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

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FILED
1988 JUN 28 AM 11: 30
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: 16-5F; 16-29B

CITE AUTHORITY: W. Va. Code, § 16-29B-8, -17, -18 & -23, and § 16-5F-3(a)

RULE TYPE: PROCEDURAL ______ INTERPRETIVE X

EXEMPT LEGISLATIVE RULE ______
CITE STATUTE(s) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW

______

AMENDMENT TO AN EXISTING RULE: YES___, NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: ______

TITLE OF RULE BEING AMENDED: ______

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

TITLE OF RULE BEING ADOPTED: Coverage of Financial Disclosure Acts And Utilization Review Requirements (Please note change in title)

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS July 28, 1988

WALTER J. DALE
Chairman

B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Coverage of Financial Disclosure Acts and Utilization Review

FILED 1988 JUN 28 SECRETARY OF STATE

Type of Rule: ____ Legislative __X__ Interpretive ____ Procedural

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

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

2. Explanation of above estimates:

All of the regulatory programs affected by this rule are already in place. No new programs are implemented by these rules.

3. Objectives of these rules: To express the agency's opinion that psychiatric hospitals are within the programs implementing the Health Care Facility Financial Disclosure Act, W. Va. Code, § 16-5F-1 et seq., and the Health Care Cost Review Authority Act, W. Va. Code, § 16-29B-1 et seq. Rehabilitation hospitals are also stated to be within the terms of the Health Care Facility Financial Disclosure Act, W. Va. Code, § 16-5F-1 et seq.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

As to additional cost, there should no be any. Inclusion of these hospitals under the Health Care Cost Review Authority Act will generate more revenue for the Authority's operations.

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

None for political subdivision and groups of citizens. There will be costs imposed upon the hospitals including up to one-tenth of one percent (0.1%) of its gross revenue. Most of the documents to be filed by the hospitals are copies of documents the hospitals already have to prepare for other purposes. Of the documents prepared specifically for these Acts the average cost should be $2,500.00.

C. Economic Impact on Citizens/Public at Large.

None.

Date: June 28, 1988

Signature of Agency Head or Authorized Representative

WALTER J. DALE
Chairman

Arch A. Moore, Jr.
Governor

STATE OF WEST VIRGINIA
HEALTH CARE COST REVIEW AUTHORITY

Walter J. Dale
Chairman

Board Members
Larry C. Fizer
Don M. Keesling

June 27, 1988

Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, WV 25305

FILED
1988 JUN 28 AM 11:30
SECRETARY OF STATE

Dear Mr. Hechler:

Re: Interpretive Rule: Coverage Of Financial Disclosure Acts And Utilization Review Requirements

Enclosed herewith for filing in the usual manner, please find the following documents related to the promulgation of the above-titled rule:

(1) Original and one copy of the agency approved rule;

(2) Original and one copy of the Fiscal Note;

(3) Original and one copy of the notice of agency adoption;

(4) Two copies of the attendance sheet for the public hearing held on June 13, 1988;

(5) Two copies of the comments received including a transcript of the hearing;

(6) Two copies of the rule showing deletions as strike throughs and additions with underlining;

(7) Two copies of a memorandum discussing the reasons for the changes; and

(8) Original and one copy of the Promulgation History Abstract.

With much appreciation for your assistance in this matter, I remain

Very truly yours,

John H. Kozak

JOHN H. KOZAK
General Counsel

JHK/jmh

Enclosures

100 Dee Drive Charleston, West Virginia 25311 Telephone: (304) 343-3701

<u>Promulgation History Abstract</u>

Rule Title: Coverage Of Financial Disclosure Acts and
Utilization Review Requirements

Rule Type: Interpretive

Filed Notice for Public Hearing: May 9, 1988

Public Hearing Held: June 13, 1988

Final Rule Filed with Secretary of State: June 28, 1988

Effective Date: July 28, 1988

WALTER J. DALE
Chairman

Entered

FILED
1988 JUN 28 AM 11:30
SECRETARY OF STATE

WEST VIRGINIA INTERPRETIVE RULE
HEALTH CARE COST REVIEW AUTHORITY
CHAPTERS 16-5F and 16-29B

SERIES XII

Title: COVERAGE OF FINANCIAL DISCLOSURE ACTS AND UTILIZATION REVIEW REQUIREMENTS

Section 1. General

2. Definitions

3. Introduction

4. Utilization Review and Quality Assurance

5. Annual Financial Reporting System

6. Health Care Facility Financial Disclosure

7. Rate Review Act

8. Discrete Part Units

WEST VIRGINIA INTERPRETIVE RULE
HEALTH CARE COST REVIEW AUTHORITY
CHAPTERS 16-5F and 16-29B

SERIES XII

FILED
1988 JUN 28 AM 11:30
SECRETARY OF STATE

Title: COVERAGE OF FINANCIAL DISCLOSURE ACTS AND UTILIZATION REVIEW REQUIREMENTS

Section 1. General

1.1 Scope - This interpretive rule is intended to provide guidance to certain free-standing, speciality hospitals that, in the agency's opinion, are subject either to the requirements of the Health Care Facility Financial Disclosure Act, W. Va. Code, § 16-5F-1 et seq., or of the West Virginia Health Care Cost Review Authority Act, W. Va. Code, § 16-29B-1 et seq., or both. Pursuant to W. Va. Code, § 16-29B-10, and § 16-29B-16(a), both of those Acts are administered by the board of the Health Care Cost Review Authority, W. Va. Code, § 16-29B-5.

1.2. Authority - W. Va. Code, § 16-29B-8, -17, -18, & -23, and § 16-5F-3(a).

1.3. Filing Date - June 28, 1988.

1.4. Effective Date - July 28, 1988.

Section 2. Definitions.

2.1 The term "Authority" refers to the agency known as the West Virginia Health Care Cost Review Authority created by W. Va. Code, § 16-29B-5.

2.2 The term "board" refers to the three-member board which is charged with carrying out the duties imposed upon the Authority. W. Va. Code, § 16-29B-5(a).

2.3. The term "free-standing" as applied to a hospital or other inpatient facility means a physical structure which is physically independent from other inpatient facilities or an inpatient facility which is administered and managed separately from other inpatient facilities, or both.

2.4. The term "psychiatric hospital" means an acute-care institution which primarily provides to inpatients, by or under the supervision of a physician, specialized services for the diagnosis, treatment and rehabilitation of mentally ill and emotionally disturbed persons.

2.5. The term "rehabilitation hospital" means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

Section 3. Introduction.

