



APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Hospital Rate Setting Methodology

Type of Rule:  Legislative  Interpretive  Procedural

Agency Health Care Cost Review Authority Address Suite 201, 100 Dee Drive  
Charleston, WV 25311

1. Effect of Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	\$ -0-	\$ -0-	\$ -0-	\$ -0-	\$ -0-
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Other					

2. Explanation of above estimates.

The rate setting program has been in operation since July 1, 1984. The proposed rule will not impact on the costs of the ongoing program.

3. Objectives of these rules:

To establish a permanent methodology for setting hospitals' rates pursuant to the West Virginia Health Care Cost Review Authority Act, § 16-29B-1 et seq.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None. The program is already established and is functional. The proposed rule should not expand the established program.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of citizens.

It is not expected that the proposed rule will increase to any great extent the costs to the hospital industry in complying with the requirements of the new methodology.

C. Economic Impact on Citizens/Public at Large.

The expectation for the permanent rules is that it will be more effective in saving the consumers of hospital based medical care resources than the temporary phase I methodology or than not having any rate setting program.

Date JULY 18, 1988

Signature of Agency Head or Authorized Representative



WALTER J. DALE  
Chairman

Brief Summary of Proposed Legislative Rule  
Hospital Rate Setting Methodology

FILED  
1938 JUL 19 AM 11:39  
U. S. DEPARTMENT OF JUSTICE  
SECRETARY OF STATE

The proposed rule implements the permanent methodology for the setting of hospital rates under the provisions of the West Virginia Health Care Cost Review Authority Act, W. Va. Code, § 16-29B-1 et seq. The rule establishes a budget review based methodology which will begin with an examination of the hospital's proposed expenses for the upcoming fiscal year. Increases or decreases in the proposed expenses will be studied in order to ascertain that they are reasonable. From there, the board will examine the profit needs for each of the hospitals including the amount of profit needed to retire past bonded indebtedness, in order to accumulate funds for future capital expenditures, and for the other long-term needs of the facility. Once the total financial needs of the hospital are ascertained, it will then be possible to set revenue limits on a per day basis, a per adjusted day basis, and a per discharge basis. The revenue limits shall take into account the nature of the different classes of payors for a hospital; that is, its payor mix.

The rule establishes a procedure and a criteria for evaluating situations where a hospital may exceed its various revenue limits. The rule also examines the various types of penalties that may be imposed upon a hospital which does exceed its revenue limits.

Finally, the rule defines the criteria for becoming an interested person; that is, someone who wishes to participate in an administrative hearing conducted by the board as part of a review or investigation of a given hospital.

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

SERIES V

Title: HOSPITAL RATE SETTING METHODOLOGY

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

FILED  
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SERIES V

Title: HOSPITAL RATE SETTING METHODOLOGY

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§ 65-5-1. General.

1.1. Scope - This legislative rule replaces Title 65, C.S.R., Series 5, "Hospital Cost Containment Methodology - Phase 1 (1985), and establishes the permanent methodology for implementing the Health Care Cost Review Authority Act, West Virginia Code, § 16-29B-1 et seq.

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

1.3. Filing Date - \_\_\_\_\_.

1.4. Effective Date - \_\_\_\_\_.

1.5.

§ 65-5-2. Introduction.

2.1. In March 1983, the legislature created the Health Care Cost Review Authority for the purpose of protecting the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as ensuring the continuation of appropriate acute care hospital services. In order to achieve this purpose, the legislature directed that information on hospital costs be gathered, a system of cost control be developed, and an entity of state government be given authority to ensure the containment of acute care hospital costs. In construing and applying this rule, these principles shall serve as the ultimate goals to be pursued.

HCCRA  
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Series V, Sec. 2

2.2. In construing and applying both the Act and this rule, any outcome which would have the effect of infringing upon either the expenses or revenues from either the medicare program or the medicaid program, or both, shall be avoided. The HCCRA recognizes that such an infringement would be unconstitutional under the federal constitution's supremacy clause and directs that any such unconstitutional construction or application, or both, of this rule is to be avoided. In addition, several other programs operate under revenues set by federal or state statutes and rules. In keeping with section 20(a)(2) of the Act, this rule shall be construed so as not to conflict with those statutes and rules.

2.3. Under the former legislative rule, "Hospital Cost Containment Methodology - Phase 1," 65 C.S.R. 5 (1985), the HCCRA recognized that it lacked the data upon which to fashion a complex regulatory mechanism which utilized multiple restraints. Hence, the phase 1 methodology attempted to slow down the rate of increase in health care costs while ensuring the continuation of appropriate acute care hospital services in West Virginia. It did so by directing a review of a hospital's proposed budget and total revenue requirements. Thus, the initial focus was upon increases in a hospital's revenues.

2.4. After some four years of rate review experience and data collection, the HCCRA is of the opinion that it now has a sufficient data base to begin examining the individual components of a hospital's expense base and to examine how those components change from year to year. Those changes shall be studied based upon several factors:

2.4.1. The hospital's own historical trends from year-to-year.

2.4.2. Trends in state hospitals of a similar size, similar array of services, and similar age of facilities.

2.4.3. State-wide averages and medians.

2.4.4. Nationwide averages and medians including regional variations.

2.4.5. Anticipated changes peculiar to the hospital under review which the hospital is able to justify to a reasonable degree of certainty.

2.5. The HCCRA recognizes that a delicate balance exists between the twin goals of the Act; that is, ensuring both the reasonable expenditure of economic resources for hospital services and the continuation of appropriate acute care hospital services. A reasonable expenditure of economic resources will depend upon what is required to maintain a source of necessary health care services. In the current environment, the incidence of service (that is, utilization) is an important variable in determining the overall expenses of a hospital and the overall revenues of the hospital needed to maintain it as a viable economic entity. Since at least the year 1983, utilization of both inpatient services and outpatient services of the state's hospitals -- as well as that of the entire nation's hospitals -- has been volatile. There has been a dramatic decrease in the numbers of inpatient admissions and a dramatic increase in the number of outpatient visits. While the rate of change in each type of admission and visit can now be expected to level off, it must be recognized that the state's hospitals will continue to be reacting to these changes for some time in the future. How an individual hospital relocates itself in the field of the provision of health care services will be crucial to its continued survival. This is especially

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true for the state's small and rural hospitals which may be relatively isolated in terms of competition with other hospitals but which may have a limited population to serve and which limitation may also restrict the array of services which may be feasibly offered by the hospital. The HCCRA recognizes the importance to the state's citizens of maintaining these out-posts of health care provision; but, in addition, the HCCRA expects the management of these hospitals to be innovative in their restructuring of these facilities both in terms of the variety of services offered (including non-traditional hospital services) and in terms of controlling their expenses.

