medicare/Medicaid expense	Line 1 minus (Lines 2 + 3 + 4)
6	Total supervisory wages, salaries and fringe benefits	Records, Budget
7	Total non-supervisory wages, salaries and fringe benefits	Records, Budget
8	All other expenses	Line 1 minus (Lines 6 + 7)
9	Medicare portion of supervisory wages, salaries and fringe benefits	(Line 2 ÷ Line 1) x Line 6
10	Medicare portion of non-supervisory wages, salaries and fringe benefits	(Line 2 ÷ Line 1) x Line 7
11	Medicare portion of all other expenses	Line 2 - (Lines 9 + 10)
12	Medicaid inpatient portion of supervisory wages, salaries and fringe benefits	(Line 3 ÷ Line 1) x Line 6
13	Medicaid inpatient portion of non-supervisory wages, salaries and fringe benefits	(Line 3 ÷ Line 1) x Line 7
14	Medicaid inpatient portion of all other expenses	Line 3 minus (Lines 12 + 13)
15	Medicaid outpatient portion of supervisory wages, salaries and fringe benefits	(Line 4 ÷ Line 1) x Line 6
16	Medicaid outpatient portion of non-supervisory wages, salaries and fringe benefits	(Line 4 ÷ Line 1) x Line 7
17	Medicaid outpatient portion of all other expenses	Line 4 minus (Lines 15 + 16)
18	All other payors' portion of supervisory wages, salaries and fringe benefits	Line 6 minus (Lines 9 + 12 + 15)
19	All other payors' portion of non-supervisory wages, salaries and fringe benefits	Line 7 minus (Lines 10 + 13 + 16)
20	All other payors' portion of all other expenses	Line 8 minus (Lines 11 + 14 + 17)

CALCULATION OF ALLOWED REVENUE

R-5C

Institution Name _____ Fiscal Year _____

Institution Number _____ Budget Year _____

	OPERATING EXPENSES	SOURCE	TOTAL
1	Calculate expenses which exclude government expenses and non-supervisory wage, salary & fringe benefit expense	R-5B, Line 18 + 20	
2	Calculate allowance for Medicaid outpatient	R-5A, Line U - Line T	
3	Calculate charges for charity and uncollectable accounts	R-5A, Line C + Line D	
4	Calculate cost-to-charge ratio	R-5A, Line F - Line A	
5	Calculate allowance for charity and uncollectable accounts	R-5C, Line 3 x Line 4	
6	Calculate expense base	R-5C, Line 1 + Line 2 + Line 5	
7	Inflation factor	HCCRA	
8	Calculate inflated expense base	R-5C, (Line 6 x Line 7) + (Line 6)	
9	Charges for non-government contractual allowance	R-5A, Line W	
10	Total wages, salaries, and fringe benefits for non-supervisory personnel projected for next fiscal year	Budget for next fiscal year	
11	Calculate non-supervisory wages and fringe benefits for non-government patients	R-5C, (Line 10) x (R-5B, Line 19 - R-5B, Line 7)	
12	Calculate total revenue requirements	R-5C, Line 8 + Line 9 + Line 11	

CALCULATION OF ALLOWED REVENUE
Page Two

R-5C

Institution Name _____ Fiscal Year _____

Institution Number _____ Budget Year _____

	OPERATING EXPENSES	SOURCE	TOTAL
13	Fund balance	Records, budget	
14	Calculate return on equity	R-5C, Line 13 x inflation factor to be provided by HCCRA	
15	Total operating revenue	R-5A, Line G	
16	Interest income (excluding legally restricted interest income)	Records, budget	
17	Calculate allowed gross patient revenue before adjustments	R-5C, (Line 12 + Line 14) - (Line 15 + Line 16)	
18	Adjustments (for special considerations, etc.)	Supplied by HCCRA	
19	Total allowed gross patient revenue for non-Medicare and non-Medicaid	Supplied by HCCRA	

JUNE 8, 1984

EMERGENCY FILING

STATEMENT OF POLICY:
HOSPITAL COST CONTAINMENT METHODOLOGY

WEST VIRGINIA
HEALTH CARE COST REVIEW AUTHORITY

TABLE OF CONTENTS

I. INTRODUCTION

The West Virginia Health Care Cost Review Authority was created by an Act of the West Virginia Legislature (S.B. 320) in March 1983. Under this legislation, the Authority's primary responsibilities are to: (1) develop a rate-setting system to ensure the containment of consumers' costs for hospital acute care services, (2) develop a uniform system of reporting hospital data, and (3) ensure the continuation of appropriate acute care hospital services in West Virginia.