The board administers several different statutory programs. Two of those programs are involved in this interpretive rule. First, the West Virginia Health Care Cost Review Authority Act, W. Va. Code, § 16-29B-1 et seq., provides for a uniform system of accounts and financial reporting (section 17), for an annual financial reporting (section 18), and for a utilization review and quality assurance program (section 23). Second, the West Virginia Health Care Facility Financial Disclosure Act, § 16-5F-1 et seq., requires the annual publication and filing of certain financial reports as well as permitting the board to develop other requirements. The purpose of this interpretive rule is to express the board's interpretation of these provisions regarding free-standing acute-care psychiatric hospitals and free-standing rehabilitation hospitals.

Section 4. Utilization Review and Quality Assurance

By a legislative rule titled "Legislative Rules To Implement Utilization Review and Quality Assurance Program - Phase 1," 65 CSR 4 (1985), the board has adopted a program of patient data submission from West Virginia hospitals to the Authority. It is the opinion of the board that free-standing acute-care psychiatric hospitals are subject to the provisions of that legislative rule.

Section 5. Annual Financial Reporting System

The board has implemented the provisions of sections 17 and 18 of the Health Care Cost Review Authority Act, § 16-29B-1 et seq., by adopting a "Uniform Reporting System and Annual Wage and Salary Survey." That system was exempt from the rule-making requirements of the Administrative Procedures Act, W. Va. Code, § 29A-3-1 et seq. See W. Va. Code, § 16-29B-17(a). It is the opinion of the board that free-standing acute-care psychiatric hospitals are subject to the provisions of that system.

Section 6. Health Care Facility Financial Disclosure

The board, pursuant to W. Va. Code, § 16-29B-16(a), replaced the director of the department of health as the administrator of the West Virginia Health Care Facility Financial Disclosure Act, § 16-5F-1 et seq. That Act requires "covered facilities" to publish and file certain financial reports and documents on an annual basis. It is the opinion of the board that free-standing acute-care psychiatric and free-standing rehabilitation hospitals are subject to the provisions of that Act.

Section 7. Rate Review Act

7.1. Nothing in this interpretive rule is intended to change the policy of the board as expressed in the "Procedural Rule For Requests For Hospital Rate Changes," 65 CSR 3 (1987), that presently excludes free-standing acute-care psychiatric hospitals from the requirements of the rate review and rate setting programs of W. Va. Code, § 16-29B-1 et seq. If that policy is subsequently changed in a later phase of the rate review and rate setting programs, rules incorporating those changes will then be issued.

7.2. It is the present position of the board that it will not attempt to apply the provisions of the rate setting act, W. Va. Code, § 16-29B-1 et. seq., to free-standing rehabilitation hospitals. If after further study the inclusion of free-standing rehabilitation hospitals appears to be appropriate, then the board will engage in rule making to that effect. This present exclusion of such hospitals is not a waiver of the board's jurisdiction to make such a later change.

Section 8. Discrete Part Units

It is the opinion of the board that if an acute-care, inpatient facility (that is, a hospital) has, among its other services, either a discrete part psychiatric unit or a discrete part rehabilitation unit, or both, those units as part of an otherwise covered hospital are subject to all of the publication and reporting requirements discussed in sections 4, 5, and 6 of this interpretive rule

and are also subject to the requirements of the rate review and rate setting programs; i.e., such units must be included by the hospital in its submissions to the rate review and rate setting programs.

Before The West Virginia Health Care Cost Review Authority

Public Statement

of

American Health Enterprises, Ltd.
(Southern Hills Regional Rehabilitation Hospital)

and

West Virginia Rehabilitation Services, Inc.
(Western Hills Regional Rehabilitation Hospital)

June 13, 1988

INTRODUCTION

Mr. Chairman, my name is H. J. Simmons, III. I presently reside in Valley Forge, Pennsylvania, and serve as President and CEO of The Medicon Group (Medicon), a Radnor, Pennsylvania health care company. I am a native West Virginian with family roots extending back nearly 250 years and proud graduate of West Virginia University.

I am appearing before the Authority today as the President of the Board of Directors of two separate companies that own and operate 40 bed, free-standing, comprehensive, Level II, medical rehabilitation facilities located in Princeton and Parkersburg, West Virginia, respectively.

These two operating companies are American Health Enterprises, Ltd. (AHEL) trading as Southern Hills Regional Rehabilitation Hospital (Princeton), and West Virginia Rehabilitation Services, Inc. (WVRSI) trading as Western Hills Regional Rehabilitation Hospital (Parkersburg). Appearing with me today is Irene Keeley, an attorney with the firm of Steptoe & Johnson, who is serving as special counsel to AHEL and WVRSI for this matter. Also present is Dr. Stephen J. Scheer, Director of the Department of Physical Medicine and Rehabilitation of the University of Cincinnati. Dr. Scheer is a paid consultant to AHEL

and WVRSI for this matter and has no other interest in or connection with Medicon, AHEL or WVRSI. Both Mrs. Keeley and Dr. Scheer will be providing comments during our testimony and, along with me, are prepared to respond to any questions which the Board or its staff may have concerning this matter.

BACKGROUND

As a general point of departure for our comments and testimony, let me briefly summarize the status of the two facilities and their projected impact upon the local economy. Southern Hills (Princeton) opened for business on March 11, 1987 and through December 31, 1987, provided 195 inpatients with over 5,800 days of care and experienced nearly 3,000 outpatient treatments. During this start-up year, Southern Hills lost slightly over $437,000. Through May 31, 1988, Southern Hills has served 147 inpatients, with over 4,100 patient days and experienced nearly 1,300 outpatient treatments. Southern Hills is currently at the financial breakeven point through May 31, 1988.

Western Hills (Parkersburg) opened for business on February 16, 1988, and through May 31, 1988, has served 56 inpatients with nearly 1,200 patient days and experienced 140 outpatient treatments. Western Hills, through May 31, 1988, has lost over $280,000, which is slightly better than the budgeted results for this period.

Let me further summarize the combined estimated economic impact of these two facilities when they both become fully operational:

Total Capital Investment	$18,800,000
Total New Jobs	220-240
Total Annual Payroll	$6,000,000
Total Annual Locally Purchased Goods/Services	$ 3,000,000
Total Annual State and Local Taxes	$ 500,000

It should be clear from my preliminary comments that AHEL and WVRSI have a strong interest in the outcome of this process. I wish to state for the record that the proposed HCCRA rulemaking is considered as both contrary to existing law as well as ill-timed from a State policy standpoint. The balance of our testimony is intended to address, in more detail, the reasons for our opposition to the proposed rulemaking.