2.7. The HCCRA recognizes that all of the state's acute care hospitals are economic entities. Thus, each hospital must receive revenues sufficient to cover its legitimate expenses as well as to provide it with a profit so as to continue the growth necessary for any economic entity. The term "nonprofit hospital" is mainly a term of importance for taxation purposes. Thus, it is the goal of this methodology that each of the state's hospitals receives sufficient revenues to cover its legitimate expenses and to earn it a reasonable profit with which to prepare for the future.

2.8. The major area of importance for rate setting purposes of the term "nonprofit hospital" relates to the obligations of such a hospital to its community. The HCCRA is of the opinion that all hospitals -- for profit as well as nonprofit -- have an obligation to their communities for the provision of a reasonable level of uncompensated care as a result of their privileged positions as licensed health care providers. A nonprofit hospital has an even greater

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obligation for the provision of such services. Under federal and state laws, a nonprofit hospital is afforded relief from the payment of certain taxes. The principle behind this policy is that the hospital has an eleemosynary purpose. The freedom from taxation is intended to encourage the implementation of that purpose. The HCCRA expects to see in every hospital's proposed budget and past financial statements, a provision for the delivery of a reasonable amount of uncompensated care. If a hospital is not providing a reasonable share of uncompensated care, then the HCCRA will make a negative adjustment when it evaluates the hospital's payor mix and the appropriate amount of revenues to be generated therefrom.

2.8.1. The HCCRA notes that the State Tax Department has issued regulations for non-profit hospitals' provision of charity care. The HCCRA will accept for purposes of this section of this rule a hospital's compliance with those tax regulations. Hence, compliance with the tax department's regulations will be sufficient evidence for a determination that a non-profit hospital's level of uncompensated care is satisfactory.

2.8.2. Also in furtherance of this policy of encouraging and requiring the delivery of a reasonable amount of uncompensated care, each hospital (for-profit as well as non-profit) shall file with the HCCRA and shall post in a prominent position in the hospital and which is available to the general public a written statement of the hospital's charity care policy. The written policy must be approved by the hospital's governing body.

2.9. The HCCRA recognizes that by means of an amendment to the Act in 1987 the legislature added a new subsection (j) to section 20. The effect of subsection 20(j) is to allow for an expedited review of rate increase applications when the requested increase is equal to or less than the rate of inflation for the hospital industry nationally. Any hospital which requests a rate increase which falls under the requirements of subsection 20(j) shall be reviewed under that subsection and the appropriate procedural rule notwithstanding anything which might appear to the contrary in this legislative rule.

2.10. The principles stated in these rules shall apply in the following instances:

2.10.1. Rate increase applications in excess of the rate of inflation for the hospital industry nationally.

2.10.2. Reviews initiated by the HCCRA for the purpose of determining a hospital's compliance with prior orders and decisions of the HCCRA.

2.10.3. Reviews and investigations initiated by the HCCRA of hospital rates and the establishment and approval of such rates.

2.10.4. Reviews and investigations initiated by the HCCRA of hospital rates for specific services and of the component factors which determine such rates.

2.10.5. Reviews and investigations initiated by the HCCRA of hospital budgets and of the specific components of such budgets.

2.10.6. Approvals and disapprovals of hospital rates and budgets.

§ 65-5-3. Overview.

3.1. The methodology stated in this rule may be thought of as a budget review system. The HCCRA will examine the charges and expenses of the hospital from an historical point of view as well as from a view reflecting anticipated changes in those charges and expenses. The reasonableness of the anticipated changes shall be evaluated. In addition, the hospital shall be allowed a profit based upon the hospital's invested capital and need to finance capital debts. Moreover, the hospital's needs for a reasonable amount of working capital shall be evaluated and provided for as part of the hospital's anticipated profit. Thus, a review will end with the fixing of several revenue limits: average charge per inpatient day and per adjusted inpatient day; average charge per inpatient discharge; gross patient charges, and gross revenue. At that time, a hospital's schedule of rates will also be approved or modified and approved.

3.2. In conducting its reviews and investigations, before approving any rate increase, schedule of rates, or budget, the HCCRA shall make the following findings and conclusions:

3.2.1. That the costs of the hospital's services are reasonably related to the services provided and the rates are reasonably related to the costs.

3.2.2. That the rates are equitably established among all purchasers or classes of purchasers within a hospital without discrimination unless federal or state statutes or regulations require otherwise.

3.2.3. The rates are equitable in comparison to prevailing rates for similar services in similar hospitals as determined by the board.

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3.2.4. That the projected gross revenues for the hospital are appropriate in relation to the charges for services and the anticipated incidence of service.

3.2.5. That the amount of net revenue over expenditures is appropriate for the effective operation of the hospital.

3.3. In the course of making each of the findings required by this section 3, the HCCRA shall consider all relevant factors. Included in those relevant factors shall be the following items; however, the hospital, any interested party, or the HCCRA may suggest other factors to be considered during a review or investigation which, upon appropriate and reasonable notice to all parties, may be included in the course of making the required findings.

3.3.1. The economic factors in the hospital's area.

3.3.2. The hospital's efforts to share services.

3.3.3. The hospital's efforts to employ less costly alternatives for delivering substantially similar services or producing substantially similar or better results in terms of the health status of those served.

3.3.4. The efficiency of the hospital as to cost and delivery of health care.

3.3.5. The quality of care delivered.

3.3.6. The occupancy or utilization level.

3.3.7. A fair return on invested capital, not otherwise compensated for.

3.3.8. Whether the hospital is operated for profit or not for profit.

3.3.9. The costs of education.

3.3.10. The revenue and expenses from any investments and assets not associated with patient care; including, but not limited to, parking garages, residences, office buildings, and income from foundations, controlled corporations, and restricted funds whether or not so associated.

3.4. During the course of any rate review for a requested increase, the hospital shall submit and the HCCRA shall evaluate the written report required by section 21(a)(2) of the Act. In that written report, the hospital must establish that it has thoroughly investigated and considered each of the following factors:

3.4.1. The economic and social impact of any proposed rate increase, or service decrease, on hospital cost containment and upon health care purchasers, including classes of purchasers, such as the elderly and low and fixed income persons.

3.4.2. State-of-the-art advances in health care cost containment, hospital management and rate design, as alternatives to or in mitigation of any rate increase, or service decrease, which report shall describe the state-of-the-art advances considered and shall contain specific findings as to each consideration, including the reasons for adoption or rejection of each.

3.4.3. Implementation of cost control systems, including the elimination of unnecessary or duplicative facilities and services, promotion of alternative forms of care, and other cost control mechanisms.

3.4.4. Initiatives to create alternative delivery systems.

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3.4.5. Efforts to encourage third-party payors, including, but not limited to, insurers, health service, care and maintenance organizations, to control costs, including a combination of education, persuasion, financial incentives and disincentives to control costs.