It is the Authority's position that initial regulation should be constraining yet allow flexibility. It is neither practical nor desirable to begin regulation with a complex mechanism utilizing multiple constraints. Rather, the regulatory process should be adaptive in nature. As the data base develops, regulation conforms to information and to circumstances in the industry. Constraints will be applied with prior knowledge of financial impact. Using this "phased" approach to regulation, the Authority will attempt to slow the increase in health care costs, while ensuring the continuation of appropriate acute care hospital services in West Virginia. Accordingly, the Authority has chosen to implement the Cost Containment Methodology in West Virginia in two phases. Phase One should last approximately two years, and will review a hospital's proposed budget and total revenue requirements. In Phase Two, the Authority will review departmental expenses and revenue requirements, unless the information available indicates such methodology is not in the best interest of the State's hospitals or consumers of health care.

In developing a methodology to implement prospective rate-setting, the Authority was guided by legislative intent. The West Virginia Code, Chapter 16, Article 29B, refers to the welfare of the citizens of this state being threatened by unreasonable increases in the cost of acute care hospital services. It is this rate of increase in aggregate revenues which is the major focus of the initial rate-setting mechanism. In Phase One, it is the Authority's intent that the rate of increase in aggregate revenues be limited to that of inflation in the national hospital industry. In Phase Two, it is anticipated that the rate of increase will be limited by an inflation factor which will be applied to individual department rather than to total hospital revenues.

The Authority recognizes the need to evaluate each hospital's operating expenses for reasonableness, efficiency, and relationship to rates. However, prior to analysis, it is necessary to establish a data base with an expense categorization which is both comprehensive and comparable among hospitals. The data base begins with a uniform method of reporting costs and revenues for services provided to individual patients. With the legislatively mandated uniform reporting system, scheduled for July 1984 implementation, the Authority will begin to acquire uniform data. The constraints applied in Phase Two will evolve from this information.

Clearly it was a legislative intent to achieve equity among payors. Currently some payors receive "discounts" from rates charged other payors. In Phase One, the Authority will conduct a study which will quantify factors used in establishing this discount or

"differential." The results of the study will be applied to various payor rates in Phase Two.

It was also the legislative intent that the rate-setting mechanism allow for differences among hospitals by conforming to individual hospital circumstances. In Phase One, this mandate is met by reviewing each hospital's financial requirements and setting revenue limits to meet these requirements. Additionally, each hospital is guaranteed consideration of unique circumstances in that it may apply for a rate change at any time.

The law recognizes utilization review as an important part of the process. In Phase One, the Authority will work closely with the Professional Review Organization (PRO) to develop a utilization review process to evaluate services provided to individual patients. Once the parameters of inappropriate care are known, the Authority will incorporate incentives and limits into the regulatory process.

The law also requires the Authority to request a waiver for Medicare payments. This, in effect, transfers the choice of the rate-setting mechanism from the Federal Government to the state agency. Although the Health Care Financing Administration has opposed states controlling the Medicare program, a state that meets the Congressional requirements must be granted a waiver. The Authority is confident that those requirements will be fulfilled and that West Virginia will receive a waiver. Once a waiver is obtained, the State will follow Federal guidelines in disallowing payment for utilization deemed inappropriate by PRO.

In order to obtain a waiver, absolute budget neutrality must be achieved for Medicare revenues. Whatever the method of setting rates, the Authority intends to assure the Federal Government that total Medicare expenditures, using the State system, will not exceed what would have been paid under the Federal system. Prior to receiving a Medicare waiver, revenue limits set by the Authority will exclude Medicare revenues.

II. PHASE ONE OF THE METHODOLOGY

In order to facilitate the review process, the Authority has chosen to place hospitals into groups according to their fiscal years (see Appendix A). The review process will begin in June 1984 for group one hospitals with the remaining groups beginning the review process approximately one month prior to the start of their 1985 fiscal years.

