WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION
Form #5

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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF AGENCY ADOPTION OF A PROCEDURAL OR INTERPRETIVE RULE OR A LEGISLATIVE RULE EXEMPT FROM LEGISLATIVE REVIEW

AGENCY: Health Care Cost Review Authority TITLE NUMBER: 65

CITE AUTHORITY: W. Va. Code §16-29B-19a

RULE TYPE: PROCEDURAL ______ INTERPRETIVE ______

EXEMPT LEGISLATIVE RULE X
CITE STATUTE(s) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW
W. Va. Code §16-29B-19a

AMENDMENT TO AN EXISTING RULE: YES X , NO ______

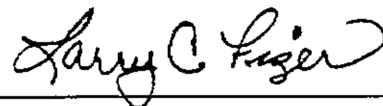
IF YES, SERIES NUMBER OF RULE BEING AMENDED: 5

TITLE OF RULE BEING AMENDED: "Hospital Cost-Based Rate Review System"

IF NO, SERIES NUMBER OF NEW RULE BEING ADOPTED: ______

TITLE OF RULE BEING ADOPTED: ______

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS April 29, 1993



LARRY C. FIZER, Chairman

Mar 29 3 13 PM '93

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APPENDIX B

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FISCAL NOTE FOR PROPOSED RULES

Rule Title: Hospital Cost-Based Rate Review System (Title 65 - Series 5)

Type of Rule: x Legislative ___ Interpretive ___ Procedural

Agency Health Care Cost Review Authority Address 100 Dee Drive, Suite 201
Charleston, WV 25311-1692

1. Effect of Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	$ 134,244	$ —	$ 134,244	$ 80,526	$ 84,552
Personal Services	76,691	—	76,691	80,526	84,552
Current Expense	6,990	—	6,990	—	—
Repairs and Alterations	—	—	—	—	—
Equipment	50,563		50,563	—	—
Other	—	—	—	—	—

2. Explanation of above estimates.

The degree of accounting sophistication required to administer the Cost-Based Rate Setting Methodology requires the development of a computer system, with an appropriated hardware configuration to maintain the financial and utilization data collected from hospitals and with software to enable that data to be analyzed by the Board Members and staff who support them. A staff member to oversee the integrity of the data and two additional analysts are needed to accurately and expediently evaluate hospital expenses and revenues and calculate rates using this methodology.

3. Objectives of these rules:

To implement Enrolled Committee substitute for House Bill 2194 passed March 6, 1991, by the W. Va. Legislature. It requires the HCCRA to implement a cost-based review system for the hospital rate setting. Previous to the July 1, 1992, effective date of these regulations, hospitals' rates were set by the HCCRA using a revenue based methodology. The intent of the legislation and these regulations is to further control hospital costs to non-governmental patients by setting rates based on a comparison of costs incurred by peer hospitals; thus encouraging cost reductions and efficiencies.

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4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None - The HCCRA is funded by a revenue account derived from an annual assessment of hospitals.

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

See C. below

C. Economic Impact on Citizens/Public at Large.

By setting hospital rates utilizing a cost-based methodology, the increase in the cost of hospital services should be reduced for non-governmental patients under what it would otherwise be. We estimate that reduction in the next year will be $40,000,000.00.

Date August 4, 1992

Signature of Agency Head or Authorized Representative

LARRY C. FIZER, CHAIRMAN

SUMMARY OF AMENDMENT

TO 65 C.S.R. 5

The amendment provides a process for temporary approval and retroactive review of certain discount contracts between hospitals and third-party payors. Contracts must be with a new entity and the parties must have been unable to complete negotiations within the regular time period.

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TITLE 65
HEALTH CARE COST REVIEW AUTHORITY

SERIES 5

Title: Hospital Cost-Based Rate Review System

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§65-5-1 General

1.1. Scope - This rule establishes a cost-based rate review system for acute care hospitals in West Virginia.

1.2. Authority - W. Va. Code §§16-29B-19a, 20(j) and 20(k).

1.3. Filing Date - August 4, 1992.

1.4. Effective Date - August 4, 1992.

1.5. This rule repeals and replaces the "Procedural Rule for Requests for Hospital Rate Changes," §65 C.S.R. 3, the "Hospital Cost Containment Methodology - Phase 1," §65 C.S.R. 5, the "Review For Automatic Rate Changes," §65 C.S.R. 19, and the "Expedited Review For Rate Changes," §65 C.S.R. 14.

§65-5-2 Introduction

This legislative rule which is exempt from legislative review implements certain provisions of Enrolled Committee Substitute for House Bill 2194 which was passed by the Legislature on March 6, 1991, effective from passage, and was signed by the Governor on March 20, 1991. This bill created a new Code section, W. Va. Code §16-29B-19a, which directs the board of the Health Care Cost Review Authority to develop a cost-based rate review system and to adopt regulations to implement the cost-based rate review methodology by July 1, 1992.

§65-5-3 Definitions

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

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

3.2. "Adjusted days" means the total acute care inpatient days plus an amount of equivalent outpatient days. The total adjusted days is computed as follows:

STEP 1	$\frac{A \& B}{C}$	=	D
STEP 2	$\frac{E}{D}$	=	F
STEP 3	C + F	=	Adjusted Days

Where:

A = Acute Care Routine Inpatient Revenue

B = Acute Care Ancillary Inpatient Revenue

C = Acute Care Inpatient Days

D = Average Acute Care Inpatient Revenue per Day

E = Outpatient Revenue

F = Equivalent Outpatient Days

3.3. "Affected party" means any interested party which is recognized by the Authority as an affected party.

3.4. "Authority" means the West Virginia Health Care Cost Review Authority.

3.5. "Case Mix Index" means an index determined by multiplying the respective DRG weights in effect at the time of the discharges by the number of discharges for each DRG weight classification in order to arrive at a weighted DRG for each DRG classification, which DRG classifications are then added together

and divided by the total number of discharges for the hospital to arrive at a case mix index for the respective category of payors, all as determined by the Authority based upon information submitted by the hospital and other sources of information.

3.6. "Discount Contract" means any contract for the payment of patient care services between a purchaser or third party payor and a hospital which contract establishes discounts to the purchaser or third-party payor and which contract is subject to the approval of the Authority pursuant to W. Va. Code §16-29-20. Examples of discount contracts shall include, but not be limited to, written contracts between a hospital and a third party payor or purchaser establishing a discount to the payor or purchaser in the form of a percentage reduction in the amount of charges or other adjustments that have the effect of decreasing the amount of charges and informal arrangements between hospitals and purchasers or third party payors which have the effect of decreasing the amount of charges for a group of patients.

3.7. "Hospital" means a facility subject to licensure as a hospital under the provisions of W. Va. Code §16-5B-1 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.

3.8. "Inflation Factor" means the DRI McGraw-Hill "hospital market basket moving average inflation factor" or any other generally accepted indicator of the rate of inflation for hospital services as approved by the Authority.

3.9. "Interested party" means any individual, group or organization which files a written request with the Authority on or before the prehearing conference stating that the individual, group or organization is aggrieved or is likely to be aggrieved based upon information and belief by any act or failure to act by the Authority or by any rule, regulation or final order of the Authority and setting forth with particularity the basis for such request.

3.10. "Median" means the point that divides the distribution of hospitals in a peer group into two parts such that an equal number of hospitals fall above and below that point. When the number of hospitals is an even number, then the average of the two middle scores is taken as the median.

3.11. "Nongovernmental payors" means payors for health care services exclusive of payors covered by the Medicare Program, Medicaid Program, and any other federal or state

governmental program which separately establishes rates for hospitals for a group of payors and which preempts the Authority from establishing rates for such group.

3.12. "Nonsupervisory employee" means 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, and who may exercise only authority of a routine or clerical nature, and does not require the use of independent judgement.

3.13. "Overage" means an excess of revenues over the approved revenue limits for the hospital as established by the most recent order of the Authority; provided that, any proposed justification for such overage in accordance with this rule may not offset the amount of any such overage unless and until accepted by order of the Authority.

§65-5-4 Overview

This is an overview of the Hospital Cost-Based Rate Review System that the Health Care Cost Review Authority (hereinafter "Authority") proposes to implement July 1, 1992. The focus of this new system will be the determination of revenues which determine the rates to be charged to nongovernmental payors.

The Authority will utilize rate application request forms, to be developed, as the primary source of information in setting prospective rates. The Authority will also utilize the audited financial statements, the Uniform Reporting System Financial Report, the Medicare Cost Report, the hospital's trial balance, and UB-82 discharge bills as additional sources of data. The audited financial statement, the Uniform Financial Report and the Medicare Cost Report will be compared to information in the rate application to determine that the data contained in the rate application is consistent in all material respects. UB-82 information will also be used to compare discharges and case mix indices. The case mix index for each hospital will be determined from DRG weights in effect during that hospital's fiscal year. Initially the DRG weights will be the Medicare weights, however, the Authority will work toward development of West Virginia specific weights for use in future years.