3.5. In no event shall a hospital's receipt of emergency disaster funds from the federal government be included in that hospital's gross revenues for rate-setting purposes. Similarly, the costs and expenses associated with the purposes for which such emergency disaster funds are obtained will not be included in the hospital's expense base for rate-setting purposes to the extent that the expenses are less than or equal to the funds received.

3.6. Reimbursement of capital and operating costs for new institutional health services and capital projects subject to certificate of need review pursuant to article two-D, chapter 16, of the West Virginia Code of 1931, as amended, shall not be allowed as part of the hospital's expense base and capital expenditures by the HCCRA if such costs were incurred subsequent to July 8, 1977, unless they were exempt from review or approved by the certificate of need agency.

3.7. Unless the HCCRA first determines that wages, salaries, and benefits paid to or on behalf of nonsupervisory employees of hospitals are unreasonably or uncustomarily high or low, such wages, salaries, and benefits shall not be subject to review and shall be automatically accepted as part of the hospital's expense base.

HCCRA  
Leg. Rule, 16-29B  
Series V, Sec. 3

3.7.1. If such wages, salaries, or benefits are found to be either unreasonably or uncustomarily, or both, high, then the HCCRA shall delete the excess amount from the hospital's expense base.

3.7.2. If such wages, salaries, or benefits are found to be either unreasonably or uncustomarily, or both, low, then the HCCRA shall make an explicit finding so concluding and shall publish that fact as part of its written decision. However, no adjustment shall be made, without further request by the hospital, to the hospital's expense base or its revenue base.

3.7.3. While this pass-through provision applies to all reasonable and customary wages, salaries, and benefits for individual non-supervisory employees, it does not forbid or prohibit the HCCRA from making findings regarding the overall numbers of nonsupervisory employees of the hospital or from adjusting the hospital's expense base and revenue base in the cases of excess or inefficient staffing.

3.8. The HCCRA shall include within the hospital's expense base those costs associated with individual health care providers or health care provider groups providing inpatient or outpatient services under a contractual agreement with a hospital (excluding simple admitting privileges).

3.9. The HCCRA shall, consequently, include within the hospital's revenue base those charges associated with individual health care providers or health care provider groups providing inpatient or outpatient services under a contractual agreement with a hospital (excluding simple admitting privileges).

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3.10. Notwithstanding the provisions stated in subsection 3.8 and 3.9 of this rule, HCCRA's jurisdiction does not extend to the regulation of rates of private health care providers or health care groups providing inpatient or outpatient services under a contractual agreement with hospitals when the provision of such service is outside of the hospital setting; further, such jurisdiction does not extend to the regulation of rates of all other private health care providers practicing outside of the hospital setting; provided that, in either such instance, that such practice outside of the hospital setting is not found to be an evasion of the purposes of the Act.

3.11. In determining whether or not to approve a hospital's schedule of rates and budget, the HCCRA shall take into account the situation of the hospital if it serves disproportionate numbers of low income patients and shall assure that such individuals have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. In addition, while the jurisdiction of the HCCRA does not extend to a hospital's medicaid revenues and expenses associated with the treatment of medicaid patients, the HCCRA shall consider as one factor of any review or investigation whether all of the hospital's medicaid related expenses are covered by its medicaid revenues. In those instances where the expenses exceed the revenues, the HCCRA, if it first finds it necessary for the efficient and economical operation of the hospital, may adjust the hospital's net patient revenue and, consequently, its gross patient revenue to provide for revenue to cover those excess expenses.

3.12. All rates set by the HCCRA shall be in advance of the year during which they apply (except for emergency situations) and shall not be adjusted for costs actually incurred.

3.13. All determinations, orders, and decisions of the HCCRA with respect to rates and revenues shall be prospective in nature.

3.14. No hospital may charge for services at rates in excess of those established under the Act and this rule.

3.15. All documents containing financial information that are submitted to the HCCRA must be prepared and presented in accordance with generally accepted accounting principles. To the extent that any information is not so prepared or presented, the hospital or person submitting the information shall note that fact and explain why the information was prepared or presented in the manner chosen.

3.16. Similarly, the HCCRA will conduct its reviews in accordance with the audit guide of the American Institute of Certified Public Accountants and generally accepted accounting principles unless a provision of the Act or this rule requires otherwise.

§ 65-5-4. The Focus Of Rate Review

4.1. The costs of a hospital's services to the individual patient is generally referred to as a "charge." The accumulation of all of a hospital's charges in return for actually delivered services is termed "gross patient

revenue." Gross patient revenue is largely an accounting term since only a portion of a hospital's payors actually pay at the full charge level.

4.2. Because only a portion of a hospital's payors pay at the full charge level, the term "gross patient revenue" is not the equivalent of "net patient revenue." The differences between the two terms vary in accordance with a number of factors:

4.2.1. The contractual allowances imposed by law for the medicare and medicaid programs.

4.2.2. The amount of uncompensated (i.e., charity and bad debt) care delivered by a hospital.

4.2.3. The amounts of payor discounts required of the hospital by state or federal law or regulation as well as by agreements between the hospital and a given payor. Examples of such payors are as follows:

4.2.3.1. Blue Cross.

4.2.3.2. CHAMPUS.

4.2.3.3. Black lung programs.

4.2.3.4. Commercial insurance companies.

4.2.3.5. The United Mine Workers of America Health and Retirement Funds.

4.2.3.6. Preferred provider organizations (PPO).

4.2.3.7. Health maintenance organizations (HMO).

4.2.3.8. State government programs such as maternal and child health, public employees insurance agency, workers' compensation, and the department of vocational rehabilitation.

4.3. A hospital's entire universe of patients are classified by the patients' payor representatives. The classification results are referred to as the hospital's "payor mix." As the individual components of the "payor mix" change, a consequent change will be reflected in the hospital's net patient revenue; however, such changes will not necessarily have an effect upon the hospital's gross patient revenue. Gross patient revenue is affected solely by the volume of patients to whom services are rendered and the charges imposed for those services.

4.4. In practice then, it is a hospital's net patient revenue which is the actual focus of rate review. The amount of net patient revenue must be sufficient to meet the hospital's expenses for operating (including the expenses associated with the health services delivered) and the amount of reasonable profit needed by the hospital to remain a viable economic entity while taking into account both the hospital's other operating and non-operating revenues and expenses. Once the amount of required net patient revenue is determined, it is then necessary to adjust upwards by taking into account the hospital's payor mix and the discounts allotted therein in order to arrive at the hospital's gross patient revenue.