A. DETERMINING ALLOWED REVENUE REQUIREMENTS

1. Determining the Rate of Increase

In determining the allowed revenue limit for the next fiscal year, it is necessary to establish a base revenue upon which to adjust future revenues. This amount will be derived from hospital data submitted to the Authority. The Authority will provide reporting forms which will require revenue, expense, and utilization data. In

addition to the historic data, a proposed budget for the next fiscal year must be submitted. Assumptions used in making budget projections will also be required, including documentation and supporting evidence of anticipated volume changes. An expense base will be calculated to include operating expenses, depreciation and interest expenses, interest expenses related to the acquisition of working capital, education expenses, and other similar elements. Expenses and revenues for Medicare and Medicaid will be set aside until the Department of Health and Human Services has approved the necessary changes in the State Medicaid Plan and/or approved the Authority's application for a Medicare Waiver. Next, an inflation factor plus an allowed percentage for technology will be applied to the expense base. The inflated base may then be adjusted for anticipated changes in volume and/or services, or changes in wages, salaries, and benefits to non-supervisory personnel. An amount sufficient to cover charity care, uncollectable accounts, and non-government contracted allowances will be added to the expense base to yield allowable revenues for the next fiscal year. This amount will be compared to the hospital's budgeted revenues, and a proposed revenue limit set by the Authority. The Authority will then propose the initial schedule of allowed revenues and will send a notice of its decision to the hospital by certified mail.

2. Approval of Budget and Schedule of Rates

The hospital must then submit a budget with the schedule of rates attached, including any revisions of rates necessary to accommodate the revenue limits set by the Authority for final approval. The Authority will then approve the budget and rate schedule and will send a notice of its decision to the hospital by registered mail, and to the community and interested persons by other means. Announcement of the approved budget and rate schedule will also be made to the local media in the geographical location of the facility. Any revisions of rates necessary to accommodate the revenue amounts must be implemented within sixty days after notice of approval of the budget and rate schedule by the Authority is received. As the law requires, the hospital or other aggrieved party may contest the proposed amount by written notice to the Authority within twenty days after notice of approval is received. However, the hospital may implement the contested rate schedule subject to refund as specified in Chapter 16, Article 29B, Section 21. If the budget or schedule of rates are contested, a final order concerning the schedule must be given by the Authority within ninety days from the date of the notice of approval. Further appeals will follow the procedures outlined in the West Virginia Code, Chapter 16, Article 29B, Section 13.

3. Adjustments

All volume levels currently experienced by a hospital will be assumed to continue for the next fiscal year unless the hospital has submitted for approval, information and supporting data to justify a change in volume. At the end of the hospital's fiscal year, a comparison will be made between actual and assumed volume and an adjustment to the next year's allowed revenue will be made if necessary. Hospital volume will be examined on both an inpatient and outpatient basis.

Inpatient Volume - Inpatient volume will be measured by using inpatient days. If inpatient days are higher than assumed, a one-time adjustment to the succeeding year's allowed revenue will be made allowing the hospital's variable costs for the additional volume. Variable costs will be calculated separately for each hospital.

Outpatient Volume - Outpatient volume will be measured by visits. If outpatient volume is higher than assumed, a one-time adjustment to the succeeding year's allowed revenue will be made allowing 100% of the charges for the additional volume.

Revenue Adjustment - Hospitals which, during the year, experience a need for a rate change to prevent insolvency, maintain accreditation, relieve undue financial hardship, or for emergency repairs, as stated in Senate Bill 320, may apply at that time to the Authority for an allowed revenue increase or a rate change. Hospitals which, at year end, identify significant changes in volume or services, or an identifiable cost beyond control which would cause undue financial hardship, may request an adjustment to the following year's expense base when submitting data during the review process. Hospitals must submit appropriate justification and/or information documenting the need of the requested adjustment. In setting the prospective allowed revenue amount, prior year changes will be taken into account. Compliance of each hospital's allowed revenue amount will be monitored through quarterly reviews of financial and utilization data.