DISCUSSION OF LAW

HCCRA has overreached in its attempt to use an interpretative rule to improperly subject rehabilitation facilities operating in West Virginia to the provisions of W.Va. Code §16-29B-1 et seq. The practical effect of the proposed rule is not to interpret existing law, but to determine private rights, privileges or interests by subjecting them to the regulatory and assessment scheme of article 29B.

Under W.Va. Code §29A-1-2(c), an interpretative rule is defined as a rule

> adopted by an agency independently of any delegation of legislative power which is intended by the agency to provide information or guidance to the public regarding the agency's interpretations, policy or opinions upon the law enforced or administered by it and which is not intended by the agency to <u>be determinative of any issue affecting private rights, privileges or interest</u> (emphasis added).

Interpretative rules give definition or clarification to a statute; they do not confer rights or obligations having substantial effects on the regulated entity. According to Neely, <u>Administrative Law in West Virginia</u>, the legitimacy of an interpretative rule turns on its consistency with legislative intent. <u>Id</u>. at 233. The West Virginia Supreme Court of Appeals previously has set aside interpretative rules found to differ from the Court's assessment of legislative intent. In <u>Ye Olde Apothecary v. McClellan</u>, 253 S.E. 2d 545 (W.Va. 1979), the Court abrogated an interpretative rule of the State Board of Pharmacy defining "sale" and substituted its own view of the proper interpretation of a statute prohibiting retail sales of certain drugs by persons other than registered pharmacists. <u>See also Mason County Board of Education v. State Superintendent</u>, 295 S.E. 2d 719, 722 (W.Va. 1982).

Even if the Board's use of an interpretative rule to subject rehabilitation facilities to the regulatory and assessment scheme of §16-29B-1 <u>et seq</u>. could somehow

be considered procedurally correct, the clear intent of the Legislature under article 29B was not to regulate post-acute rehabilitation facilities. A careful review of that statute, as well as this agency's own implementing legislative rules, supports this conclusion.

Section 16-29B-1, which sets forth the legislative findings and purpose of article 29B, states that the purpose of that article is "to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate acute care hospital services" (emphasis added). HCCRA Rule §65-5-2 amplifies this by stating that the Authority's primary responsibilities are to (1) develop a rate-setting system "for hospital acute care services;" (2) develop a uniform system of reporting hospital data; and (3) ensure the continuation of appropriate "acute care hospital services" in West Virginia.[1] (emphasis added)

HCCRA apparently is relying on the broad definitions of "hospital" under W.Va. Code §16-29B-3 and W.Va. Code §16-5B-1 as the jurisdictional predicates for its contemplated regulation of rehabilitation facilities. Such reliance, however, is misplaced.

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[1] HCCRA itself has previously recognized that article 29B was not intended to regulate rehabilitation facilities. Upon the advent of such facilities in West Virginia in 1986, HCCRA specifically stated that it did not intend to apply §16-29B-1 et seq. to such facilities. See letter of John H. Kozak to Jill Baitty dated November 20, 1986.

Section 3 of article 29B defines a hospital as "a facility subject to licensure as such under the provisions of Article Five-B [§16-5B-1 et seq.] of this chapter and any acute care facility operated by the state government ... and does not include state mental health facilities or state long-term care facilities." W.Va. Code §16-5B-1 defines a hospital as "any institution, place, building or agency in which an accommodation of five or more beds is maintained, furnished or offered for the hospitalization of the sick or injured." It further specifically excludes "extended care facilities not operated in connection with a hospital." This definition clearly does not contemplate the inclusion of rehabilitation facilities. Even though such facilities may be identified generally as "hospital" because such facilities provide post-acute or extended care, they are clearly outside the purview of this statute. Further support for this position is found at §5(a) of article 5B which exempts from periodic license inspection all "hospitals" (as defined at §16-5B-1) accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the American Osteopathic Association (AOA). Thus, any §1 "hospital" in West Virginia which is accredited by either JCAHO or AOA, the national accreditation agencies for acute care hospitals, does not have to undergo annual licensure inspection by the West Virginia Department of Health. Rehabilitation facilities, by virtue of Chapter 15 of the State Health Plan, are not accredited by either

JCAHO or AOA. Instead, by mandate of the SHP, they must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the only national organization that specifically accredits rehabilitation facilities. It is unreasonable to assume that in adopting §5(a) the Legislature either merely overlooked the different accreditation status of rehabilitation facilities or intended to subject them to more rigorous license inspection than acute care hospitals. The obvious inference to be drawn is that the Legislature recognized that rehabilitation facilities operating pursuant to the goals and objectives of Chapter 15 of the State Health Plan and accredited by CARF are not "hospitals" pursuant to article 5B. Therefore, no exemption under §5(a) was deemed necessary.

AHEL and WVRSI concede that they presently are licensed as acute care hospitals in West Virginia. It would be erroneous, however, to assume that this licensure classification is definitive of their legal status under either article 5B or article 29B. Since the advent of rehabilitation services in West Virginia in 1986, the Department of Health has failed to implement the intent of the Legislature, as expressed in Chapter 15 of the State Health Plan, to distinguish the function of rehabilitation facilities from that of acute care hospitals. Unlike our neighboring states of Pennsylvania, Maryland, Kentucky and Ohio, which have created a separate licensure category for rehabilitation facilities, West Virginia, by inattention of the Department of Health, maintains

only two licensure categories - acute hospital and nursing home. Southern Hills in Princeton and Western Hills in Parkersburg are licensed as acute hospitals solely because there is no appropriate rehabilitation classification available to them.

Given that the clear intent of articles 5B and 29B is to regulate only acute care hospitals, any attempt to bring rehabilitation facilities under the regulatory and assessment scheme of article 29B basedon a licensure misclassification is arbitrary and capricious.

APPLICABILITY OF THE STATE HEALTH PLAN

The Medical Rehabilitation Chapter (Chapter 15) of West Virginia's State Health Plan contains the definitive analysis of rehabilitation facilities in West Virginia, and further evidences that rehabilitation services are not considered as acute services in West Virginia. The Chapter is the product of a unique initiative on the part of the West Virginia Legislature to resolve a significant health services gap for an increasingly large number of West Virginians being disabled by illness and/or accidents.