Initially the Authority will use fiscal years which end in the calendar years 1990 and 1991 as the base years because they are the most recent years for which the Authority has consistent data available for each hospital. The base years shall apply to hospitals with fiscal years ended June 30, 1990 and 1991; August 31, 1990 and 1991; September 30, 1990 and 1991; October 31, 1990 and 1991; and December 31, 1990 and 1991. Inflation and volume adjustments will be made to a hospital's base year to arrive at an appropriate level of costs to evaluate the reasonableness of

the hospital's budgeted rate request. The inflation factor after the initial filing will be applied to the lower of actual costs or the approved rates.

Volume changes (increases or decreases) up to the hospital's most recent fiscal year filing under the new methodology will also be taken into consideration, as well as a technology factor to be developed by the Authority. The technology factor may be based on the review hospital's case mix or its relationship to the peer group.

The base year Medicare Cost Report may be unaudited at the time it is utilized. However, adjustments to future year rates may be necessary to reflect the impact of significant differences that arise as a result of Medicare Cost Report audit adjustments. No adjustments will be made to the base year as the result of Medicare audit adjustments unless the hospital or its independent accountant are required to make such adjustments because of significant changes by the Medicare Intermediary that result in a refiling of the cost report.

Standards will be developed by the Authority which will allow for a comparison of an applicant hospital to a peer group of hospitals. The base operating expenses per discharge of the hospital requesting a rate increase will be compared to the same base operating expenses per discharge in the peer group. The

Authority shall establish standards of variance to be applied to these base operating expenses to be used to determine efficient or inefficient hospitals and to provide for incentives and penalties, where practicable.

This rule is directed at acute care hospital costs unless otherwise specified.

§65-5-5 Full Financial Requirements (FFR)

The first step in the calculation of a hospital specific rate is the identification of the full financial requirements (FFR) of each hospital in its base years. FFR can be defined as the total revenue needed from all services by a hospital to maintain financial viability. The components of FFR include, but are not limited to, total operating expenses, capital related costs (i.e., depreciation, interest expense, insurance, property taxes, leased equipment costs, etc), charity, bad debts, interest on short term loans for working capital, and a fair return on invested capital. The Authority assumes that hospitals budget for their needs, including the need for working capital.

5.1. Operating Expenses

5.1.1. Operating Expenses shall include, but not be limited to the following:

a. Non-supervisory salaries, wages and benefits; [Will remain subject to pass through pursuant to W. Va. Code §16-29B-20(d)];

b. Supervisory salaries and wages;

c. Employee benefits;

d. Consumable supplies such as, office supplies; food and dietary supplies; medical supplies, both consumable and saleable; pharmacy supplies, both consumable and saleable; laundry supplies; etc;

e. Other expenses such as, employee recruitment expense, travel expense, education expense other than medical education expense, etc;

f. Utilities, including energy, water, telephone and waste disposal.

5.1.2. Operating expenses should not include expenses associated with loans to employees, officers, physicians or other related organizations. Such expense would be interest on loans or defaulted loan principal repayment that may be made by the hospital.

5.1.3. The base operating expenses per discharge of the hospital requesting a rate increase will be compared to the same base operating expenses per discharge of hospitals in its peer group. In determining the base operating expense per discharge, the total operating expenses should not include the cost of items

enumerated below. A portion, or possibly all, of the cost of items a) through f) below must be added back to the base operating expense in order to establish the hospital's acute care charge for services that it provides.

a. Capital related costs
b. Professional compensation and fees
c. Medical liability (malpractice) insurance
d. Medical education (direct and accumulated indirect)
e. Excluded units and services
f. Other items unique to a specific hospital and as determined by the Authority

5.1.4. Other Factors Affecting Operating Expense

Hospitals may have operating units and/or special care units that cause operating expenses to be above the peer group average (e.g. obstetric unit, nursery, neonatal intensive care unit, burn unit, mobile units, medical staff office buildings, especially in hospitals in rural areas).

Based on a particular hospital's level of service and case mix the Authority may give consideration to any additional costs up to a percentage to be determined by the Authority. In no case will costs for these types of services exceed a maximum established by the Authority.

5.1.5. Nonsupervisory salaries, wages, and benefits

Although this expense shall remain subject to the pass through pursuant to W. Va. Code §16-29B-20(d), the Authority shall monitor the amount expended by the hospital for these items and compare the actual expenditure to the amount budgeted by the hospital. If the hospital expends less than the budgeted amount for nonsupervisory salaries, wages, and benefits, the Authority may make an adjustment in the hospital's revenue limits during the next rate review application process; provided that the rate application is not filed pursuant to section 7 of this rule.

5.2. Additional costs and/or expenses that make up the hospital's full financial requirements are further discussed in this rule. These expenses are initially separated from hospital operating expenses in order to place hospitals on a more comparable level. Each of the following expenses will be compared to the peer group with the overall goal of moving these costs toward the peer group average.

5.3. Capital Costs/Depreciation And Interest

A. Depreciation

The Methodology Task Force approved the use of a straight line depreciation method using estimated lives based on

the American Hospital Association's latest guidelines entitled, "Estimated Useful Lives of Depreciable Hospital Assets," which was published in 1988.

B. <u>Other Capital Costs consist of the following components</u>:

1. Leases and rentals for depreciable assets used for patient care.
2. Interest expense incurred in acquiring property, plant or equipment used in patient care, including the interest expense on debt associated with such purchases.
3. Insurance on property, plant and equipment used for patient care or insurance that provides for the continuing payment of capital related costs during interruptions in patient care.
4. Real and personal property taxes on land or other property, plant or equipment used in patient care.

C. <u>Donated Property, Plant and Equipment</u>

The donation of assets or funds to acquire property, plant and equipment is a unique situation not found in investor owned entities. Many health care entities are charitable, or tax exempt organizations. As with other charitable organizations,

donors and grantors often place terms and conditions on how their support may be used by the hospital or other health care entity. This places a fiduciary responsibility on the health care entity to comply with the specific restrictions. The American Institute of Certified Public Accountants (AICPA) recognized this unique aspect of hospital accounting in the "Hospital Audit Guide" published in 1972 and reaffirmed in the 1990 edition of "Audits of Providers of Health Care Services." The AICPA formalized the accounting principle that donated assets are to be reported on the hospital's books and records at the fair market value as of the date of the gift.

The fair market value of the gift of these donated assets would be depreciated in the same manner as other property plant and equipment.

D. <u>Capital Cost/Non-patient Related</u>

1. The amount of capital cost, as defined above, for non-patient related property and equipment such as parking garages, and other non-patient service areas such as cafeterias, snack bars, gift shops, etc. will be determined by the hospital. The hospital will have the option to use either the lower of costs or the revenue derived from these sources as a reduction of capital costs. In the event the hospital cannot determine the capital

cost related to non-patient property, plant and equipment, the revenues derived from the operation of these areas will be used as direct offsets to the capital related costs.

2. Hospitals that own and/or operate parking garages and/or cafeterias that are solely for employees' use, and for which no charge is made may be allowed to include the full cost of these areas in the total allowable cost. The hospital will be required to furnish additional information to the Authority. The additional information must be based on auditable records maintained by the hospital.

3. Hospitals that own and/or maintain office buildings, especially those occupied by physicians, will be required to furnish additional information to the Authority. It is the Authority's intent that medical staff office buildings will be self-sufficient.

E. Other

All capital related costs should be separated from the base operating expenses for peer group comparison. These costs

shall be added back after comparison to the peer group in order to determine the hospital's total costs. The Authority will review the capital related costs on a continuing basis and make changes to this methodology as necessary.

5.4. Professional Compensation And Fees

Professional compensation and fees are made up of several different components. These can include payments to physicians for their direct services to patients in the hospital or for supervisory services performed by the physicians. Fees or compensation paid to non-physician professionals, such as physical therapists and CRNAs may be in the form of salaries, or in the form of contractual arrangements. Professional fees for physicians are generally adjusted out of the hospital's reimbursable cost for Medicare because the physicians are paid from the Medicare Part B trust fund. Medicare recognizes amounts paid for supervisory services as part of hospital costs, but not all hospitals have costs related to physician supervisory services. Likewise all hospitals do not have CRNAs and physical therapists. Therefore, compensation paid to the above-referenced health care professionals whether for patient care or supervisory service should be separated from the base operating expenses for peer group comparison. Costs for compensation of these health care professionals may be added back after the peer group comparisons if the services provided by

these health care professionals were not separately billed by the hospital.