4. New Services

Prior to the implementation of a new service, the hospital must apply to the Authority for approval of a rate schedule for the service. Announcement of the approved rate schedule must be made to the local media in the geographic location of the facility. The publication shall notify

interested parties that approved rates will go into effect in thirty days. As the law requires, interested and affected parties may contest the proposed amount by written notice to the Authority within two weeks from the date of publication.

B. UNIFORM REPORTING SYSTEM

For fiscal years beginning on or after July 1, 1984, hospitals will report financial data in accordance with a Chart of Accounts furnished by the Authority pursuant to the legislation. This uniform reporting system requires departmental reporting of financial data, patient utilization data, and numbers and types of services provided. The Authority will collect patient data in the form of UB-82 or a form containing similar data elements. Hospitals with appropriate data processing capabilities may submit patient information on computer tape. Hospitals which lack those data processing capabilities will submit paper copies of their uniform bill. Also, in Phase One, it is the Authority's intention for all hospitals to identify and report those operating costs that are considered non-allowable by various payors (i.e., Medicare, Medicaid, Blue Cross). For example, costs currently not allowed by government payors include: costs of meals sold to visitors, costs of drugs sold to those other than patients, the cost of operating a gift shop, advertising and marketing to attract patients, telephones for patient use, and other similar items.

This information will allow the Authority to study the impact of these costs on the industry.

A copy of the uniform reporting manual will be distributed to the hospitals in April, and implementation will begin with the facilities' respective fiscal years beginning on or after July 1, 1984. Some hospitals, because of their size, may not be required to complete all reporting schedules.

C. WAGES, SALARIES, AND FRINGE BENEFITS

In order to meet the requirements of Chapter 16, Article 29B of the West Virginia Code, the Authority must monitor wages, salaries and fringe benefits of non-supervisory employees. As a result, hospitals will be required to submit to the Authority information regarding the wages, salaries, and fringe benefits of non-supervisory personnel by job classification on forms provided by the Authority. Also required will be a projection of the total wages, salaries, and benefits to be paid to non-supervisory employees during the next fiscal year. Wages, salaries, and benefits paid to, or on behalf of, non-supervisory employees of hospitals 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. The Authority will review the number of full-time equivalent non-supervisory employees in the review process and may require justification of existing or projected non-

supervisory FTE's. The Authority will utilize the National Labor Relations Act definition in defining non-supervisory personnel. In essence, a non-supervisory employee is one who does not have the authority to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or the responsibility to direct them, or to adjust their grievance, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

D. MAJOR ISSUES RELATING TO PHASE ONE

Initially, the Authority will assume that existing aggregate expenditures are reasonable. However, each hospital's aggregate expenditures will be subject to audit to verify the accuracy of data submitted to the Authority.

This section explains the Authority's position on specific line item expenses. These expenses are defined as allowable within the existing expenditure level, not as additions to that expenditure level.

1. Capital Facilities Allowance

In Phase One, the Authority will allow a capital facilities allowance on major moveable equipment and buildings,

which will include straight-line depreciation, interest costs, and a return on equity. Equity is defined as the difference between Total Assets and Total Liabilities. The allowed return on equity will be calculated and adjusted based on an inflation factor provided by the Authority. A study will be undertaken by the Authority during Phase One to evaluate the feasibility of allowing replacement cost depreciation beginning in Phase Two.

2. Working Capital

The Authority recognizes a hospital's need for funds for daily operations. It is assumed that hospitals include provisions for working capital in their present expense base (i.e., the interest expense associated with short-term loans used to finance working capital). Hospitals experiencing shortages of working capital should find solutions within the allowed revenue limit. Hospitals unable to remedy working capital shortages may submit an application for an increase to allowed revenue.

3. Hospital-Based Physicians

The Authority will consider hospital-based physicians' fees as a separate expense classification. Hospitals

will provide annually a copy of the contract, with a schedule of fees, for all contracted physicians or physician groups, mid-level practitioners, and any contracted technical staff. This is required for those individuals or groups of individuals who have a contractual agreement with the hospital and provide Medicare Part A services and/or Part B services within the hospital setting, as referred to in the legislation. The Authority will review these data during Phase One to determine any necessary changes in policy before Phase Two.