Using $150,000 of legislative funding, the Rehabilitation Services Steering Committee was formed by the West Virginia Department of Health. Its purpose was to develop the data and systems research necessary for a comprehensive medical rehabilitation services plan for the State of West Virginia. The Steering Committee included expertise from the West Virginia Medical

Association, the Hospital Association, the State's two allopathic medical schools, Vocational Rehabilitation, Workers' Compensation and the Commission on Aging. Its efforts, completed in 1984, produced a thoughtful, practical, state-of-the-art plan for a system of comprehensive medical rehabilitation units to meet the well-documented needs of the State's disabled citizens.

While the State Health Plan and its chapters are not cited as guidance for the rate-setting provisions of §16-29B-1 et seq., the 1986 Legislative Amendment of the Article establishes the SHP as guidance for the Certificate of Need process. In this role, it becomes the basic authority for defining the components of the West Virginia health care services system. The Medical Rehabilitation Chapter of the Plan clearly supports the definition of rehabilitation facilities as post acute, chronic or extended care facilities exempted from licensing as hospitals under §16-5B-1. One of its fundamental principles is the identification and clarification of rehabilitation services as being separate and distinct from those usually found in an acute care hospital setting.

Appendix G of the Plan, the Proposed Policy and Statement on Comprehensive Medical Rehabilitation of the American Hospital Association (p. 48), states: "The most logical candidates for medical rehabilitation are individuals with physical limitations, usually chronic

rather than acute, such as those resulting from disease or injury ... and whose impairments prevent them from engaging in the normal activities of daily living." The policy further recognizes that (p. 50, line 25) "patients have the best chance for rehabilitation when the institution in which they are hospitalized provides preventive and rehabilitative services to the full extent of its capabilities, and, recognizing its limitations, has accepted its responsibility to refer patients to other facilities (rehabilitation facilities are inferred by the context) that offer appropriate services of assured quality." While this 1983 statement encourages the provision of rehabilitation services as early in an "acute care illness" as possible, its basic recommendation separates (p. 50, line 42) "chronically ill and disabled individuals" from "acute and long-term patients." This Appendix G Policy is incorporated into the Chapter in its introduction (p. 5, para. 4). Thus, the Chapter not only defines rehabilitation services and facilities as post acute services and settings, but it also describes rehabilitation patients as disabled or chronic patients whose acute medical diagnosis, treatment or management is no longer the primary concern.

In the Problem Overview section, the Medical Rehabilitation Plan begins by drawing a distinction between morbidity and disability as a health status indicator. On page 4 of the same section, it goes on to state: "Acute

care hospitals provide some components of physical rehabilitation, but are not geared to a coordinated, comprehensive effort." Thus, at its opening statement, the Medical Rehabilitation Chapter distinguishes between acute care and rehabilitative care in both the condition of the patients served by medical rehabilitation <u>and</u> the services and facilities in which these patients are served.

In Section 2, <u>Scope and Organization of Physical Rehabilitation Services</u>, the latter distinction is addressed with greater specificity (p. 4): "Because of the necessity of bringing together specialists and methods from a wide variety of fields and because of architectural design and space requirements, comprehensive physical rehabilitation must be provided in specialized units or facilities." The section continues in an elaboration of rehabilitation as a part of the continuum of care which is post-acute care and devoted to achieving maximum physical or physical and vocational improvements.

The final section of the Plan's introduction to its Medical Rehabilitation Chapter is entitled <u>Benefits of Physical Rehabilitation</u>. In pointing out the increasing need for these services, the Plan says (p. 546): "As more sophisticated techniques and equipment become available, medicine is able to treat, in an acute sense, those diseases or injuries that previously would have killed .... Rehabilitation is the overall process of improving the quality of life by reducing the long-term

effects of disability and the costs of dependency." Again the separation is clear between acute medical services which provide treatment for those who are ill or injured and the rehabilitation services which improve the conditions of chronically disabled individuals.

Following the introduction, the Medical Rehabilitation Chapter of the State Health Plan begins to outline Goals and Objectives according to the West Virginia State Health Plan's health services classification scheme based upon the federal Health and Human Services Taxonomy for health care system design. There are five classifications of Goals: Community Health Promotion and Protection; Prevention and Detection; Diagnosis and Treatment; Habilitation, Rehabilitation and Maintenance; Support Services. It is significant to note that the Plan's Acute Care Chapter which deals with hospitals has no Class 4 Goals (Rehabilitation and Maintenance). Rather its direct service Goals are Class 3 (Diagnosis and Treatment). In contrast, the only Class 3 Diagnosis and Treatment Goal for Medical Rehabilitation is as follows (p. 9):

> "Diagnosis and treatment of physically disabling conditions in an acute-care setting will be at the state-of-the-art and include an assessment of rehabilitation potential."

Service goals for the establishment of rehabilitation facilities are all Class 4 Rehabilitation and Maintenance Goals. It should be noted that the classification

designation of the facility goals as Class 4 Rehabilitation and Maintenance is also found in the Plan's Long-Term Care Chapter.

The Medical Rehabilitation Chapter outlines a three-tiered facility system for the State. It describes the second tier as (p. 11), "providing therapeutic care for post- acute patients with physical disabilities (and) is composed of rehabilitation units in selected health facilities." The third tier (p. 11), "is a university-affiliated rehabilitation program which will provide.....services to its own region, serve as a statewide referral facility...and as a training and research center for the state."

In the Objective dealing with second tier units, Item 5 (p. 14) clearly states, "A skilled nursing facility may serve as a second tier rehabilitation unit if it has followed established State Health Plan and CARF guidelines and has in place appropriate transfer agreements..."

The Objective dealing with third tier units says the services must be "linked" with a state medical school and the affiliated hospitals, but Item 3 and 5 (p. 14) describes these linkages as "memoranda of agreement with performance standards for roles and functions." Both Objectives state that the beds of rehabilitation facilities are not to be considered acute care beds.

Another discussion of a rehabilitation facility's dissimilarity to an acute care hospital occurs in

Recommended Action 3, under Objective RM 1-4: (p. 16). The action requires an application for a third tier facility to include in its application a draft agreement with a medical school affiliated hospital. The agreement "must document that the rehabilitation facility is committed to...and is willing to provide its facility...for the training and research programs of medical schools in its area. (And) "must document...willingness to accept patient referrals/transfers from hospitals within its service area..."

Even where the plan recognizes that a rehabilitation facility may be hospital-based (Objective RM 1-3, Item 3 and 4, p. 14), it requires that the unit be separate from the hospital's acute-care bed complement and that it be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), not the Joint Commission on Accreditation of Hospitals (JCAH or JCAHO).

Further, Objective RM 2-2 (p. 18) says, "All traumatic acute spinal cord injury patients shall be transferred to the appropriate level rehabilitation service following medical stabilization in an acute care hospital."