5.5. Medical Liability (Malpractice) Insurance

Medical liability insurance premiums or self insured contributions are somewhat dependent upon the services offered by a hospital and somewhat dependent on the experience of the hospital. Since it is possible that hospitals in a peer group may not all provide identical services, nor have identical medical liability claims experience, the cost of medical liability insurance or contributions to self insured plans should be separated from the base operating expenses for peer group comparison. These costs would have to be added back after comparison to the peer group in order to determine the hospital's total costs.

5.6. Medical Education

Approved medical education programs are not engaged in by all hospitals. Generally, approved education activities mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution. These programs may include the costs of interns and residents, students, nursing schools and medical education of paraprofessionals (e.g., radiologic technicians). These programs

do not include on-the-job training or activities such as patient education or general health awareness programs offered to the community at large.

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; and (2) the program is licensed by the State of West Virginia and /or accredited and approved by the Board of Trustees for the West Virginia University System or the Board of Trustees for the State College System and/or the program has been accredited by the recognized national professional organization related to the program and approved by the Authority.

Since all hospitals do not have approved medical education programs, the accumulated direct and indirect cost of such programs should be separated from the base operating expenses for peer group comparison. These costs would have to be added back after comparison to the peer group in order to determine the hospital's total costs.

5.7. Excluded Units And Services

A number of providers have distinct part units which require CON approval and provide services which are different from

the services in the acute care hospital. These distinct part units include skilled nursing facilities (SNF), psychiatric care units, substance abuse units, and rehabilitation units. The costs associated with providing care in these distinct part units may be significantly different from the costs of providing acute care inpatient hospital services to patients.

The operating expenses attributable to each of the distinct part units shall be determined through the allocation method used in the Medicare Cost Report and the Authority Uniform Reporting System. The operating expenses for each distinct part unit including the ancillary revenue department expenses shall be separated from the operating expenses for peer group comparison. The hospital and each of the distinct part units shall be allocated an appropriate part of the uncompensated care and return on equity. The revenue limits for each distinct part unit shall be based on the accumulation of costs divided by total patient days.

The Authority will accumulate the above information in a database during the initial years of the new methodology. In the meantime it is anticipated that charges for excluded units will be adequate to cover, at a minimum, the direct expenses for the distinct part units.

5.8. Taxes

A. Disproportionate Share Act

The Governor signed on April 4, 1991, H.B. 2251 [§9-4A-1 et. seq.], known as the Medicaid Uncompensated Care Fund, (hereinafter the "Fund"). This Fund was established for the purpose of receiving money from the following sources, (1) all public funds transferred by any agency to the department of health and human resources medicaid program for deposit in the fund; (2) all private funds contributed, donated or bequeathed to the fund; (3) interest which accrued on amounts in the fund; and (4) federal financial participation matching the amounts referred to in (1), (2) and (3). These funds will be used to reimburse eligible disproportionate share hospitals for services rendered to medicaid beneficiaries.

The net Medicaid Uncompensated Care Funds received, (i.e., the gross amount minus any contributions by the hospital) should be recorded on the books of the hospital in an account that results in a reduction of the Medicaid contractual allowances. This reduction of allowances should result in an increase in the hospital's total excess of revenues over expenses, which should also reduce the hospital's rate increase request for non-governmental payors. All appropriate accruals should be made to

account for disproportionate share funds (net of donations) for the hospital's fiscal year.

B. Provider Medicaid Enhancement Act

The Governor signed on November 4, 1991, H.B. 210, [§9-4B-1 et. seq;, 9-4C-1, et. seq.; 11-26-1 et. seq.] known as the Medicaid Enhancement Act (hereinafter the "Act"). This Act established a provider medicaid enhancement tax which is levied against medicaid reimbursements of health care providers. The money received from all sources are to be used to match federal medicaid funds.

All of the funds received are to be used to increase provider medicaid reimbursement through approved increased fees; increased utilization due to program growth and to cover administrative costs.

C. Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234)

The President signed into law the above-referenced Act on December 12, 1991. This Act provides that the use of donations and taxes, as described in A and B above, as a source of a state's share of Medicaid funding is currently scheduled to end no later than June 30, 1993.

D. Federal and State Income Tax

Investor owned hospitals are subject to both federal and state income taxes that are not applicable to hospitals exempt under Section 501(c)(3) of the Internal Revenue Code. The Authority recognizes this situation and in order to allow the investor owned hospital an equivalent rate of return, it will allow a return on equity, as described in Section IX, equal to a percentage that will permit a net return that approximates the return for tax exempt hospitals.

5.9. Uncompensated Care

Uncompensated Care results from a variety of situations. Below are just three broad examples of ways that uncompensated care arises:

A. Individuals who are unemployed or Medicaid recipients who have exhausted their Medicaid benefits and are thereby unable to pay for any medical services provided to them. These situations may be considered to be charity care; or

B. Individuals who are employed, but whose incomes are at or near the poverty income guideline level or individuals who are employed, have significant medical problems and have no

insurance. These individuals also may fall in the category of charity care, or;

C. Those individuals who are employed, or who have substantial means, or who are able to purchase or otherwise acquire health care coverage and who refuse or evade the payment for co-payments, deductibles or such other part of a bill which is a personal liability to the hospital. These individuals may be considered to be bad debts after all reasonable efforts have been made to collect the full amount due the hospital.

Uncompensated care (i.e., charity and bad debts) resulting from either Medicare or Medicaid are generally handled as follows:

D. The Medicare Program makes provision for bad debts related to deductibles and co-payments arising from hospital medical services provided to Medicare beneficiaries. The Medicare Program will pay for such unpaid deductibles and co-payments if the provider can demonstrate that it made bonafide efforts to collect such amounts from the recipient, therefore, the effect is that there are no bad debts or charity associated with the Medicare program.

E. The Medicaid Program is a payor of last resort and normally there is no deductible or co-payment to be paid by the

covered recipient. Therefore, upon exhaustion of benefits any amount associated with a Medicaid beneficiary that is not covered by the program should be classified as a self pay nongovernmental patient and in effect becomes a nongovernmental charity account.

F. The Authority believes that accounts receivable from all payors who are not properly classified as charity accounts should be vigorously pursued through all commercially reasonable efforts. If the hospital can demonstrate that it made bona fide efforts to collect such accounts these amounts will be considered as part of the reimbursable bad debts.

G. However, there are significant costs associated with bad debts and charity care for nongovernmental payors. The cost of treating nongovernmental patients properly classified as charity care or as bad debts is already included in the hospital's operating expenses. It is recognized that patients so classified may not pay for all of the services received by them. Therefore, it may be necessary to adjust a hospital's revenue limits to include the unpaid expenses arising from nongovernmental payors, in an amount to be paid by nongovernmental payors. The factor to be used to make such adjustment will be based on each hospital's percentage of charity care and bad debts in relation to the charges in the base years.

H. After the first year a cost to charge relationship will be determined for each hospital and new ratios for charity and bad debts will be developed.

I. The following are to be used as guidelines to define the elements of uncompensated care:

1. Charity Care/Bad Debts

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

b. Persons who meet West Virginia Department of Health and Human Services Income and Resource Guidelines, but who are not eligible for Medicaid coverage.

c.1. Persons who fall within the "U.S. Department of Health and Human Services Annual Update of the (HHS) Poverty Income Guidelines" published annually in the Federal Register and who are further impoverished as a result of an extended uninsured illness.

c.2. Persons who fall within 101% and 200% of the HHS Poverty Income Guidelines may also be considered as patients eligible for charity care. These patients should be considered on a graduated scale ranging from 99% to 0%.

d. Medicaid recipients who have exhausted the covered days allowed by the Medicaid Program.

e. The contractual allowance associated with Medicare and Medicaid covered services must not be considered as charity care or bad debt.

5.10. Contractual Allowances And Discounts

A. Contractual Allowances

Hospitals generally record revenues and the related accounts receivable in the accounting records on an accrual basis at the hospital's full established rates. But, a significant portion of the revenues are received in whole or in part from third-parties which pay according to allowable costs or a predetermined (prospective) contractual rate rather than the hospital's established rates for service.

The provision for contractual adjustments (i.e., the difference between established rates and third-party payor payments) and discounts (i.e., the difference between established rates and the amount collectible) are recognized on an accrual basis and deducted from gross patient revenue to determine net patient revenue.

The Authority recognizes that the cause of cost shifting is the failure of all payors to pay the full financial requirements of hospitals. The result of this cost shifting is contractual allowances for both governmental and nongovernmental payors. The cost shifting therefore increases the cost of acute care hospital services to nongovernmental purchasers and other third parties who are unable to contract with the hospital.

The Authority recognizes that cost shifting resulting from governmental contractual allowances is a significant problem that this agency may not be able to resolve totally. The Authority will continue to review this problem and will work to reduce the amount of cost shifting from governmental programs.