4. Education

The net cost of an approved educational program will be considered as an allowable operating expense if the program meets the following Medicare educational requirements: (1) the activity is intended to improve the quality of health care in the institution or to improve the administration of the institution; and (2) the program is licensed by the State of West Virginia and/or accredited and approved by the West Virginia Board of Regents and, if applicable, the program has approval from the recognized national professional organization related to the program.

Approved programs refer to those formally organized or planned programs of study operated or supported by a provider.

5. Research Costs

Net research costs will be allowed at the existing expenditure level of the last completed fiscal year. These costs will be included in the expense base which will be inflated by the HCCRA inflation factor to calculate an allowed revenue limit for the next fiscal year. Additional research costs will be considered upon submission of an appropriate rate increase application. Research costs are costs incurred for research purposes related to patient care over and above usual patient care costs.

6. Other Operating Revenue; Non-operating Revenue

In setting revenue limits, the Authority will include net revenues from other operations and interest income. It is the Authority's intention to encourage philanthropy in the hospital industry. Therefore, gifts, contributions, and interest income from contributions which have not been commingled with other hospital funds will not be considered in setting revenue limits.

7. Fund Raising

The net amount of income generated from fund-raising activities to support patient care related programs should be reported as a separate non-operating income. The costs of these activities should not be offset by patient revenues.

8. Differentials

To ensure equalization of rates and to comply with the legislation, differentials will be granted to individual classes of payors. A differential is a discount from hospital charges given to payors based upon cost reduction efforts such as early payment policies or reducing charity care and bad debt.

During Phase One, a comprehensive pricing differential study will be made by the Authority. This differential study will enable the Authority to quantify the allowances hospitals may grant individual classes of payors. The conclusions and recommendations of the study will be implemented after a Medicare Waiver is received from the United States Department of Health and Human Services.

In calculating revenue requirements during Phase One, the Authority will set an allowed gross revenue limit to include charity care, uncollectable accounts, and non-government contractual allowances. Thus, a hospital during Phase One, may negotiate payor differentials based on the approved revenue limits.

9. Uncompensated Care

Uncompensated care refers to hospital services provided to patients who are unable or unwilling to pay. This includes both charity and uncollectable accounts.

Charity:

Charity care poses a unique problem for the hospital industry in West Virginia. The current facts suggest that hospitals in the State are not equally sharing in the financial burden of caring for the indigent patient. It is an objective of the Authority to distribute these costs more equitably among the State's hospitals. During Phase One, the Advisory Council will study the issue of charity care in order to make recommendations to the Authority and the Legislature for addressing this issue.

Charity care is to be reported separately from bad debt. The amount of charity care that is required to be provided by the hospital in order to fulfill Hill-Burton requirements must also be reported. Forms for this purpose will be distributed by the Authority.

The following guidelines should be used to determine eligibility for charity care:

a. Recipients of Medicaid should be considered for non-covered medically necessary days. The contractual allowance associated with Medicaid- and Medicare-covered days cannot be considered as charity care. Recipients of Medicare should be considered for non-covered days on an eligibility basis as in items b, c, and d.

b. Persons deemed to be bankrupt either by the filing of a bankruptcy notice or proof of bankruptcy claim.

c. Patients who meet West Virginia Department of Human Services income and resource guidelines but who are not eligible for Medicaid coverage.

d. Patients who fall within the national poverty guidelines and are further impoverished as a result of a long-term catastrophic illness.

Uncollectable accounts:

Bad debt is a financial loss resulting from the provision of services to a patient who, after reasonable collection efforts, does not pay. Bad debt must be reported separately from charity care. Patients categorized as charity care may not have their account balance considered as a bad debt. Information regarding bad debt collection policies and efforts will be gathered and evaluated during Phase One for possible recommendations in Phase Two.

Employee Discounts:

Currently some facilities report employee and professional discounts as part of charity care. Employee and professional discounts must be recorded as a courtesy allowance rather than as charity care.

Adjustments for Uncompensated Care:

In Phase I, uncompensated care is allowed at the expense rather than the charge level. Thus, a hospital which provides uncompensated care equal to or greater than that delivered in the prior year will be allowed a year-end adjustment to its allowed gross revenue. This adjustment will be made upon a hospital request supported by documentation. Each hospital must present evidence that the amount of charity care reported complies with the definition of charity care set forth in these regulations. The hospital must also provide documentation of agressive collection efforts utilized in writing off accounts as uncollectable.