4.5. Whereas the phase one methodology focused upon increases to a hospital's charges and, thus, its gross patient revenue, this rule focuses upon the

components of the hospital's net patient revenues, the other operating and non-operating expenses and revenues, and the profits that the net patient revenue cover. Thus, this rule requires that each factor of a hospital's proposed budget be tested for reasonableness.

§ 65-5-5. Operating Expense.

5.1. A hospital's projected operating expenses -- both for patient services and for non-patient services -- is the beginning point for evaluating a hospital's proposed budget.

5.2. For reviews or investigations being conducted under this rule, the hospital's 1987 fiscal year shall be considered as its base year. If, however, a hospital has on file with the Authority all of the required financial disclosure information for its 1988 fiscal year at the time a review or investigation is instituted for that hospital, then the hospital's 1988 fiscal year shall be the hospital's base year.

5.3. Notwithstanding the provisions stated in section 5.2 of this rule, if a hospital exceeds any of its revenue limits for either its 1987 or 1988 fiscal year, the Authority shall adjust the revenue limits for those years as is appropriate. In that event, the adjusted fiscal year shall serve as the hospital's base year.

5.4. In a review or investigation of a hospital, the Authority shall compare the hospital's budgeted total operating expenses, operating expense per patient day and per adjusted patient day, and operating expense per patient

discharge with the current and prior fiscal years. The reasonableness of operating expenses will be determined by considering each of the following factors:

5.4.1. The trends shown from the hospital's own experiences as reflected by its base year and prior years.

5.4.2. The trends reflected by other state hospitals of similar size, similar services that are offered, and of similar age of facilities.

5.4.3. The trends in such rates of increase as reflected by the national averages and median for the hospital industry shall be compared with the proposed rates of increase for the hospital under review or investigation. The data for the national hospital industry shall be taken from the projected rates of increases as shown by the most recent Data Resources, Incorporated, publications or a successor publication.

5.4.4. The hospital may also justify its proposed rates of increases by demonstrating that, although the rates of increases exceed the above noted averages and median, there is good cause for such an excess. Such good cause may be shown by, among others, the following factors:

5.4.4.1. A change in the services offered by the hospital during the forthcoming fiscal year.

5.4.4.2. A change in the physicians practicing at the hospital or a change in the nature of those physician's practices.

5.4.4.3. Evidence that the hospital will be treating more severely ill or injured patients in the forthcoming fiscal year.

5.5. At the time of a hospital's second and successor applications under this rule, the HCCRA will use as the hospital's base year for comparison purposes the last completed fiscal year for which the HCCRA has actual, complete data and after that data has been subject to all required adjustments such as for justified overages and unjustified overages. All trend analyses, however, shall be conducted by taking into account the hospital's past fiscal years which the HCCRA deems to be comparable.

§ 65-5-6. Profits.

6.1. As was stated in section 2.7 of this rule, the HCCRA recognizes the need for a reasonable profit by a hospital. Thus, a hospital must have a sufficient level of incoming revenues to cover its total operating expenses plus its ongoing debt service and to provide it with a reasonable profit. The need for profit varies across hospitals and with the following factors among others:

6.1.1. The operating efficiency of a hospital.

6.1.2. The debt service of a hospital.

6.1.3. The level of equity financing of past and future capital expenditures.

6.2. In order to provide a hospital with the proper incentive to operate and manage itself efficiently, the HCCRA shall allow the hospital to retain the resulting savings if the hospital is more efficient than originally anticipated.

6.3. Similarly, if it appears that the hospital was operated or was managed less efficiently than was anticipated, the hospital may bear the resulting loss.

6.4. Evidence similar to that provided for by section 5.4.4 of this rule may be introduced to show that the hospital was being operated and managed efficiently despite the loss. Upon such a showing, the HCCRA may make the appropriate adjustments to the hospital's forthcoming proposed operating expense budget. In the absence of such a showing, the HCCRA shall disallow the upwards adjustment of the proposed operating expense budget for the forthcoming fiscal year.

6.5. The HCCRA shall evaluate a hospital's proposed level of profit by the use of the following factors, among others:

6.5.1. The hospital's historic profit levels.

6.5.2. The profit levels measured in percentages resulting from an average and a median of all the state's hospitals that actually earn a profit (i.e., excluding those that operate at a loss).

6.5.3. The profit levels resulting from an average and a median of all the nation's hospitals.

6.5.4. In instances where the proposed profit level for a hospital is in excess of the amounts indicated above, the hospital may demonstrate good cause for such excess by providing evidence that its special or unique circumstances require such an excess. Such unique or special circumstances may be shown by the following factors, among others:

6.5.4.1. Its own level of debt service as compared with state and national averages and medians of debt services.

6.5.4.2. Its own level of capital expenditures as compared with state and national averages and medians of debt service.

6.5.4.3. Its own level of needed working capital as compared with state and national averages and medians of working capital.

6.5.4.4. Such other evidence of special or unique requirements as the hospital under review or investigation may demonstrate.

6.5.5. Whether the hospital is for profit and, thus, subject to taxation.

6.5.6. In making the above-noted comparisons, the HCCRA shall use standard ratio analysis of the hospital's financial status and such other analysis as may be shown to be reasonable by the hospital, an interested party, or the HCCRA.

§ 65-5-7. Net Patient Revenue.

7.1. Net patient revenue is that revenue which a hospital should collect to cover its patient operating expenses and its profit. Net patient revenue differs from gross patient revenue in that gross patient revenue reflects the full charge level for services provided. Thus, gross patient revenue less contractual allowances, discounts, and uncompensated care equals net patient revenue.

7.2. In order to establish the appropriate amount of net patient revenue for a hospital, the HCCRA must evaluate the hospital's proposed level in

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light of the operating expenses established under section 5 of this rule and in light of the level of profits established under section 6 of this rule. However, that resulting amount must be adjusted for the hospital's other operating and non-operating revenues.

7.3. A hospital's other operating revenues relate to a hospital's non-patient related activities, such as: gift shops, parking lots and garages, and medical office buildings. These revenues will be treated as an offset to the hospital's required net patient revenue as provided for in section 7.2.

7.4. Within the concept of non-patient related other operating revenues and expenses are included revenues and expenses related to subsidiary, sibling, and parent companies of the hospital that are controlled by the hospital or are existing for the benefit of the hospital. Revenues or other assets transferred from a controlled entity to the hospital shall be treated as other operating revenue of the hospital. Funds or other assets transferred from the hospital to such a controlled entity shall be treated as an asset of the hospital. In addition, where a hospital has transferred its funds or other assets to a controlled entity, the HCCRA will infer a reasonable return for each fiscal year on such funds to the hospital whether or not such a return is actually obtained unless a hospital demonstrates good cause for not making such an inference. Good cause may be shown by evidence that the controlled entity is using such funds in a good faith attempt to earn a return but that such an attempt cannot reasonably be expected to, as yet, make a return. Similarly, good cause may be shown by demonstrating that the controlled entity is accumulating the funds for

some purpose or purposes which in the future will result in a return to the hospital. An example would be a foundation which is investing transferred funds and saving the interest earned for the purchase of major medical equipment or needed construction for the hospital. Other demonstrations of good cause may be made by the hospital.