B. Discount Contracts

In accordance with W. Va. Code §16-29B-20 no contract for payment of patient care services between a purchaser and third party payor and a hospital can take effect until it is approved by the Board. The Board shall approve or deny the proposed contract within the annual rate review period. The Authority, in its review of nongovernmental discount contracts shall eliminate cost shifting as a result of these contracts during the first year of the cost based methodology.

5.11. Return On Equity

The Authority recognizes that the FFR includes a fair return on invested capital, and will develop a factor in order to determine what rate of return on invested capital is appropriate in order to provide sufficient funds for working capital and for the acquisition and/or replacement of property, plant and equipment. This factor shall be referred to as the "return on equity (ROE)". The ROE is to be added to total operating expenses in order to determine the hospital's FFR. During the first year of the cost based review system, the Authority will use a ROE factor based upon the DRI McGraw-Hill "Hospital Basket Moving Average Inflation Factor," as adjusted for efficient hospitals or inefficient hospitals, as the case may be, and certain other adjustments described hereinafter. The ROE factor, as adjusted, shall then be applied to the fund balance for tax exempt hospitals or to the stockholders' equity for investor owned hospitals in order to arrive at the hospital's FFR.

The Authority shall determine if a hospital is operating efficiently or inefficiently, and may adjust the ROE factor accordingly to promote efficiency. The Authority shall compare the total operating costs of the hospital to the median for the hospital's peer group in order to determine if a hospital is operating efficiently. The Authority shall allow efficient hospitals, which shall be defined as hospitals operating at costs

less than or equal to the peer group median, the full amount of the ROE factor, and may, at the discretion of the Authority allow an additional increase not to exceed two percent (2%) for efficient hospitals as an incentive to promote efficiency. The Authority may, in its discretion, decrease the ROE factor for inefficient hospitals by an amount to be determined by the Authority, which shall be defined as hospitals operating at a total cost in excess of the peer group median.

In addition to adjustments to the ROE factor for efficiency and inefficiency, the Authority may, in its discretion, increase the DRI McGraw-Hill "Hospital Market Basket Moving Average Inflation Factor" during the first year of the cost based rate review system for a hospital by a certain percentage to be determined by the Authority in order to arrive at an appropriate level of FFR.

The Authority, in its discretion, may increase or decrease a hospital's fund balance or stockholder's equity, as the case may be, in order to compensate for changes required by generally accepted accounting principles or for other unique and extraordinary circumstances which could not reasonably have been foreseen by the hospital.

After the first year under the cost based rate review system, the Authority may, in its discretion, amend the DRI

McGraw-Hill "Hospital Market Basket Moving Average Inflation Factor" standard or provide a substitute standard upon thirty (30) days advance notice, which notice shall be published in the State Register and the Saturday Charleston newspapers and which notice shall provide for a thirty (30) day period after publication for public comment. Hospitals receiving a final decision on rate applications during the thirty (30) day comment period may seek reconsideration of the rate decision if the amended or substituted standard would result in a substantial change to the rate previously allowed in said decision.

5.12 Outpatient Services

The cost for outpatient services will be determined through the allocation method used in the Medicare Cost Report and the Authority Uniform Reporting System. Total outpatient costs will be accumulated for patients on the appropriate rate setting form. These total costs will be used to determine the outpatient cost per visit. The Authority will continue to review outpatient charge methodologies used in other states, as well as the methodology being developed by the Medicare program to determine the applicability of these systems to West Virginia hospitals.

5.13. Peer Group

Hospitals will be placed into two major groups based on bed size. The first group consists of hospitals with one hundred (100) beds or less, and the second group consists of hospitals with more than one hundred (100) beds.

The hospitals in each category are ranked through the use of a Peer Group Index, which is computed by weighing the following factors and determining an index for each item in order to establish the rank of each factor as well as the overall rank. The adjusted days rank plus the Medicare rank plus the case mix rank are then used to calculate an overall ranking for each of the two major groups. (See Computation of Rank below).

The actual peer group used when evaluating a hospital will consist of four (4) hospitals above and four (4) below the review hospital. The hospital under review is not included with the hospitals in its "peer group" when the peer group median is determined. The peer group is a "floating" group of hospitals in that a given hospital can be involved with several different "peer groups" when the median is determined. Review hospitals with less than four (4) other hospitals below or above them in the overall ranking shall be compared to a lesser number which is between four (4) and eight (8) peer hospitals. For

example a hospital located third from the top of a category will be compared to six other hospitals, two (2) above and four below.

The method used to compute a rank (or index) for each rating factor is defined below:

1. For a given category, e.g., Adjusted Days, the average is computed by summing the values and dividing by the number of items.

2. For each item, the difference between the average and the value for that item is computed. The total of the differences is divided by the number of items to arrive at a value. The square root of that value is then computed to arrive at the standard deviation which is a measure of "distance" from the average.

3. The rank for each item is computed by dividing the standard deviation into the difference between the value for that item and the average. In this manner, each value is expressed as a positive or negative value in terms of "standard deviations" from the average.

The above calculation results in an overall ranking that is used to order the hospitals within the peer group.

5.14. Other Policy Issues

A. Projected Patient Utilization for Inpatient and Outpatient Services.

There are several recognized methods of forecasting available to hospital management and the Authority will encourage the use of these forecasting methods particularly the regression analysis method. Other suitable forecasting methods may also be accepted by the Authority.

In some circumstances, the hospital may experience greater utilization than was anticipated, which may also result in the actual revenue exceeding the projected gross patient revenue limits. If, and when, such circumstances occur and the hospital has projected volume and revenue using a suitable projection methodology applied to the hospital's historical data the Authority shall consider this fact in its review of overages.

B. New Services Which Require A Certificate of Need

The effect of the proposed project on the hospital's operating costs must be evaluated in the CON financial feasibility study. At the time the feasibility study is prepared the cost of the project will have been developed based on the best information

available at that time. However, during the time of implementation of the project circumstances may cause the actual cost to exceed the projected costs.

When such cost overruns occur and the Authority's approval has been received during the implementation of the project, the Authority shall consider the cause and include the additional expenditure as part of the hospital's total operating costs. However, when the hospital has not filed progress reports or otherwise kept the Authority informed and has not received approval from Authority for the cost overruns, the Authority may not allow the additional expenditure as part of the hospital's total operating costs.

C. New Services Which Do Not Require a Certificate of Need

1. Rate adjustments will be considered upon application to the Authority and as provided in §16-29B-21.

2. Rate adjustments will be evaluated by examining the hospital's estimated financial projections of costs, utilization and charge per unit.

§65-5-6 Procedure for Requesting a Permanent Rate Increase - Standard Application

6.1. Pre-application Conference

Prior to the filing of any rate increase application, a hospital may request a preapplication conference with the Authority's staff. The purpose of said conference is to discuss the information needed to justify the requested increase.

6.2. Standard Application

Every acute care hospital with a fiscal year which ends September 30, 1992, through the period ending August 31, 1993, must file a standard application with the Authority, as further described in this section, a minimum of forty-five (45) days prior to the beginning of its fiscal year. The purpose of this requirement is to allow the Authority to establish revenue limits for every acute care hospital under the cost-based rate review system. Only hospitals specifically and temporarily exempted from this requirement by a consent order signed by the hospital and the Authority may file a standard application at a time otherwise established by the Authority.

For subsequent fiscal years the hospital, if eligible, may file an expedited or automatic rate request. A

hospital which does not file an expedited or automatic rate application and which intends to revise any of its previously approved revenue limits must file with the Authority an application containing the information described in this subsection and be in compliance with all other requirements contained in this rule and the Act.

A hospital is not required to annually file a rate application. However, if it intends to revise any of its approved revenue limits, it must do so within the time periods and in accordance with the procedure specified herein. Furthermore, a hospital shall not file more than one rate increase application per fiscal year unless the application is filed pursuant to section 7 of this rule.

The hospital must file its application with the Authority a minimum of forty-five (45) days prior to the beginning of its fiscal year.

