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WEST VIRGINIA LEGISLATIVE RULE
WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY
CHAPTER 16-29B
SERIES V

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Title 65

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SECRETARY OF STATE

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Section 1. General

1.1 Scope - This legislative rule establishes the methodology for implementing the first phase of the initial rate reviews for each of West Virginia's acute care hospitals.

1.2 Authority - West Virginia Code, §16-29B-8(a)(1).

1.3 Filing Date - May 20, 1985

1.4 Effective Date - May 20, 1985

Section 2. 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.

2.1 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 gross patient 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 gross patient 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.

2.2 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.

2.3 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.

2.4 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. In setting revenue limits to meet these requirements the Authority will review the hospital's proposed budget, the calculated revenue limit derived on Form 5-C of the Procedural Rules, and any other pertinent information regarding a hospital's financial needs. Additionally, each hospital is guaranteed consideration of unique circumstances in that it may apply for a rate change at any time.

2.5 The Authority notes that Section 20 (b) of the Act requires the Board to consider the appropriateness of both the projected gross revenues and the amount of net revenue over expenditures for each hospital. In this regard, no one item or form of information is determinative of the Board's final decisons on these issues. Rather, the Board will take into consideration all information provided to it and will weigh each item of information against the others in arriving at its decisions. While the hospital's proposed budget and the calculated revenue limits from the procedural forms are entitled to weight in the Board's decision making process, neither item is conclusive. Rather, it is the hospital's overall financial condition with which the Board is concerned.

2.6 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.

2.7 Should a conflict arise between the gross patient revenue limit set by the Board and the revenue generated or anticipated by the schedule of rates, the gross patient 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 patient 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.

2.8 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.

2.9 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.

Section 3. 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.

3.1 DETERMINING ALLOWED REVENUE REQUIREMENTS

3.1.1 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 board approved 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. A return on equity will be allowed for proprietary and non-proprietary hospitals. For non-proprietary hospitals this return will be equal to the inflation factor, for proprietary hospitals, the return will be adjusted by the corporate tax rate. The total amount will then be evaluated along with the hospital's budgeted revenues and the other information available to the Authority. A proposed revenue limit will be set by the Authority on the basis of this overall review. 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.

3.1.2 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.

3.1.3. 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.

3.1.4 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.

3.1.5 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.

3.2 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.

3.3 Wages, Salaries, and 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.

3.4 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.

3.4.1 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.

3.4.2 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.

3.4.3 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.

3.4.4 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.

3.4.5 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.

3.4.6 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.

3.4.7 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.

3.4.8 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.

3.4.9 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.

3.4.9.1 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:

3.4.9.1 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.

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

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

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

3.4.9.2 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.

3.4.9.3 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.

3.4.9.4 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.

Section 4. PHASE TWO OF THE METHODOLOGY

4.1 The review process for Phase Two will begin in mid 1986 for group one hospitals. However, the receipt of a Medicare waiver could accelerate the implementation of the Phase Two methodology. Otherwise, the remaining groups will begin the Phase Two review process approximately one to two months prior to the start of their 1987 fiscal year.

4.2 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.

4.3 The Act requires that the Authority apply for a Medicare waiver. In the event that the requirements for obtaining that waiver from the Secretary of the United States Department of Health and Human Services require variations from the policies set forth herein, then it is the intention of the Authority to comply with the Secretary's requirements. However, all federal and state rules for adopting changes in this Statement of Policy or in issuing a new Statement of Policy shall be complied with by the Authority.

APPENDIX

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. Reynolds Memorial Hospital
12. Roane General Hospital
13. Sacred Heart Hospital
14. St. Joseph's Hospital (Buckhannon)
15. St. Mary's Hospital
16. Stonewall Jackson Memorial Hospital
17. United Hospital Center
18. Wheeling Hospital
19. Williamson Memorial Hospital
20. 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. Putnam General Hospital
16. Raleigh General Hospital
17. St. Francis Hospital
18. St. Joseph's Hospital (Parkersburg)
19. Sistersville General Hospital
20. Summersville Memorial Hospital
21. Tucker County Hospital
22. Weirton Osteopathic Hospital
23. West Virginia University Hospital

GROUP 6 HOSPITALS (FISCAL YEAR BEGINS APRIL 1)

1. Stevens Clinic Hospital