7.5. With the exception of gift income, a hospital's non-operating revenues shall be deemed to be available to make the section 7.2 adjustment. As for gift income, if the gift is intended by the donor to reduce operating expenses of the hospital, then such gift revenue shall be deemed available to make the section 7.2 adjustment. However, if the donor's intent was not to reduce operating expenses but was instead for some other purpose such as adding to the hospital's funds to acquire some particular item of major medical equipment, then such gift revenue will not be deemed available to make the section 7.2 adjustment until the revenue is actually expended and then only for purposes of meeting expenses associated with the donor's intended acquisition or other activity.

7.6. As for a hospital's non-operating revenues other than gifts, such revenues generally arise from the interest income from a hospital's board restricted funds, other restricted funds, and funded depreciation accounts.

7.6.1. Funds which are restricted by discretionary action on the part of the hospital's controlling body shall be treated as an asset of the hospital. Thus, all interest income from such funds will be treated as an offset for the section 7.2 adjustment.

7.6.2. Funds which are restricted as a result of some non-discretionary action by the hospital's controlling body (i.e., bond requirements) shall not be treated as an offset for the section 7.2 adjustment. However, when the interest income of such restricted funds becomes available for the use of the hospital through the discretion of the hospital's controlling body, such interest income shall be treated as an offset for the section 7.2 adjustment.

7.6.3. As to interest income from funded depreciation accounts, such interest income will be treated in accordance with either subsection 7.6.1 or subsection 7.6.2 in accordance with generally accepted accounting principles. To the extent that neither subsection 7.6.1 nor subsection 7.6.2 are applicable, then the interest income from funded depreciation accounts shall be treated as an offset against the amount of profit needed by the hospital as part of its net operating revenue.

7.7. The reporting requirements for this section 7 shall include a statement by the hospital of its anticipated revenues and expenses plus documentation of any assumed changes in that statement from the current and immediate past fiscal years.

§ 65-5-8. Gross Patient Revenue.

8.1. A hospital's reasonable amount of gross patient revenue is determined by the amount of net patient revenue found under section 7 as well as by the hospital's payor mix, payor volumes, payor discounts, and contractual allowances.

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8.2. Contractual allowances refers to the differences between a hospital's charges and the amounts paid by the federal medicare and medicaid programs. Since the Act does not apply to expenses and revenues associated with those federal programs, the HCCRA shall not review or investigate them; except that, if a hospital requests that it be permitted to shift costs associated with the medicare or medicaid programs to other payors, then the hospital must demonstrate the need for the shift as well as the amount to be shifted. The HCCRA will not ordinarily permit such cost shifting. However, where a hospital's continued viability as a health care provider is significantly threatened and where the hospital has demonstrated that it has made every other reasonable effort to reduce expenses related to the medicare or medicaid program, then the HCCRA may permit such cost shifting unless good cause exists for not doing so.

8.3. Two different categories of payor discounts are recognized under this rule.

8.3.1. First, a discount required of the hospital by a state or federal law or regulation shall be permitted and shall be treated in the same fashion (including possible cost shifting) as is a contractual allowance under section 8.2.

8.3.2. However, from the effective date of this rule, no hospital shall institute or permit to continue any discount to any other payor or class of payors; provided that, if the hospital or a third party payor demonstrates that the service, coverages, and payment characteristics of a class of patients equitably justifies a discount, then the HCCRA shall permit the discount on a hospital-by-hospital basis.

8.4. The demonstration required by section 8.3.2 of this rule shall include:

8.4.1. That the hospital's total financial requirements for the efficient provision of necessary services across all categories of payors will be met if the discount is permitted.

8.4.2. The discount must be shown to result from activities and programs of the payor or class of payors which result in quantifiable savings to the hospital with respect to patient care costs, bad debts, free care or working capital, or reductions in the payments of other payors.

8.4.3. Each component utilized in determining the differential shall be individually quantified so that the differential shall equal the value assigned to each component.

8.4.4. The effects of the discount must be shown not to negatively impact upon the coverage available to individual subscribers, the elderly and small groups, payment practices, savings in hospital administrative costs, cost containment programs, and working capital.

8.4.5. This demonstration shall be made each time the hospital files a rate review application and each time the HCCRA conducts a review or investigation of the hospital. In no event, however, will more than thirty-six (36) months elapse between the approval of such a discount and a reexamination of the discount.

8.5. All requested third party payor discounts will be compared with the hospital's prior fiscal years' medicare cost reports for the reasonableness of

anticipated levels of third party payor discounts. Any deviation from prior years' levels must be justified by the hospital.

8.6. A hospital's anticipated payor mix and volume of utilization will be compared with the levels experienced by the hospital in prior fiscal years. Changes may be permitted by the HCCRA upon justification by the hospital. Justification may be demonstrated by evidence of:

- 8.6.1. Changes in economic factors in the hospital's service area.
- 8.6.2. Changes in the hospital's medical staff.
- 8.6.3. Changes in the hospital's services.

8.7. The HCCRA shall calculate a hospital's average charge per inpatient day in accordance with the following algebraic formula. The calculation apportions a hospital's medicare, medicaid, and other state and federal patients' revenues and expenses on a direct proportional basis with their number of inpatient days. In the event that a hospital, an interested party, or the HCCRA wishes to demonstrate that some other apportionment system is more accurate for a given hospital, it may present evidence so demonstrating. If the HCCRA determines that the alternative system is more reasonable than the system used here, that alternative system may be employed. In any event, the system employed is used to avoid cost shifting between the federal and state programs and the hospital's other remaining patients. To the extent that the HCCRA determines to permit some form of cost shifting, the assumptions used in the formula will have to be modified.

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8.7.1. The algebraic formula is:  $(N_m \times P_m) R + (N_s \times P_s) R + (N_d \times P_d) R + (N_u \times P_u) R + (N_o \times P_o) R = \text{Net Inpatient Revenue.}$

8.7.2. As used in this formula, the following letters have the indicated meanings.

8.7.2.1. "N" means the number of inpatient days for given class of purchasers over the course of some time period (normally a fiscal year).

8.7.2.2. "P" means the percentage of charges that a given class of purchasers is assumed to pay or actually pays if the HCCRA so permits.

8.7.2.3. "R" means the average charge per inpatient day for the hospital over the course of some time period (normally a fiscal year).