The application must contain:

(a) all of the information requested on forms provided by the Authority;

(b) a written report, including the information described in W. Va. Code §16-29B-21(a)(2);

(c) a proposed budget which is identical in content to the budget approved by the hospital's board. The budget must contain not only all usual information under generally accepted accounting principles for a budget, but must also contain a full and specific statement of all assumptions relied upon in preparing the budget;

(d) in the event the hospital has implemented a new service within the previous twelve (12) months, a request for an adjustment in gross patient revenue due to the implementation of a new service must be supported by a certificate of need decision, if applicable. The request must also include projected utilization, a rate schedule and an operating budget detailing the revenues and direct expenses for the new service;

(e) in the event the hospital intends to obtain approval of any discount contract pursuant to W. Va. Code §16-29B-20, the hospital shall also file with the Authority all of the information requested on forms provided by the Authority, which shall include an explanation

of the requirements set forth in W. Va. Code §16-29B-20; the hospital shall also file a summary of the basic terms of the contract; a copy of the proposed discount contract; and, any other information required by the Authority. The Authority shall approve or deny the proposed discount contract within the one hundred eighty (180) day time period for review of rate applications set forth in subsection 6.5 of this rule. All information contained in the proposed discount contract or related thereto shall be subject to public disclosure as a public record. The provisions of this rule for consideration of discount contracts in the rate review process shall supplement the provisions for retroactive review of discount contracts for certain border hospitals pursuant to W. Va. C.S.R. §65-22-1, et seq., insofar as such provisions relate to such retroactive review of discount contracts for border hospitals previously temporarily approved under C.S.R. §65-22-1, et seq., and otherwise the provisions under C.S.R. §65-22-1, et seq., regarding temporary approval of discount contracts for certain

border hospitals shall apply to the temporary approval thereof.

(f) such additional information as the hospital chooses to submit or the Authority may require.

6.3. Interim Order

If a hearing is requested on the hospital's rate application by an affected party, which affected party is not the applicant or the Authority, and the request for hearing is not later withdrawn by the affected party, the hospital may request, within fifteen (15) days of receipt of the hearing request, the Authority to establish an interim rate pending the final order of the Authority.

The interim rate will be calculated by the Authority from the information contained in the pending application. The Authority will review any overage which the hospital may have at the time of the filing of the rate application and consider the amount of the overage in determining the interim rate.

The Authority will approve or deny an interim rate for the hospital within thirty (30) days after the receipt of the request for an interim rate by the hospital.

The interim rate will remain in effect for six months from the effective date of the interim order or until the effective date of a final order, whichever first occurs. If a final order is not entered within six months from the effective date of the interim rate, the interim rate shall expire at the conclusion of the six month period and the hospital shall implement the rates which were last approved by the Authority by a final order.

The Authority may rescind the interim rate during the six month period if it finds that the hospital made material misrepresentations to the Authority; that the application and/or interim rate request is based upon inaccurate data; or that other good cause exists for such rescission.

If the Authority approves an interim rate increase for the hospital, the Authority may order the hospital to keep a detailed and accurate account of all amounts received by reason of the increase in rates and the purchasers and third-party payors from whom such amounts were received. The Authority may order the hospital to refund with interest to each affected purchaser and/or third-party payor any part of the increase in rates that may be held to be excessive or unreasonable. In the event a refund is not practicable, the hospital shall, under appropriate terms and conditions determined by the board, temporarily decrease its rates by an amount equal to the income realized from that portion of the

increase in rates which was subsequently held to be excessive or unreasonable.

If the final order subsequently entered by the Authority establishes revenue limits for the hospital which are greater than the interim revenue limits, the hospital is prohibited from increasing its rates in excess of the limits approved by the final order.

The interim rate request is discretionary with the hospital and the interim order issued by the Authority is not a final or appealable order pursuant to W. Va. Code §16-29B-13.

6.4. Review By Authority

Upon receipt of the hospital's application, the Authority's staff shall review and analyze the application and submit to the Authority proposed revenue limits for that hospital. The Authority's staff may also require a conference with the hospital and any affected parties after the application is filed. Thereafter, the Authority shall issue a final order setting the hospital's revenue limits.

6.5. Final Order

The final order shall be sent by certified mail, return receipt requested, to the hospital and all affected parties. The hospital's community shall be notified of the final order through an announcement in the local media.

The final order on any proposed change or amendment shall not be issued more than one hundred eighty (180) days from the date the application is deemed complete by the Authority. If the Authority fails to complete its review of the application within the time period specified for the review, the rate request shall be deemed to have been approved by the Authority; unless an interim order has been issued by the Authority prior to the expiration of the one hundred eighty (180) day period.

6.6. Revised Budget and Schedule of Rates

Within twenty (20) days of receipt of the final order, the hospital must file with the Authority a revised budget, and schedule of rates, each of which shall be drafted in accordance with the revenue limits set by the final order of the Authority. The schedule of rates shall indicate the date of implementation of the rates. Thereafter, the Authority shall issue a notice acknowledging receipt of the hospital's budget and schedule of rates. All revenue limits established by the final order of the

Authority must be implemented by the hospital within twenty (20) days of its receipt of the final order. The Authority may rescind the final order if the hospital fails to implement the approved rates within the twenty (20) day time period.

6.7. Notice to the Community

Contemporaneously with the filing of the application pursuant to subsection 6.2 of this rule, the hospital shall publish in a newspaper of general circulation in the county in which the hospital is located a legal advertisement setting forth the fact that the hospital is applying to the Authority for a change or amendment to its schedule of rates. The legal advertisement must state the requested amount of the rate increase or decrease based upon the hospital's current actual and current approved revenue limits per nongovernmental discharge, summarize the effect of the requested relief, and further state that any person desiring to inspect the application may do so at the hospital during the hospital's regular business hours and also at the offices of the Authority. Also, the legal advertisement must advise the public that any person or entity who claims to be an interested party in the proceedings for the changing or amending of the schedule of rates must file with the Authority a written notice setting forth the interested party's name, address and the facts relied upon to establish his or her interest. The legal advertisement must inform the public that interested parties must file this notice within

thirty (30) days of the hospital's filing of its application with the Authority or else the Authority will, except for good cause shown, reject the affected party's notice. The Authority will then send notices of all proceedings and copies of all orders to those parties deemed by the Authority to be affected parties in the matter. Proof of publication of the legal advertisement by the hospital must be submitted to the Authority within ten (10) days of the filing of its application.

§65-5-7 Temporary/Emergency Rate Applications

7.1. A hospital is eligible to obtain a temporary change in its rates if it is in the public interest and it is necessary: a) to prevent insolvency, b) to maintain accreditation, c) for emergency repairs, or d) to relieve undue financial hardship.

To qualify for a temporary change in its rates, a hospital shall submit an application to the Authority which addresses the above described criteria, describes in detail the facts which support the temporary rate change, the amount of increase in rates required to alleviate its situation, and shall summarize the overall effect of the rate increase. The claim shall be verified by the chairman of the hospital's governing body ~~and~~ <u>or</u> by the chief executive officer of the hospital.

7.2. Immediate effectiveness of application.

Upon receipt by the Authority of the application for a temporary rate change, the rate change shall be effective, at the hospital's discretion, immediately and until such time as the Authority may inform the hospital that the temporary rate change is to be modified to a stated amount or is denied. The hospital is required to keep a detailed and accurate account of all amounts received by reason of the temporary rate increase and the purchasers and third-party payors from whom such amounts were received.

If the rate increase is modified so that the hospital is granted only a partial increase in its rate schedule the hospital may charge at the rate approved by the Authority without resubmitting a request. The Authority's decision may be treated as a final order and an appeal or reconsideration may be requested by the hospital or an affected party pursuant to sections 16 and 17 of this rule. The order shall be issued by certified mail, return receipt requested, to the hospital. The final order shall set final revenue limits and shall specify the effective date of any proposed changes.

The final order on any proposed change or amendment shall not be issued more than one hundred eighty (180) days from the date of filing of the application with the Authority. If the

Authority fails to complete its review of the proposed change within the time period specified for the review, the proposed change shall be deemed to have been approved by the Authority.

7.3. Preferential review of application.

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

7.4. Full review of application.

All claims for a temporary change in a hospital's schedule of rates shall be subject to full review by the Authority in accordance with the requirements contained in section 6 *et seq*. of this rule; except that, the hospital shall cause the required legal advertisement to be published within seven (7) days of filing of the application for a temporary rate change. The hospital shall submit the information normally contained in a standard application within thirty (30) days of the request for a temporary rate increase.

7.5. Following its review of the requested increase, the Authority may allow the temporary rate increase to become permanent, deny any increase, allow a lesser increase, or allow a greater increase. In the event the Authority desires to deny or reduce the increase, the Authority may choose to either order a refund to the purchasers and/or third-party payors or a temporary rate decrease so as to compensate the hospital's patients and community for the disallowed increase while it was in place.

65-5-8 Automatic Rate Increase Applications

Any hospital which is licensed for one hundred (100) beds or less and is not located in a standard metropolitan statistical area which intends to revise any of its previously approved revenue limits in an amount equal to or less than the inflation factor approved by the Authority shall do so in accordance with this rule, provided that the hospital has previously implemented revenue limits approved by the Authority pursuant to the cost based rate review system and as required by section 6 of this rule.