Finally, Goal RM 3 (p. 19) says that "the average length of stay in any physical rehabilitation unit or facility in West Virginia should not exceed 40 days in any one year...excluding any prior acute care stay." Contrast this with the State Health Plan's definition of acute care (Volume 1, p. 235) as "medical care provided patients requiring immediate and continuous attention of short duration."

In the elaboration of Objective RM 3-2 dealing with utilization review (p. 20), the Plan goes on, "Because physical rehabilitation is essentially different from acute care, different standards must be used to determine appropriateness of services and the length of stay."

Under Objective RM 4-1 on p. 22, the Plan requires a specific transfer of patients from the acute care hospital to its hospital-based rehabilitation facility.

DESCRIPTION OF A MEDICAL REHABILITATION FACILITY

It might be useful to describe, briefly, a typical medical rehabilitation facility and how it operates. First, I would like to provide a working definition of medical rehabilitation.

> Medical rehabilitation is a process that applies disgnostic and therapeutic disciplines to patients with disabling injuries or diseases. The goal of rehabilitation is to mitigate or eliminate functional limitations in daily living tasks, mobility, communication and employment. Patients receive rehabilitation through a type of care which is post-acute and totally unlike the nature of care commonly provided in an acute care hospital. Patients requiring this type of post-acute care are medically stable.

Let me, furthermore, describe the key characteristics of a medical rehabilitation facility.

1. Complicated physical impairment

   Only patients with complicated physical impairment (i.e., two or more functional problems) that are properly referred from acute care hospitals or other settings are admitted and treated at a medical rehabilitation facility.

2. Case Mix

The typical case mix of a medical rehabilitation facility includes stroke, spinal cord injury, neurologic disorders, hip fractures and replacement, amputation, traumatic brain injury, major multiple trauma, polyarthritis, burns and congenital deformity. Four of these diagnoses, ie. stroke, spinal cord injury, traumatic brain injury and amputation, represent nearly 75% of rehabilitation facility admissions. These same four diagnoses are less than 5% of the admissions to a typical acute care hospital.

3. Length of Stay

The average length of stay of a rehabilitation facility is 30 days. The average length of stay of an acute care hospital is 7.3 days or less than one-fourth the length of stay for a rehabilitation hospital.

4. Medical Stability

A typical patient admitted to a medical rehabilitation facility is medically stable. Rehabilitation facilities are prepared to manage the medical problems of such patients as they progress through the medical rehabilitation program. However, if they become medically unstable, they are referred back to an acute care hospital until the patient is restabilized.

5. Services Provided

Rehabilitation facilities do not provide surgical, emergent or obstetric services. Even most sophisticated diagnostic services are provided on site at local hospitals. The services normally provided include therapies which promote the functional restoration of the patients.

6. Inter-disciplinary team approach

Medical rehabilitation facilities use an inter-disciplinary team approach in the care of patients. This team is directed by a physiatrist (a specialist in physical medicine and rehabilitation) and includes physician, consultants, physical therapists, occupational therapists, recreation therapists, speech pathologists, social workers, psychologists, rehabilitation nurses and vocational counselors.

7. Patient Care and Discharge Planning

A patient entering a medical rehabilitation facility must have potential to benefit from the program. A pre-admission evaluation is performed through which specific objectives are established for the patient. A plan of care is prepared, followed and revised as necessary. Each patient has an individualized set of functional goals. Discharge planning begins upon admission. 90% of the patients are discharged to home and 10% are discharged to a custodial facility .

Let me try to compare and contrast some additional characteristics of a medical rehabilitation hospital to and with those of an acute care hospital.

Characteristics	Acute Care Hospital	Medical Rehabilitation Facility
Mode of Care	.Hierarchic Medical Model	.Inter-disciplinary Team
Concern for Functional Status	.Low Priority	.Primary Emphasis
Patient Participation Participants	.Passive Recipient of Care	.Patient and Family are Active
Social/Vocational Status	.Not Applicable	.Integral Part of Care Plan
Admission Guidelines	.Emergency, Acute or Elective Medical/ Surgical Need	.Extensive Physical /Cognitive Impairment
Goals	.Manage Acute Problem	.Maximize Independence
Medical Status	.Critical to Stable .24 Hour Medical and Nursing Intervention	.Medically Stable .Daily Physician Intervention and 24-Hour Nursing Intervention

This analysis clearly documents the differences between an acute care hospital and a medical rehabilitation facility. In simple terms, a medical rehabilitation facility is simply not comparable to an acute care hospital.

A final point needs to be made concerning the uniqueness of a medical rehabilitation facility regarding resource consumption. Rate review and control systems imposed on acute care hospitals at the Federal and State level have been based on a predicatable level of resource consumption tied to patient diagnoses. Research concerning medical rehabilitation concludes that the unique characteristics of the patients served by a rehabilitation facility preclude the ability to predict by diagnosis.

The United States Department of Health and Human Services (DHHS) has continued to maintain in its mandated annual report to Congress on development progress of prospective payment system for excluded hospitals (rehabilitation, psychiatric, children and chronic care) that:

> Diagnostic condition explains little, whereas functional status explains substantially more of the variance in total charges for a rehabilitation stay. A nationally accepted set of functional status measures has not yet been developed for application in a classification system for rehabilitation facilities.

ECONOMIC REASONS FOR REHABILITATION EXCLUSION

In addition to the very compelling legal and operational reasons establishing that rehabilitation facilities are not acute care hospitals subject to regulation under article 29B, there are several significant economic reasons which argue for the exclusion of rehabilitation hospitals from the proposed rulemaking:

1. The regulations carry an assessment equal to one-tenth of one percent (0.1%) of gross revenues. If applied to either facility at full operation, this assessment will increase costs at each facility by at least $7,000 annually. These increased costs will inevitably be passed on to patients and their insurers in the form of additional costs or charges. This pass through directly affects specific groups of citizens (rehabilitation patients) contrary to the analysis of economic impact offered under the Fiscal Note for Proposed Rules (Sections 4B and 4C) issued by the Commission.

2. Compliance with certain reporting requirements, namely the annual wage and salary survey, will require additional data collection and handling costs projected to significantly exceed the estimate of $2,500 per facility reflected in the Fiscal Note for Proposed Rules (Section 4B). This cost is estimated by management staffs at each facility to be $5,000 - $6,000 annually and will also be passed on to patients and their insurers.