8.7.2.4. "Net Inpatient Revenue" means all of the revenues for health care services for a hospital's inpatients over the course of some time period (normally a fiscal year). See also the definition stated at subsection 13.7 below.

8.7.2.5. The small letter "m" refers to the medicare class of purchasers.

8.7.2.6. The small letter "s" refers to the medicaid class of purchasers.

8.7.2.7. The small letter "d" refers to the various classes of purchasers covered by the various state and federal programs whose rates are determined by statute or regulation.

8.7.2.8. The small letter "u" means the uncompensated classes of purchasers; i.e., those who will result in bad debts or charity care.

8.7.2.9. The small letter "o" means the other classes of purchasers who pay at the charge level.

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8.7.3. Unless the HCCRA determines otherwise as stated in subsection 8.7 above, the components "Pm", "Ps", "Pd", and "Po" shall be treated as at the 100% level. In this event, the subsection 8.7.1 formula will be employed twice: first, with all classes of payors at 100% payments; and, second, after deleting the classes such as medicare and medicaid that actually pay less than charges and after subtracting their imputed revenues from the first operation of the formula from the Net Inpatient Revenue amount.

8.8. The HCCRA shall calculate a hospital's average charge per discharge in accordance with the following algebraic formula. The calculation apportions a hospital's medicare, medicaid, and other state and federal patients' revenues and expenses on a direct proportional basis with their number of discharges. In the event that a hospital, an interested party, or the HCCRA wishes to demonstrate that some other apportionment system is more accurate for a given hospital, it may present evidence so demonstrating. If the HCCRA determines that the alternative system is more reasonable than the system used here, that alternative system may be employed. In any event, the system employed is used to avoid cost shifting between the federal and state programs and the hospital's other remaining patients. To the extent that the HCCRA determines to permit some form of cost shifting, the assumptions used in the formula will have to be modified.

8.8.1. The algebraic formula is:  $(N'm \times Pm) R' + (N's \times Ps) R' + (N'd \times Pd) R' + (N'u \times Pu) R' + (N'o \times Po) R' = \text{Net Inpatient Revenue.}$

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8.8.2. As used in this formula, the following letters have the indicated meanings.

8.8.2.1. "N" means the number of discharges for a given class of purchasers over the course of some time period (normally a fiscal year).

8.8.2.2. "P" means the percentage of charges that a given class of purchasers is assumed to pay or actually pays if the HCCRA so permits.

8.8.2.3. "R" means the average charge per discharge for the hospital over the course of some time period (normally a fiscal year).

8.8.2.4. "Net Inpatient Revenue" means all of the revenues for health care services for a hospital's inpatients over the course of some time period (normally a fiscal year). See also the definition stated at subsection 13.7 below.

8.8.2.5. The small letter "m" refers to the medicare class of purchasers.

8.8.2.6. The small letter "s" refers to the medicaid class of purchasers.

8.8.2.7. The small letter "d" refers to the various classes of purchasers covered by the various state and federal programs whose rates are determined by statute or regulation.

8.8.2.8. The small letter "u" means the uncompensated classes of purchasers; i.e., those who will result in bad debts or charity care.

8.8.2.9. The small letter "o" means the other classes of purchasers who pay at the charge level.

8.8.3. Unless the HCCRA determines otherwise as stated in subsection 8.8 above, the components "Pm", "Ps", "Pd", and "Po" shall be treated as at the 100% level. In this event, the subsection 8.8.1 formula will be employed twice:

first, with all classes of payors at 100% payments; and, second, after deleting the classes such as medicare and medicaid that actually pay less than charges and after subtracting their imputed revenues from the first operation of the formula from the Net Inpatient Revenue amount.

8.9. The HCCRA shall calculate a hospital's average charge per adjusted inpatient day in accordance with the following algebraic formula. The calculation apportions a hospital's medicare, medicaid, and other state and federal patients' revenues and expenses on a direct proportional basis with their number of adjusted inpatient days. In the event that a hospital, an interested party, or the HCCRA wishes to demonstrate that some other apportionment system is more accurate for a given hospital, it may present evidence so demonstrating. If the HCCRA determines that the alternative system is more reasonable than the system used here, that alternative system may be employed. In any event, the system employed is used to avoid cost shifting between the federal and state programs and the hospital's other remaining patients. To the extent that the HCCRA determines to permit some form of cost shifting, the assumptions used in the formula will have to be modified.

8.9.1. The algebraic formula is:  $(N^m \times P_m) R + (N^s \times P_s) R + (N^d \times P_d) R + (N^u \times P_u) R + (N^o \times P_o) R = \text{Net Patient Revenue}$ .

8.9.2. As used in this formula, the following letters have the indicated meanings.

8.9.2.1. "N" means the number of adjusted inpatient days for a given class of purchasers over the course of some time period (normally a fiscal year).

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8.9.2.2. "P" means the percentage of charges that a given class of purchasers is assumed to pay or actually pays if the HCCRA so permits.

8.9.2.3. "R" " means the average charge per adjusted inpatient day for the hospital over the course of some time period (normally a fiscal year).

8.9.2.4. "Net Patient Revenue" means the adjusted combination of net inpatient revenue and net outpatient revenue for the same fiscal year.

8.9.2.5. The small letter "m" refers to the medicare class of purchasers.

8.9.2.6. The small letter "s" refers to the medicaid class of purchasers.

8.9.2.7. The small letter "d" refers to the various classes of purchasers covered by the various state and federal programs whose rates are determined by statute or regulation.

8.9.2.8. The small letter "u" means the uncompensated classes of purchasers; i.e., those who will result in bad debts or charity care.

8.9.2.9. The small letter "o" means the other classes of purchasers who pay at the charge level.

8.9.3. Unless the HCCRA determines otherwise as stated in subsection 8.9 above, the components "Pm", "Ps", "Pd", and "Po" shall be treated as at the 100% level. In this event, the subsection 8.9.1 formula will be employed twice: first, with all classes of payors at 100% payments; and, second, after deleting the classes such as medicare and medicaid that actually pay less than charges and after subtracting their imputed revenues from the first operation of the formula from the Net Patient Revenue amount.

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8.10. At the completion of this analysis, the HCCRA shall fix the hospital's average charge per inpatient day, its average charge per adjusted inpatient day, its average charge per discharge, gross patient revenue limit, its gross revenue limit, and shall approve the hospital's proposed budget with the modifications, if any, required by the HCCRA's scrutiny of the budget. Thereafter, the hospital's proposed schedule of rates which is designed to achieve and be within the approved revenue limits shall be approved.

8.10.1 A hospital's gross patient revenue limit shall be calculated by multiplying a hospital's number of adjusted inpatient days by its average charge per adjusted inpatient day.