8.1. Application - The hospital shall file an application with the Authority at least ten (10) days prior to the beginning of its fiscal year on forms to be provided by the Authority. The hospital shall submit with its application a copy of its current license issued pursuant to West Virginia Code §16-5B-1 et seq. The

hospital shall also submit with its application a copy of the budget approved by the hospital's board for the fiscal year affected by the increase. The budget must contain all usual information under generally accepted accounting principles for a budget and a full and specific statement of all assumptions relied upon in preparing the budget. In the event the hospital intends to obtain approval of any discount contract pursuant to W. Va. Code §16-29B-20, the hospital shall also file with the Authority all of the information requested on forms provided by the Authority, which shall include an explanation of the requirements set forth in W. Va. Code §16-29B-20; the hospital shall also file a summary of the basic terms of the contract; a copy of the proposed discount contract; and, any other information required by the Authority. All information contained in the proposed discount contract or related thereto shall be subject to public disclosure as a public record. The provisions of this rule for consideration of discount contracts in the rate review process shall supplement the provisions for retroactive review of discount contracts for certain border hospitals pursuant to C.S.R. §65-22-1, et seq., insofar as such provisions relate to such retroactive review of discount contracts for border hospitals previously temporarily approved under C.S.R. §65-22-1, et seq., and otherwise the provisions under C.S.R. §65-22-1, et seq., regarding temporary approval of discount contracts for certain border hospitals shall apply to the temporary approval thereof. The application shall include a certification by the chief executive officer and the chairman of the board of the

hospital that the information contained therein is true and accurate.

8.2. The hospital must notify the Authority at least ten (10) days prior to instituting the rate increase.

8.3. Unless a hearing is held pursuant to section 15 of this rule, the Authority shall issue a final order approving or disapproving the increase put into effect by the hospital within thirty (30) days of receipt of the application. The hospital is not prohibited from implementing the rate increase during this thirty (30) day period. The Authority's evaluation will establish that the increases in a) gross inpatient revenue per day, b) gross inpatient revenue per discharge, c) gross inpatient acute care revenue, d) outpatient revenue per visit, and e) gross outpatient revenue are equal to or less than the approved inflation factor. The determination shall be made upon the facts presented by the hospital and the records on file with the Authority. The decision shall be treated as a final order.

8.4. Within twenty (20) days of receipt of the final order, the hospital must file with the Authority a schedule of rates, each of which shall be drafted in accordance with the revenue limits set by the final order of the Authority. The schedule of rates shall indicate the date of implementation of the

rates. Thereafter, the Authority shall issue a notice acknowledging receipt of the schedule of rates.

8.5. If the Authority subsequently determines that the increase put into effect by the hospital actually exceeded the rates approved by the Authority, for whatever reason, the Authority may institute a review and investigation of the hospital's rates and budget and take such action as it deems necessary to establish a new rate schedule and also direct a refund to the hospital's patients or a temporary decrease in the hospital's rates. The decision resulting from any such review and investigation may be treated as a final order.

8.6. If the hospital experiences less inpatient or outpatient utilization for the twelve (12) months following the increase than it had anticipated when the automatic rate of inflation increase was obtained, the hospital's average rate per discharge or the outpatient revenue per visit shall not later be increased to compensate for the decline in revenue without permission of the Authority.

8.7. If the hospital actually experiences revenues for non-governmental payors in excess of the limits allowed, then the hospital is notified that it is subject to all of the penalties provided for in the Act and this rule.

8.8. The Authority will continue to monitor the hospital's compliance with the Authority's prior orders. Should such monitoring reveal that the hospital exceeded its prior approved revenue limits, then the Authority will take corrective action against the hospital as a result of that excess and will also take corrective action against the rates being charged by the hospital after any automatic rate of inflation increase.

8.9. A hospital shall not file more than one rate increase application per fiscal year unless the application is filed pursuant to section 7 of this rule.

§65-5-9 Expedited Review

Any hospital which is licensed for more than one hundred (100) beds or that is located in a Standard Metropolitan Statistical Area which intends to revise any of its previously approved revenue limits in an amount equal to or less than the inflation factor approved by the Authority may do so in accordance with this rule if the hospital has previously implemented revenue limits approved by the Authority pursuant to the cost based rate system.

9.1. The hospital shall file an application with the Authority at least forty-five (45) days prior to the beginning of its fiscal year on forms to be provided by the Authority. The

hospital shall submit with its application a copy of its current license issued pursuant to West Virginia Code §16-5B-1 et seq. The hospital shall also submit with its application a copy of the budget approved by the hospital's board for the fiscal year affected by the increase. The budget must contain all usual information under generally accepted accounting principles for a budget and a full and specific statement of all assumptions relied upon in preparing the budget. In the event the hospital intends to obtain approval of any discount contract pursuant to W. Va. Code §16-29B-20, the hospital shall also file with the Authority all of the information requested on forms provided by the Authority, which shall include an explanation of the requirements set forth in W. Va. Code §16-29B-20; the hospital shall also file a summary of the basic terms of the contract a copy of the proposed discount contract; and, any other information required by the Authority. The Authority shall approve or deny the proposed discount contract within the one hundred eighty (180) day time period for review of rate applications set forth in subsection 6.5 of this rule. All information contained in the proposed discount contract or related thereto shall be subject to public disclosure as a public record. The provisions of this rule for consideration of discount contracts in the rate review process shall supplement the provisions for retroactive review of discount contracts for certain border hospitals pursuant to C.S.R. §65-22-1, et seq., insofar as such provisions relate to such retroactive review of discount contracts for border hospitals previously temporarily approved under C.S.R.

§65-22-1, *et seq.*, and otherwise the provisions under C.S.R. §65-22-1, *et seq.*, regarding temporary approval of discount contracts for certain border hospitals shall apply to the temporary approval thereof. The application shall include a certification by the chief executive officer and the chairman of the board of the hospital that the information contained therein is true and accurate.

9.2. Eligibility standards - Upon receipt of the application, license and budget, the Authority shall determine: (1) if the hospital, in its current fiscal year, has provided charity care equal to or greater than the most recent state average as published by the Authority. Charity care shall be determined in accordance with the guidelines contained in this rule and shall not include bad debt; and (2) if the hospital is in compliance with its approved revenue limits in all of these categories: (a) gross inpatient revenue per day, (b) gross inpatient revenue per discharge, (c) gross inpatient acute care revenue, (d) outpatient revenue per visit, (e) gross outpatient revenue; and (f) individual revenue limits for distinct part units.

If the Authority determines the hospital has met these requirements the hospital is eligible to request an expedited rate increase pursuant to this section. If the hospital fails to meet these requirements, the hospital shall not request a rate increase pursuant to this section.

9.3. Review by the Authority - Unless a hearing is held pursuant to section 15 of this rule, the Authority shall issue an order approving or disapproving the increase requested by the hospital within forty-five (45) days of receipt of the hospital's complete application, license and budget. This forty-five (45) day period shall not begin until the Authority receives from the hospital all the information required pursuant to this rule for a complete application including the license and budget. Within twenty (20) days of receipt by the hospital of this order, the hospital shall file with the Authority a schedule of rates, which shall be drafted in accordance with the revenue limits set by the Authority. The schedule of rates shall indicate the date of implementation of the rates. Thereafter, the Authority shall issue a notice acknowledging receipt of the schedule of rates.

9.4. Notice to the community - Contemporaneously with the filing of the application, license and budget pursuant to section 9.1 of this rule, the hospital shall also cause to be published in a newspaper of general circulation in the county in which the hospital is located a legal advertisement setting forth the fact that the hospital is applying to the board for a change or amendment to its schedule of rates. The legal advertisement must state the requested amount of the rate increase based upon the hospital's current actual and current approved revenue limits, summarize the effect of the requested relief and further state that any person desiring to inspect the application and budget may do so

at the hospital during the hospital's regular business hours and also at the offices of the board. Also, the legal advertisement shall advise the public that any person or entity who claims to be an interested party in the proceedings for the changing or amending of the schedule of rates must file with the Authority a written notice setting forth the interested party's name, address and the facts relied upon to establish his or her interest. The legal advertisement must inform the public that interested parties must file this notice within ten (10) days of the hospital's filing of its application with the Authority or else the Authority will, except for good cause shown, deny the interested party's notice. The Authority will then send notices of all proceedings and copies of all orders to those parties deemed to be affected parties in the matter. Proof of publication of the legal advertisement by the hospital must be submitted to the Authority within ten (10) days of the filing of its application, license and budget.

9.5. If the Authority determines after a final order is issued that the increase requested by the hospital actually exceeded the inflation factor approved by the Authority for whatever reason, the Authority may institute a review and investigation of the hospital's rates and budget and take such action as it deems necessary to establish a new rate schedule and also direct a refund to the hospital's patients or a temporary decrease in the hospital's rates if necessary. The decision resulting from any such review and investigation may be treated as

a final order and an appeal or reconsideration may be requested by the hospital or an affected party pursuant to sections 16 and 17 of this rule.