   Since the Board has previously expressed intent to excuse rehabilitation facilities from rate-setting, this reporting requirement is a costly, unnecessary and merely cumulative data

exercise. Financially burdening start-up facilities that have and are incurring significant operating losses is not in the best economic interests of the general public or of rehabilitation patients and their families. This result is contrary to the analysis contained in the Fiscal Note for Proposed Rules (Section 4C).

3. Imposing the reporting requirements of West Virginia Code §16-29B-1 et seq. effectively places these fledgling facilities under the impending threat of actual rate setting, HCCRA's protestations and current attitude notwithstanding. Such a threat only serves to discourage existing rehabilitation providers from investing capital in additional programs and facilities. It also sends a clear signal to those interested in investing capital in rehabilitation as new providers. Both of these results have a clearly adverse economic and financial impact upon this segment of the health care industry of West Virginia. This is contrary to the Fiscal Note for Proposed Rules (Section 4C) issued by the Board.

4. Finally, rehabilitation facilities in West Virginia are neither economically stable nor financially mature at this time. Any additional regulatory

burdens - from supposedly benign reporting requirements to onerous rate setting schemes - may result in the business failure of one or more of these entities. Such an event serves no beneficial public purpose and, in effect, contravenes the expressed goals and objectives of West Virginia's own State Health Plan.

POLICY REASONS FOR REHABILITATION EXCLUSION

It may also be useful to consider the policy implications which arise for the State of West Virginia in this proposed rulemaking for regulatory reporting and, eventually, rate setting of rehabilitation facilities.

1. West Virginia Business Environment

Although West Virginia's business environment has improved, it still suffers from a negative business image. As evidence of this fact, I note a recent article in The Wall Street Journal. In two surveys reported upon by The Wall Street Journal the business climate of only two states - Louisiana and West Virginia - ranked in the bottom 15% of the states listed in both surveys. Several of the key factors listed by these surveys included high tax rates, lack of skilled labor and over-regulation. West Virginia was reported as having these three factors. The proposed rulemaking under consideration only reinforces

the image of over-regulation and further stultifies the business environment and economic prospects of the State.

It should also be noted for the record that, of the five neighboring states abutting West Virginia (Kentucky, Maryland, Ohio, Pennsylvania and Maryland), only Maryland has imposed a rate review/rate control system upon medical rehabilitation facilities. The absence of rate regulation in states other than Maryland serves to stimulate capital investment and the development anduse of rehabilitation facilities. I would also note for the record that the heavy regulation of health care in Maryland has resulted in a seriously underdeveloped rehabilitation system there.

2. State Health Plan and Implied Commitments

As noted earlier in this written testimony, a well-reasoned and carefully-crafted Chapter 15 of the State Health Plan delineated the goals and objectives for a coordinated medical rehabilitation system for West Virginia. Implicit in this chapter were certain commitments by both the sponsors of such facilities and the State to assure that the system which evolved would be cost effective, financially viable, of high quality and properly integrated with other health care delivery system elements.

At least two providers, AHEL and WVRSI, have met or are meeting their respective obligations under the State Health Plan. To date, there are at least three areas where State government has yet to address its implied obligations:

- The State of West Virginia has yet to fund and pay for rehabilitation services for its Medicaid beneficiaries. As a result, a significant segment of the population, and those most likely to need and benefit from rehabilitation services, are unable to receive these services.
- The State of West Virginia has yet to mandate rehabilitation benefits under private insurance plans. This lack of mandated coverage exposes large, privately-insured groups such as Blue Cross of West Virginia, to non-coverage for rehabilitation services.
- The State of West Virginia has yet to assure that its own Workers' Compensation cases requiring rehabilitation services will be referred to qualified, in-state facilities providing these services. This lack of policy results in geographic dislocation of patients and their families who are referred to out-of-state facilities. More significantly, it results in a lack of treatment for many West Virginia patients who are either unwilling or unable to travel to these out-of-state facilities. Finally, it results in significant tax-based revenues of the State being expended at out-of-state facilities.

I respectfully suggest that the State of West Virginia would be much better served by focusing its attention upon these important policy issues rather than imposing assessments and increasing regulations upon a financially fragile sector of an evolving rehabilitation industry. As providers who have taken a risk in the business environment of West Virginia, AHEL and WVRSI expect the State to fulfill its commitments under the State Health Plan. Fulfillment of mutual commitments, not constantly increasing regulation, is the true measure of the private/public sector partnership success.

On behalf of the Board of Directors of AHEL and WVRSI, I wish to express our appreciation to the Authority for the opportunity to present these comments. We encourage the Authority to either withdraw the proposed rule or to exclude rehabilitation facilities from it.