8.10.2. A hospital's gross revenue limit shall be calculated by adding a hospital's gross patient revenue limit to its other operating revenue and non-operating revenue.

8.11. As used above, the term "adjusted inpatient day" refers to a way of accounting for outpatient revenues. The term is calculated by dividing a hospital's outpatient revenues by the ratio of its inpatient revenues to its inpatient days. The following algebraic formula is used: adjusted inpatient days = outpatient revenue / (inpatient revenue / inpatient days).

§ 65-5-9. Overages

9.1. A hospital is expected to conduct its affairs so as to end its fiscal year within the revenue limits set for it. The HCCRA will not allow

overages which were within the managerial control of the hospital. This is in keeping with section 20(g)-(i) of the Act.

9.2. If a hospital exceeds one or more of its revenue limits and if the overage is not justified, then the hospital will be penalized for the overage. In devising an appropriate penalty, the HCCRA shall treat the following as mitigating factors:

9.2.1. The good faith attempts by the hospital to stay within its revenue limits:

9.2.2. The overall financial viability and integrity of the hospital.

9.2.3. The benefits to be attained by the community by the imposition of a penalty versus the harm that the community might suffer as a result of a penalty being imposed upon the hospital.

9.2.4. The magnitude of the overage.

9.2.5. The nature of the particular revenue limit or limits that are exceeded.

9.3. In a situation where a penalty is being imposed, the HCCRA shall craft a penalty which, in its discretion, it believes to be best suited to the hospital, the nature of the violation, and the community. The HCCRA shall choose a penalty format from among the following:

9.3.1. An order directing a refund to the individual patient (or the patient's third-party payor) in the amount of the excess.

9.3.2. An order directing that the hospital reduce the charges it otherwise would have been permitted during either its then current fiscal year or its next fiscal year by the full amount of the overage.

9.3.3. An order directing that the hospital reduce the charges it otherwise would have been permitted during either its then current fiscal year or its next fiscal year by some portion of the amount of the overage. The portion may be determined by use of the factors set forth in subsection 9.2.1 through 9.2.5 of this rule or by first determining the ratio of the hospital's fixed costs versus its variable costs and by setting the penalty in the amount of its fixed costs.

9.3.4. In conjunction with or in place of a penalty devised pursuant to subsection 9.3.3 of this rule, the HCCRA may impose an obligation upon the hospital to provide additional uncompensated care above and beyond that previously budgeted for by the hospital in an amount commensurate with the amount of the overage..

9.3.5. Alternately, the HCCRA may devise a penalty tailored to the hospital's and its community's own particular situation.

9.4. In conjunction with or as an alternative to the penalties provided for by section 9.3 of this rule, the HCCRA may elect to apply one or more of the following alternatives to a hospital or a person that is or has violated the Act, the rules promulgated under the Act, or any order or decision of the HCCRA:

9.4.1. The issuance of an order of enforcement by the HCCRA against the hospital as provided for by section 15 of the Act.

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Series V, Sec. 9

9.4.2. By obtaining an injunction or mandamus or other proper proceeding in the name of the state from an appropriate circuit court or the Supreme Court of Appeals as provided for by section 14 of the Act.

9.4.3. As provided for by section 27 of the Act, by requesting that the appropriate county prosecuting attorney obtain a conviction of the hospital or person for a misdemeanor and a fine of not more than one thousand (\$1,000.00) dollars. Each day of a continuing violation after conviction shall be considered a separate offense. No fines assessed may be considered part of the hospital's costs in the regulation of its rates.

9.5. A hospital may justify its exceeding one or more of its revenue limits by submitting evidence in support of its claim of justification. To the extent an overage is justified, the HCCRA shall modify the hospital's revenue limits for that fiscal year. Appropriate evidence to demonstrate a justification includes:

9.5.1. That the hospital obtained a greater level of appropriate utilization than it had budgeted for during that fiscal year. Such greater level may be the result of a change in the services offered by the hospital or a change in the physicians on the staff of the hospital or a change in those physicians' practices.

9.5.2. Changes in the hospital's service area which affect its level of utilization such as the closing or temporary discontinuance of services by another hospital or clinic, improved economic conditions, unexpected increases

in the population of the service area, or emergency conditions arising in the service area which lead to an unanticipated surge in delivered services.

9.5.3. Changes in the intensity of services being delivered by the hospital. Such changes would normally be the result of changes in the nature or severity of illnesses and injuries being treated at the hospital. While a case mix index can provide some support for showing such a change, a preferred method is to show a change in the number of procedures being delivered by the hospital. Increases in procedures performed is a more accurate indicator of changes of intensity of services than is the case mix index system which presently has a number of defects. The defects are such items as the subjectivity and error rate in assigning the particular patient to a given diagnostically related category.

9.5.4. Such other changes that demonstrate the lack of control by the hospital's management over a particular factual circumstance which led to the overage.

§ 65-5-10. Interested Parties. For all purposes under the Act, an interested party is a natural person, association, corporation, partnership, group, organization, or other entity who is:

10.1. The hospital under review or investigation.

10.2. A representative of consumers of the health care services of the hospital under review or investigation.

10.3. A resident of the geographic area served by the hospital under review or investigation.

10.4. A regular user of the health care services of the hospital under review or investigation.

10.5. Other hospitals or health care providers located in the service area of the hospital under review or investigation or which provides health care services to natural persons in that service area.

10.6. Third party payors which reimburse consumers of health care services in the service area of the hospital under review or investigation.

10.7. Any government agency, other than the HCCRA, which establishes rates for health care services that may be affected by results of the review or investigation being conducted.

10.8. An organization representing health care providers.

§ 65-5-11. Reports By Other Licensing Agencies.

11.1. Any state, county, or local licensing agency empowered to suggest or mandate changes in buildings or operations of hospitals shall give notice to the HCCRA of the changes suggested or mandated by sending to the HCCRA a copy of all reports, findings, conclusions, citations, or other documents embodying such suggestions or mandatory instructions.

11.2. Such notices shall be sent to the HCCRA within ten (10) days of the delivery of such reports, findings, conclusions, citations, or other documents to the affected hospital.

§ 65-5-12. Filing Requirements.

12.1. At least thirty (30) days prior to the start of its fiscal year and at the time of any rate increase application or at the time of any review or investigation initiated by the HCCRA, each hospital subject to the provisions of the Act shall file with the HCCRA a proposed budget. The proposed budget shall be in the same format and shall contain the same information as is required by the uniform system of accounting and financial reporting as it is then adopted by the HCCRA under the provisions of section 17 of the Act.

12.2. At the time of submission of the proposed budgets as is required by section 12.1 of this rule, each hospital shall also submit a yearly capital expenditures budget.