9.6. If the hospital experiences less inpatient or outpatient utilization for the twelve (12) months following the increase than it had anticipated when the expedited rate of inflation increase was obtained, the hospital's average rate per discharge or the outpatient revenue per visit shall not later be increased to compensate for the decline in revenue without permission of the Authority.

9.7. A hospital shall not file more than one rate increase application per fiscal year unless the application is filed pursuant to section 7 of this rule.

§65-5-10 Overages

10.1. Patient Revenue Limits:

The Authority establishes several limits during the rate setting process. The limits currently established are listed below. These categories are subject to change by amendment to this rule when refinements are made to the cost-based rate review system.

10.1.1. Acute Care Hospital

a. Gross inpatient revenue per day

b. Gross inpatient revenue per discharge

c. Gross inpatient acute care revenue

d. Outpatient revenue per visit

e. Gross outpatient revenue

10.1.2. Distinct Part Units

a. Inpatient psychiatric care revenue per day

b. Gross inpatient psychiatric care revenue

c. Inpatient chemical dependency care revenue per day

d. Gross inpatient chemical dependency care revenue

e. Inpatient skilled nursing facility care revenue per day

f. Gross inpatient skilled nursing facility revenue

g. Inpatient rehabilitation care revenue per day

h. Gross inpatient rehabilitation care revenue

10.2. Hospital Responsibility

A hospital is expected to monitor each of the above limits that apply to its own specific circumstances. The hospital shall take action to adjust its schedule of rates so that the end effect of such adjustment is to be in compliance with its most

recently approved revenue limits established in subsection 10.1.1 prior to the end of its fiscal year.

10.3. Justification For Overages

10.3.1. Case Mix

Each DRG has a specific weight that represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in other DRGs. All of the DRG weights are summed then divided by the total number of discharges to determine the average case weight (mix). This process is used to determine the case mix for the Medicare, Medicaid, PEIA and non-governmental patient payor categories. The case mix index is a summary statistic representing the relative cost of each hospital's mix of patients compared to other hospitals in West Virginia.

The percentage change in case mix is generally an increase from one year to the next but in certain circumstances could decrease. The percentage increase in case mix is recognized as an appropriate justification for an overage.

10.3.2. Outliers

Some hospital stays are significantly above or below the average in length and in cost. To the extent that the number of outlier stays exceed the number of outlier stays included in each hospital's 1990 and 1991 years regarding either the length or the costs of such outlier stays, the Authority will allow that portion of outliers represented by the excess over the 1990 and 1991 years in the calculation of overage justifications. For purposes of this subsection, an outlier constitutes charges in excess of $44,000 for the fiscal year ending in 1992 or stays in excess of 30 days. In successive years, this comparison shall be made to the two preceding fiscal years. The $44,000 limit shall be increased each year by the average percentage increase per discharge approved by the Authority.

10.3.3. New Services

New services which do not require a certificate of need and which were initiated by the hospital during the fiscal year in which the overage occurs may constitute a justification for an overage. The hospital must be in compliance with section 13 of this rule and the service shall not have been offered previously by the hospital.

10.3.4. Other

Certain events which could not reasonably have been foreseen by the hospital and/or extraordinary circumstances which are unique to an individual hospital may, in the discretion of the Authority, be considered a justification for an overage.

10.5. Effective Date

The justifications for an overage described in subsections 10.3.1, 10.3.2, and 10.3.3 shall be applicable to the first complete fiscal year, and every year thereafter, for which revenue limits were established pursuant to this rule. For example, hospitals with fiscal years ending September 30 may first use the justifications described in this section for overages which occur in fiscal year 1993; hospitals with fiscal years ending June 30 may first use the justifications described in this section for overages which occur in fiscal year 1994. These justifications shall not be valid for any overages which occur prior to the time periods described herein.

§65-5-11 Penalties For Overages

Unjustified overages are subject to penalties which may be imposed by the Authority. The penalty, in the discretion of

the Authority, may be a direct payment or rebate to third-party payors and/or purchasers or it may be a reduction in the hospital's future rates. Generally, penalties shall be in effect during the hospital's next fiscal year or for a period of twelve months unless the overage is such that a longer time period is required.

§65-5-12 Cost Base Adjustments

The Authority recognizes that costs continue to increase due to salary increases and increases in the cost of items the hospitals must purchase. It is inherent in this rule that actual costs and costs projected on the inflation factor will grow wider over time. Therefore, the Authority will rebase the costs periodically as necessity requires.

§65-5-13 New Service

The hospital must apply to the Authority for approval of a rate schedule for a new service. Announcement of the approved rate schedule must be made by the hospital to the local media in the geographic location of the hospital. The publication must state that approved rates will go into effect in thirty (30) days. Affected parties may contest the proposed rate by written notice to the Authority within two (2) weeks from the date of publication.

§65-5-14 Request for Hearing

The hospital or an interested party may request a public hearing to be held on an application. A request for a public hearing must be received by the Authority within thirty (30) days of the receipt by the Authority of the application or the publication of the legal advertisement as required by subsections 6.7 or 9.4 whichever is later. The Authority, if it considers necessary, may hold a public hearing on any application. Such hearing shall be held no later than forty-five days after receipt of the application unless good cause is shown to hold the hearing at a later date.

§65-5-15 Hearings

The hearing shall be conducted pursuant to the provisions of W. Va. Code §16-29B-12. The Authority may appoint a hearing examiner to conduct the hearing. The Authority or the hearing examiner may schedule and require attendance at a prehearing conference. The purposes of the prehearing conference shall be similar to the purposes of Rule 16, West Virginia Rules of Civil Procedure. Affected parties will be designated by the Authority at the prehearing conference unless good cause is shown by the party for the Authority to designate affected party status at the hearing.

§65-5-16 Reconsideration

If a hospital or affected party wants the Authority to reconsider a final order, it shall file its request in writing and shall detail the reasons for the request for reconsideration. The Authority shall consider the following as reasons to grant a request for reconsideration: a) a presentation of significant, relevant information not previously considered by the Authority, and a demonstration that with reasonable diligence the information could not have been presented before the Authority issued its final order; b) a demonstration that there have been significant changes in factors or circumstances relied upon by the Authority in issuing its final order; c) a demonstration that the Authority has materially failed to follow its adopted procedures in issuing its final order; or d) such other bases as the Authority determines constitutes good cause. Provided that, the Authority will not grant a request for reconsideration based upon an insignificant or immaterial difference between the projected data in the hospital's application and its actual data. A request for reconsideration must be filed within thirty (30) days of the receipt of the final order by the requesting party. The Authority shall respond to the request for reconsideration in writing and shall state its reasons for granting or denying the request. The Authority is not required to hold a public hearing in every reconsideration proceeding. Instead, if the Authority determines that the issues do not involve a factual dispute or otherwise do not require the taking of further

evidence upon the record, the Authority may issue its reconsideration decision without conducting a public hearing. In the event the Authority grants a reconsideration request but determines that a public hearing is not required, the Authority may enter additional evidence into the record by stipulation by the applicant and all affected parties. The one hundred eighty (180) day review period described in subsection 6.5 of this rule is not applicable to reconsideration proceedings.

§65-5-17 Appeals

A final decision of the Authority shall be reviewed by the state agency designated by the governor to hear appeals pursuant to W. Va. Code §16-2D-1 et seq. To be effective, the request for review must be received within thirty (30) days of the date upon which all parties received notice of the Authority's decision.

§65-5-18 Rates During Reconsideration Proceedings and Appeals

If the Authority modifies the request of a hospital for a change in its rates so that the hospital obtains only a partial increase in its rate schedule, the hospital shall have the right to accept the benefits of the partial increase in rates and charge its purchasers and third-party payors accordingly without in any way adversely affecting or waiving its right to contest or

appeal that portion of the final order of the Authority which denied the remainder of the requested rate increase. Similarly, if an affected party contests or appeals the final order of the Authority, the hospital may charge its purchasers in accordance with the Authority's final order until the final order is subsequently modified.

§65-5-19 Denial of an Application

The Authority may deny any application submitted by a hospital pursuant to this rule if the application:

a) fails to pass the mathematical edit;

b) is materially inconsistent, inaccurate, or contains unreliable data;

c) is materially inconsistent with other financial data required to be filed by the hospital with the Authority pursuant to 65 C.S.R. 13, "The Financial Disclosure Rule";

d) is not submitted at least forty five (45) days prior to the beginning of the hospital's fiscal year;

e) contains material misrepresentations made by the hospital to the Authority; or

f) may otherwise be denied for good cause as determined by the Authority.

If the Authority denies an application, it may, in its discretion, require the hospital to submit a new application within a specified time period.