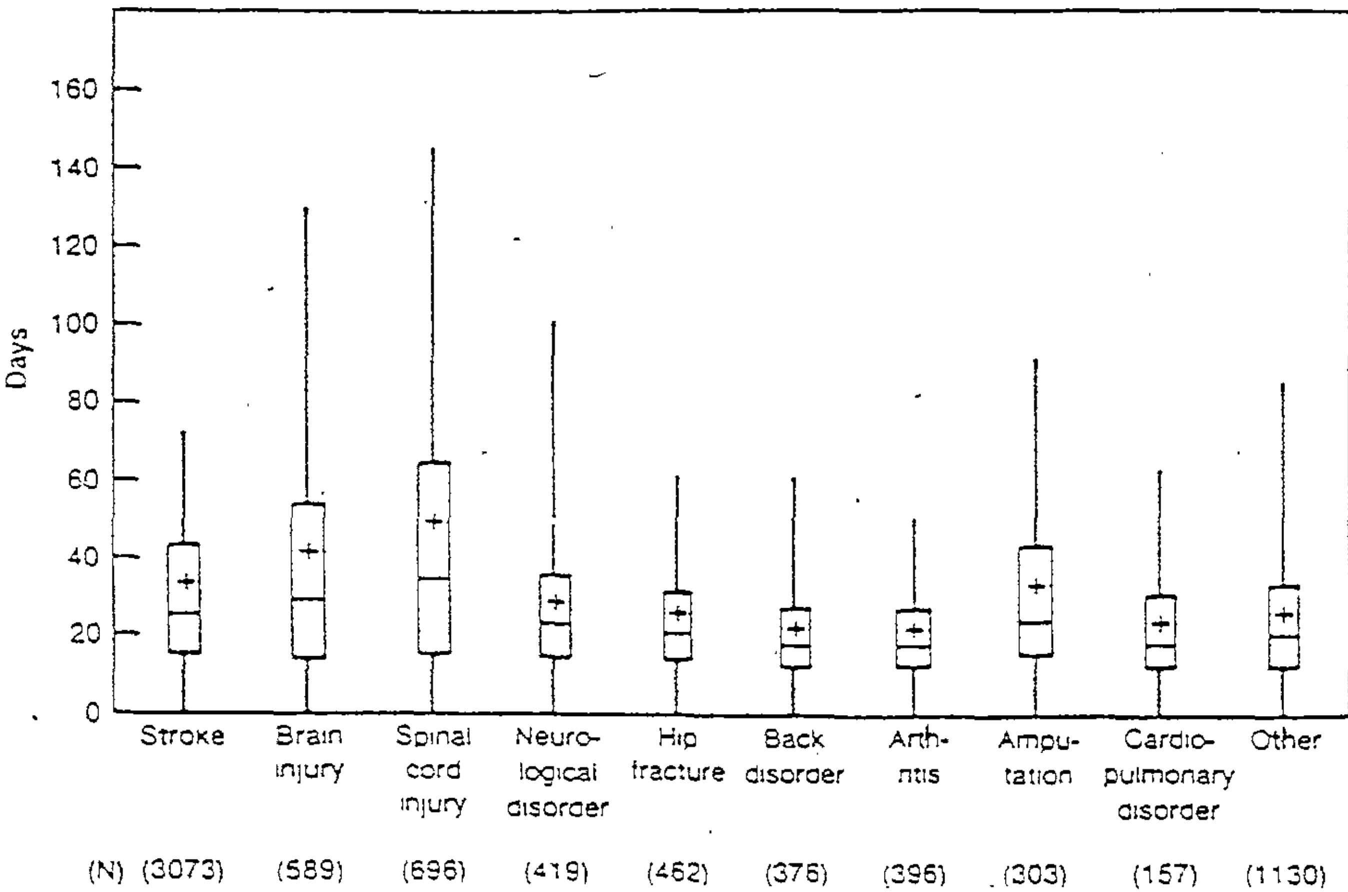

Fig. --Distribution of lengths of stay by diagnostic category

Source: Hosek, Kane, Carney, Hartman, Reboussin, Serrato, Melvin, Charles and Outcomes for Rehabilitative Care: Implications for the PPS. R-3424-HCFA. Santa Monica Rand/UCLA Center for Health Care Financing Policy Research, 1986.

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THE HOSPITAL WITH A HEART

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O. T. ORR
E. SULLIVAN

June 10, 1988

Mr. Ken Rutledge, President
West Virginia Hospital Association
3422 Pennsylvania Avenue
Charleston, West Virginia 25302

Dear Mr. Rutledge:

In response to the Interpretive Rule on Coverage by Financial Disclosure Acts and Utilization Review of Psychiatric and Rehabilitation Hospitals, please be advised that Highland Hospital is opposed to this ruling.

Currently and historically, we have not been subject to rate review by HCCRA or to any assessment. Over the years, our records clearly indicate that we have made every effort to operate this facility as cost-effectively as possible and to keep our rates as low as possible.

Area, state-wide or even national data will substantiate that for an 80 bed free-standing psychiatric hospital, our rates are lower or as low as any comparable institution.

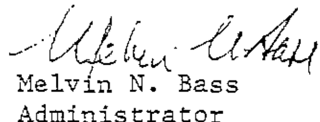
We feel that we are already sufficiently regulated and to add another layer of regulation at this time, would impose an additional fiscal burden, the cost of which, would only be passed on to the consumer.

In terms of financial disclosure, we are already providing our annual financial report and the annual wage and salary survey which we feel is sufficient.

We therefore urge the West Virginia Hospital Association to support us in opposing the interpretive rule which can only be regarded as being not only non-productive and counter-productive but destructive as well.

Please assist us in our mission and goal to provide quality and appropriate psychiatric care and treatment at realistic and nominal rates.

Very truly yours,



Melvin N. Bass
Administrator

MNB/mf

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CHARLES R. WEBB

C. E. GOODWIN
GEORGE M. SCOTT
COUNSEL

REPLY TO: Charleston

June 10, 1988

West Virginia Health Care
Cost Review Authority
100 Dee Drive
Charleston, WV 25311

RE: Proposed West Virginia Interpretive Rule, Chapters 16-5F and 16-29B, Series XII, Coverage by Financial Disclosure Acts and Utilization Review of Psychiatric Hospitals and Rehabilitation Hospitals

Dear Sir:

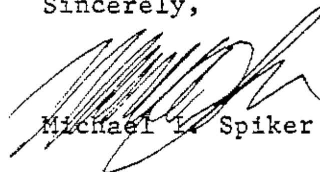
On behalf of Chestnut Ridge Hospital which is a freestanding psychiatric hospital located in Morgantown, West Virginia, please consider this letter a formal objection to the above described Proposed Rules. It is the position of Chestnut Ridge Hospital that HCCRA does not have jurisdiction over freestanding psychiatric hospitals and that they are not subject to the requirements of the West Virginia Health Care Cost Review Authority Act 16-29B-1 et. seq. and accordingly this agency does not have the power and authority to implement these proposed rules. Further, the proposed rules are being adopted as an interpretive rule and it is the position of Chestnut Ridge that this is an improper procedure and format for developing this type of rule.

Freestanding psychiatric hospitals are a unique hospital that have unique patient mixes, unique charging mechanisms for services, and provide unique services that are separate and distinct from general acute care hospitals. The forms which the agency proposes this hospital complete are inapplicable and are not appropriate for this type of facility and could not be properly completed by a freestanding psychiatric institution.

Chestnut Ridge Hospital further objects to the proposed imposition of any assessment under the provisions of W.Va. Code §16-29B-1 et. seq. and any other regulations relating to assessments on the grounds that again this agency does not have jurisdiction control over psychiatric hospitals. It was not the intent of the legislature to cover freestanding facilities.

Chestnut Ridge reserves the right to file additional documents and materials that it deems appropriate with regard to this matter.

Sincerely,



Michael I. Spiker

MIS/cac

ATTACHMENT

The following are briefly stated reasons that acute psychiatric hospitals cannot be adequately compared to acute medical/surgical hospitals, as being proposed by the West Virginia Health Care Cost Review Authority.

UNIFORM REPORTING

A. Revenues and expenses are not comparable. In general, psychiatric hospitals have lower gross daily charges and expenses than comparably sized medical/surgical facilities. The components of revenue (room and board and ancillary charges) are certainly not comparable.