12.3. At a minimum, the HCCRA shall require and the hospital shall provide the following documents in order to demonstrate that its proposed level of profit is reasonable:

12.3.1. A statement of revenue and expense by each classification of payor.

12.3.2. A balance sheet.

12.3.3. A statement of changes in financial position or a statement of cash flows.

12.4. In order to demonstrate the reasonableness of other operating and non-operating expenses and revenues for purposes of the section 7.2 adjustment, the HCCRA shall compare the proposed levels to the levels

experienced by the hospital in its base year and in other years. The hospital must then justify any anticipated deviation from prior years' levels.

§ 65-5-13. Definitions - As used in this rule, the following terms have the stated meanings unless the context requires otherwise.

13.1. "The Act" means the West Virginia Health Care Cost Review Authority Act which is set forth as West Virginia Code, § 16-29B-1 et seq.

13.2. "Average charge per discharge" means the average calculated for all charges for the hospital's non-medicare and non-medicaid inpatients divided by the total number of discharges for such inpatients over the course of a fiscal year.

13.3. "Average charge per inpatient day" means the average calculated for all charges for the hospital's non-medicare and non-medicaid inpatients divided by the total census days over a fiscal year for such inpatients.

13.4. "Average charge per occasion of outpatient services" means the average calculated for the hospital's non-medicare and non-medicaid outpatients by taking the total charges for outpatient services provided to non-medicare and non-medicaid outpatients and dividing by the total number of occasions of the delivery of such services; eg., one person who presents himself or herself as an outpatient and has three tests performed during that one visit results in three occasions of outpatient services.

13.5. "The board" means the three member board of directors of the West Virginia Health Care Cost Review Authority, an autonomous division within the state department of health.

13.6. "Charges" means the economic value established for accounting purposes of the goods and services a hospital provides for all classes of purchasers.

13.7. "Class of purchaser" means a group of potential hospital patients with common characteristics affecting the way in which their hospital care is financed.

13.8. "Controlled corporation" means any corporation which is subject to the decisions of a hospital or a hospital's parent entity whether directly or indirectly. Examples of such control is the authority of a hospital or its parent entity to appoint or approve the board members of the "controlled corporation" or where the "controlled corporation" exists for the purpose of supporting a hospital or its provision of health care services. The question of what a corporation exists for ("its purpose") shall be determined by reference to its articles of incorporation, its charter, its by-laws, or by the resolution creating the corporation whether the resolution is that of the alleged "controlled corporation" or of some other entity which creates or facilitates the creation of the alleged "controlled corporation." The question of what a corporation exists for ("its purpose") may also be determined by the actions it takes or engages in, i.e., whether the "alleged corporation" acts on or in behalf of a hospital in some manner.

13.9. "Controlled entity" means any person, company, corporation, partnership, proprietorship, association, organization, or other group and which is "controlled" in a similar fashion as that of a "controlled corporation" as described in subsection 12.8 of this rule.

13.10 "Gross inpatient revenue" means all of the revenues for health care services valued at the charge level for the hospital's non-medicare and non-medicaid inpatients over the course of a fiscal year.

13.11. "Gross outpatient revenue" means all of the revenues for health care services valued at the charge level for the hospital's non-medicare and non-medicaid outpatients over the course of a fiscal year.

13.12 "Gross patient revenue" means all of the revenues for health care services valued at the charge level for the hospital's non-medicare and non-medicaid inpatients and outpatients over the course of a fiscal year.

13.13. "Gross revenues" means all of the revenues for health care services valued at the charge level for the hospital's patients plus all of the other operating revenue and non-operating revenue of the hospital over the course of a fiscal year.

13.14. "Health care provider" means a person, partnership, corporation, facility, or institution licensed, certified, or authorized by law to provide professional health care service in this state to an individual during this individual's medical care, treatment, or confinement.

13.15. "Hospital" means a facility subject to licensure as such under the provisions of West Virginia Code, § 16-5B-1 et seq., and 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, and does not include state mental health facilities or state long-term care facilities.

13.16. "The HCCRA" means the West Virginia Health Care Cost Review Authority created by West Virginia Code, § 16-29B-5.

13.17. "Net inpatient revenue" means all of the revenues for health care services for a hospital's inpatients over the course of a fiscal year where the revenues are determined by the amount the patient or the patient's third party payor is actually expected to pay rather than at the charge level. The difference between the charge level and the amount actually expected to pay is determined by contractual allowances and discounts.

13.18. "Net outpatient revenue" means all of the revenues for health care services for a hospital's outpatients over the course of a fiscal year where the revenues are determined by the amount the patient or the patient's third party payor is actually expected to pay rather than at the charge level.

13.19. "Net patient revenue" is the adjusted combination of "net inpatient revenue" and "net outpatient revenue" for the same fiscal year.

13.20. "Nonsupervisory personnel" or "nonsupervisory employees" means, but is not limited to, employees of hospitals who are paid on an hourly basis.

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Leg. Rule, 16-29B  
Series V, Sec. 13

13.21. "Person" means an individual, trust, estate, partnership, committee, corporation, association, or other organization such as a joint stock company, a state, or political subdivision or instrumentally thereof.

13.22. "Profit" means the amount of net revenue over expenditures for a hospital.

13.23. "Purchaser" means a consumer of patient care services, a natural person who is directly or indirectly responsible for payment for such patient care services rendered by a hospital, but does not include third party payors.

13.24. "Rates" means a value given or money payable to hospitals for health care services, including fees, charges, and cost reimbursements. "Rates" can be indicative of the value given for an individual item of service (eg., room and board, gauge, individual dosages of medications) or as the value of all services rendered to a given patient, a hypothetical average patient on a given day or during a given period of hospitalization, or an aggregate of patients over a given year.

13.25. "Records" means accounts, books, and other data related to health care costs at health care facilities subject to the provisions of the Act which do not include privileged medical information, individual personal data, confidential information, the disclosure of which is prohibited by other provisions of the West Virginia Code of 1931, as amended, and the laws enacted by the federal government, and information, the disclosure of which would be an invasion of privacy. To the extent that a "record" contains such privileged,

personal or confidential information, the HCCRA is required to excise that data and preserve its confidentiality.

13.26. "Schedule of rates" means the list of all charges for all of the health care services provided by or at a hospital. "Schedule of rates" also means the compilation of the various average charges set by the HCCRA for a hospital such as average charge per inpatient day, average charge per discharge, average charge per occasion of outpatient services, gross patient revenues, other operating and non-operating revenues, and gross revenues.

13.27. "Third party payor" means any natural person, person, corporation or government entity responsible for payment for patient health care services rendered by or at hospitals.

§ 65-5-14. Severability - If any provision or provisions of this rule or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or applications of this rule which can be given effect without the invalid provision or provisions or application and to this end the provision of this rule are declared to be severable.