§65-5-20 Compliance Reports and Orders

Every hospital is required to file with the Authority a compliance report within thirty days after the end of each quarter of the hospital's fiscal year. The information requested for the compliance report will be provided by the hospital on forms to be provided by the Authority. If the hospital fails to file the compliance report within thirty days after the end of each quarter, the Authority may deny a request for a rate increase.

If the fourth quarter compliance report indicates the hospital has exceeded its approved revenue limits and does not provide a justification which is accepted by the Authority, the Authority may order the hospital to immediately reduce its rates by the amount of the overage.

§65-5-21 Reasonableness and Uniformity of Rates

Hospital rates shall be reasonably related to the cost of the services provided and uniformly applied to all patients whether inpatient or outpatient.

§65-5-22 Approval of Discount Contracts

22.1 Pursuant to W. Va. Code §16-29D-20, no contract for the payment of patient care services between a purchaser or third-party payor and a hospital which establishes discounts to the purchaser or third-party payor shall take effect until it is approved by the board. To obtain approval by the board, a hospital must file with the Authority an executed copy of the proposed contract with its rate application at least forty-five (45) days prior to the beginning of its fiscal year and as further described in subsection 6.2 of this rule.

22.2 Discount contracts may be filed with the Authority for temporary approval subject to retroactive review outside of the time period described in subsection 22.1 of this rule only under the following conditions:

(a) The hospital is a border hospital that meets the criteria and follows the procedure in legislative rule, "Temporary

Approval of Discount Contracts for Border Hospitals," W. Va. C.S.R. §65-22-1 et seq., or

(b) (1) The hospital has negotiated a discount contract with a new entity and said negotiations could not have been completed and the executed contract filed with the Authority within the time frame specified in subsection 6.2 of this rule. For purposes of this subsection "new entity" is defined as a purchaser or third-party payor which has not previously executed a contract for the payment of patient care services with the hospital. Temporary approval is not available for a contract with a third-party payor or purchaser which has previously executed or is currently a party to a contract for the payment of patient care services with the hospital.

(2) In order for a hospital to obtain temporary approval of a discount contract the hospital shall file a verified notice with the Authority, which shall be filed at least five (5) days in advance of the date upon which the proposed discount contract is to be considered temporarily approved and shall:

(A) Identify the hospital.

(B) State affirmatively that the discount contract is with a new entity as defined in subsection 22.2 (b) (1) of this rule and identify the new entity.

(C) State affirmatively that the hospital would be at risk to lose a significant portion of patients to other hospitals if the discount contract is not temporarily approved.

(D) Identify the other hospital or hospitals.

(E) State affirmatively the facts and circumstances which prevented the hospital and new entity from executing a contract and submitting it with the hospital's rate application.

(F) State affirmatively that the discount shall not decrease the charges for the services below the actual cost to the hospital.

(G) State affirmatively that the cost of the discount shall not be shifted to any other purchaser or third-party payor.

(H) State affirmatively that the discount shall not result in a decrease in the hospital's proportion of medicare, medicaid, or uncompensated care patients.

(I) State affirmatively that the discount is based on criteria which constitute a quantifiable economic benefit of the hospital.

(J) Include a copy of the discount contract.

(K) Present such other and further information or documents as may be requested by the Authority.

(3) (A) Following receipt of a verified notice complying with the requirements of this subsection, the Authority shall for the purpose of retroactive review determine within fifteen (15) days thereafter whether or not the verified notice is complete. If the verified notice is not determined complete, the Authority may request additional information from the hospital. Upon receipt of the additional information from the hospital, the Authority again has fifteen (15) days within which to determine whether or not the verified notice is complete.

(B) Upon determining that the verified notice is complete, the Authority shall publish a notice of the determination of completeness and/or temporary approval of the discount contract, as may be appropriate, in the Saturday Charleston newspapers and the State Register and shall retroactively review the proposed discount contract with the hospital's next succeeding rate application in order to determine whether the discount contract meets all of the requirements for final approval set forth in W. Va. Code 16-29B-20.

(C) Upon obtaining temporary approval of any proposed discount contract, the contract is further subject to retroactive review by the Authority in accordance with the criteria set forth in W. Va. Code §16-29B-20 and the rate review procedures set forth in W. Va. Code §16-29B-21.

(D) The effective date of any temporary approval is the date which is five (5) days from the date of filing of a verified notice meeting the requirements of subsection 22.2 (b) (2) of this rule or the date the Authority determines the verified notice is complete, whichever first occurs.

(E) In the event that the Authority determines that the discount contract does not meet all of the requirements for temporary approval set forth in this subsection, subsequent to a temporary approval of the contract, the Authority may issue an order denying and revoking the temporary approval of the discount contract at any time after such temporary approval. The order is effective as of a date established by the Authority in the order. The effective date shall not be less than ten (10) days from the date of the order and which effective date may exceed ten (10) days from the date of said order in the discretion of the Authority upon good cause shown for the extension.

(F) In the event that the Authority determines during retroactive review in accordance with this section that the

discount contract meets the standards for final approval of discount contracts set forth in W. Va. Code §16-29B-20, the Authority shall issue a final order approving the discount contract in accordance with the procedures for rate review set forth in W. Va. Code §16-29B-21.

(G) In the event that the Authority determines that the discount contract does not meet the standards for final approval of discount contracts set forth in W. Va. Code §16-29B-20, the Authority shall issue a final order denying approval of the discount contract and rescinding the previous temporary approval in accordance with the procedures for rate review set forth in W. Va. Code §16-29B-21.

§65-5-2~~2~~ 3 Failure to Comply with Rules

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

§65-5-2~~3~~ 4 Health Care Facility Financial Disclosure Act

Before any application for a rate increase will be accepted for review, the hospital must be in compliance with the Health Care Facility Financial Disclosure Act, West Virginia Code, §16-5F-1 et seq. Failure to be in such compliance shall cause the Authority to refuse to accept the application or request and to reject it.

§65-5-2~~4~~ 5 Additional Information

If the Authority requires additional information from a hospital or an interested party, then, in the discretion of the Authority, the various time limits imposed by this rule shall be tolled until the requested information is received by the Authority and the Authority determines the response is sufficient.

§65-5-2~~5~~ 6 Time Periods

2~~5~~6 .1. In each instance in this rule where a time period is stated, the period is intended to be a maximum period. In the event a given task is completed sooner than the stated period by the Authority, a hospital or an interested party, then the next time period, if any, shall commence upon the actual completion date.

2~~5~~6 .2. Calculation of time periods. Whenever in this rule the date by which some action is directed to be taken or accomplished would fall on a Saturday, Sunday or a state holiday, then the time for taking or accomplishing the action shall be extended to the next day which is not a Saturday, Sunday or a state holiday.

§65-5-2~~6~~7 Decisions and Records Available

Decisions and records of the Authority may be inspected in accordance with W. Va. Code §29B-1-3, and may be copied at a charge of twenty-five cents ($.25) per page.

§65-5-2~~7~~8 Severability

If any provisions of this rule or the application thereof to any persons 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 provisions or application and to this end the provisions of this rule are declared to be severable.

KEN HECHLER
Secretary of State

MARY P. RATLIFF
Deputy Secretary of State

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(Plus all the volunteer help we can get)

FAX: (304) 558-0900

TO: Marianne Stonestreet

AGENCY: Health Care Cost Review Auth.

FROM: JUDY COOPER, DIRECTOR, ADMINISTRATIVE LAW DIVISION

DATE: June 11, 1993

THE ATTACHED RULE FILED BY YOUR AGENCY HAS BEEN ENTERED INTO OUR COMPUTER SYSTEM. PLEASE REVIEW, PROOF AND RETURN IT WITH ANY CORRECTIONS. IF THERE ARE NO CORRECTIONS, PLEASE SIGN THIS MEMO AND RETURN IT TO THIS OFFICE. YOU WILL BE SENT A FINAL VERSION OF THE RULE FOR YOUR RECORDS.

PLEASE RETURN EITHER THE CORRECTED RULE OR THIS FORM WITHIN TEN (10) WORKING DAYS OF THE DATE YOU RECEIVED THIS REQUEST. CALL IF YOU HAVE ANY QUESTIONS.

SERIES: 5 TITLE: 65 Health Care Cost Review Auth.

* THE ATTACHED RULE HAS BEEN REVIEWED AND IS CORRECT.

SIGNED: ______________________________

TITLE OF PERSON SIGNING: ______________________________

DATE: ______________________________

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* THE ATTACHED RULE HAS BEEN REVIEWED AND NEEDS CORRECTING. THE CORRECTIONS HAVE BEEN MARKED.

SIGNED: ______________________________

TITLE OF PERSON SIGNING: ______________________________

DATE: ______________________________

NOTE: IF YOU ARE NOT THE PERSON WHO HANDLES THIS RULE, PLEASE FORWARD TO THE CORRECT PERSON.