The addition to the gross revenue limit will be the difference between uncompensated care expenses allowed on Form R-5C and the charges for the amount of uncompensated care which the hospital delivered.

III. PHASE TWO OF THE METHODOLOGY

The review process for Phase Two will begin in mid 1986 for group one hospitals.

The remaining groups will begin the Phase Two review process approximately one month prior to the start of their 1987 fiscal year.

The Authority anticipates performing a type of review similar to that in Phase One, with the exception that data will be submitted and reviewed for each department in the hospital. The Authority then plans to set revenue limits by department for each hospital.

However, in certain instances, the Authority may choose to continue to set total allowed revenues as a result of the facility's bed size, case-mix, or other variables. The Authority also intends to explore the issue of cross subsidization in Phase One. Based on data collected during Phase One, individual components of the expense base calculation may be modified before implementation in Phase Two. Hospitals will then be peer grouped according to selected variables and peer unit costs compared. The Authority will request assistance from the Technical Task Force in developing the details of the Phase Two review process.

APPENDIX

1. Beckley Appalachian Regional Hospital
2. Bluefield Community Hospital
3. Boone Memorial Hospital
4. Calhoun General Hospital
5. Camden-Clark Memorial Hospital
6. Grafton City Hospital
7. Grant Memorial Hospital
8. Hampshire Memorial Hospital
9. Man Appalachian Regional Hospital
10. Monongalia General Hospital
11. Morgan County War Memorial Hospital
12. Pocahontas Memorial Hospital
13. Potomac Valley Hospital
14. Preston Memorial Hospital
15. Princeton Community Hospital
16. Summers County Hospital
17. Webster County Memorial Hospital
18. Weirton Medical Center
19. Welch Emergency Hospital
20. Wetzel County Hospital

GROUP 2 HOSPITALS (FISCAL YEAR BEGINS SEPTEMBER 1)

1. Greenbrier Valley Hospital
2. St. Luke's Hospital

GROUP 3 HOSPITALS (FISCAL YEAR BEGINS OCTOBER 1)

1. Cabell-Huntington Hospital
2. Davis Memorial Hospital
3. Herbert J. Thomas Memorial Hospital
4. Huntington Hospital
5. Jackson General Hospital
6. Jefferson Memorial Hospital
7. Kanawha Valley Memorial Hospital
8. Memorial General Hospital
9. Ohio Valley Medical Center
10. Pleasant Valley Hospital
11. Putnam General Hospital
12. Reynolds Memorial Hospital
13. Roane General Hospital
14. Sacred Heart Hospital
15. St. Joseph's Hospital (Buckhannon)
16. St. Mary's Hospital
17. Stonewall Jackson Memorial Hospital
18. United Hospital Center
19. Wheeling Hospital
20. Williamson Memorial Hospital
21. Wyoming General Hospital

GROUP 4 HOSPITALS (FISCAL YEAR BEGINS NOVEMBER 1)

1. Guyan Valley Hospital

GROUP 5 HOSPITALS (FISCAL YEAR BEGINS JANUARY 1)

1. Beckley Hospital, Inc.
2. Braxton County Memorial Hospital
3. Broaddus Hospital
4. Charleston Area Medical Center
5. City Hospital
6. E. C. Leonard Memorial Hospital
7. Eye and Ear Clinic of Charleston
8. Fairmont General Hospital
9. Frank E. Pick Memorial Hospital
10. Guthrie Memorial Hospital
11. Holden Hospital
12. Logan General Hospital
13. Montgomery General Hospital
14. Plateau Medical Center
15. Raleigh General Hospital
16. St. Francis Hospital
17. St. Joseph's Hospital (Parkersburg)
18. Sistersville General Hospital
19. Summersville Memorial Hospital
20. Tucker County Hospital
21. Weirton Osteopathic Hospital
22. West Virginia University Hospital

GROUP 6 HOSPITALS (FISCAL YEAR BEGINS APRIL 1)

1. Stevens Clinic Hospital