Psychiatric facilities use less medical/surgical-type ancillary resources (laboratory, radiology, physical therapy, etc.) per admission than medical/surgical facilities. Psychiatric hospitals do, however, have ancillary charges which may include group therapy, individual psychotherapy, activities therapy, biofeedback, etc.

Accurate and adequate comparisons between revenues and expenses of acute psychiatric hospitals and medical/surgical hospitals are, therefore, not possible or even advisable.

B. The lengths-of-stay ("LOS") between medical/surgical and psychiatric facilities are totally unrelated. By virtue of the care and treatment given and the environment, the LOS for a psychiatric patient will be longer than for medical/surgical patients.

C. Even between psychiatric hospitals, experiences and outcomes depend greatly upon the acuity of the illness of the patient, the age of the patient, diagnosis, underlying physical conditions, presence of additional complicating psychiatric conditions, availability and use of adjunctive therapies, etc. This normal "uniqueness" between psychiatric hospitals is even more prominent at Chestnut Ridge Hospital due to its association with the West Virginia University College of Medicine.

Chestnut Ridge serves as the primary psychiatric training site for residents, interns, and medical school and allied health professional students. Costs for this training are borne by this free-standing hospital. In filling this role, Chestnut Ridge is a tertiary referral center for the most severely ill psychiatric patients from a wide geographic area. Therefore, for these reasons, it is extremely doubtful that Chestnut Ridge can be compared to any facility of any type in West Virginia.

QUALITY ASSURANCE

A. The outcomes from psychiatric treatment and medical/surgical treatment are totally different. The outcomes are usually somewhat more subjective for psychiatric treatment. The use of morbidity and mortality indicators are not comparable between psychiatric and medical/surgical hospitals.

B. Psychiatric treatment outcomes often entail a longer period of evaluation following discharge. Treatment outcomes for psychiatric patients may be less sure and measurable at the time of discharge.

C. The use of "U.B.-82" as a billing tool may generally be acceptable. However, the use of this information as a guide by which quality assurance is measured, most assuredly is not adequate for psychiatric patients. Further, the comparison of U.B.-82 information between psychiatric and medical/surgical patients will be of little benefit.

WAGE AND SALARY INFORMATION

A. While there may be some overlap of common employees and salaries, the mix of technical and professional positions and the actual salary rates will have little comparability between medical/surgical and psychiatric hospitals.

B. In general, psychiatric hospitals have fewer registered nurses, but far greater numbers of other "social skills" therapists and workers such as psychologists, social workers, recreational therapists, occupational therapists, etc.

C. While general pay levels might be compared, the actual use of the various medical professionals and workers has very little correlation between medical/surgical and psychiatric hospital.

USE OF EXISTING DATA SYSTEMS

The existing data system utilized for the "Uniform Reporting System and Annual Wage and Salary Survey" is not compatible for reporting care given, resources utilized or outcomes achieved in the treatment of psychiatric patients. Certainly, no meaningful comparisons can be made between psychiatric and medical/surgical hospitals.

U.B.-82 is a billing information report. It can not accurately measure the quality of care given. It can not be used to accurately compare medical/surgical to psychiatric hospitals.

At the very least, a totally separate, specific, all-encompassing system would need to be developed for psychiatric hospitals. Even then, with only two such existing hospitals, the comparisons would probably be meaningless.

In the final analysis, psychiatric hospitals are very different, especially from medical/surgical hospitals. Any system which would attempt to accurately and adequately compare hospitals would be very difficult and expensive to develop. The benefits to be gained, if any, would be minimal and in no way probably cost-effective.

Submitted on behalf of Chestnut Ridge Hospital, Morgantown, West Virginia.

Coverage by Financial
Disclosure Acts and Utilization
Review of Psychiatric Hospitals and
Rehabilitation Hospitals

Proposed Interpretive Rule by
Health Care Cost Review Authority

Mr. Chairman, I am Bob Whitler, Vice President for Public Policy Development of the West Virginia Hospital Association. First, I would like to express my appreciation for the opportunity to testify this morning.

The West Virginia Hospital Association is strongly opposed to the Proposed Interpretive Rule on Coverage by Financial Disclosure Acts and Utilization Review of Psychiatric and Rehabilitation Hospitals. We are opposed to the new rules for three principal reasons:

1. First and foremost, this is a blatant attempt to change the rules in the middle of the game. When the Health Care Cost Review Authority (HCCRA) was established, it was decided that free-standing psychiatric and rehabilitation hospitals were different from general acute care hospitals and, therefore, should be exempt from the assessment on hospitals and mandatory rate setting.

Because of these exemptions, investors, both out of state investors and non-profit community hospitals, decided to invest in West Virginia and have indeed developed and built new state-of-the-art free-standing psychiatric and rehabilitation hospitals in West Virginia. It is now unfair and a breach of good faith for the State of West Virginia, after the investment has been

made, to drastically change the regulatory structure under which the new facilities will be forced to operate, which will include, if these proposed rules are adopted, all of HCCRA's regulations applicable to rate setting including the hospital assessment with the exception of actual rate setting.

If these proposed rules are adopted, you will indeed be sending a very bad signal to potential investors - namely that the regulatory system in West Virginia cannot be trusted.

2. Second, at the federal level, a blue chip committee of the Health Care Financing Administration studied both rehabilitation and psychiatric hospitals and concluded that there was no rational way of handling those hospitals under the prospective payment system. If the Health Care Financing Administration cannot develop a rational way of prospectively setting prices, we would like to know how the Health Care Cost Review Authority (HCCRA) will use the data and assessment fees they now propose to collect. Did the Board of HCCRA have a considered and thoughtful discussion on how the data would be used in the development of public policy and why assessment fees needed to be collected from psychiatric and rehabilitative hospitals?

The evidence I see suggests that the proposed rules are simply a means of expanding HCCRA's assessment base. If HCCRA has no plans to implement rate setting, why does it propose to collect assessment fees? For what purpose will hospital assessment fees be used?

3. Third, the State of West Virginia does not provide Medicaid

reimbursement for rehabilitative services even though 36 other states do provide coverage for rehabilitative services. The state, then, should want to provide rehabilitation hospitals maximum flexibility so that they can adjust charges to private payors in order to compensate for the lack of reimbursement from the state's Medicaid program.

Finally, for the same 3 principals outlined above, the West Virginia Hospital Association also strongly believes that distinct part rehabilitation and psychiatric units of acute care hospitals should also be exempt from the hospital assessment and mandatory rate setting.

Again, I appreciate the opportunity to testify this morning and look forward to receiving the boards response to our comments on this very important issue.

WV HEALTH CARE COST REVIEW AUTHORITY
MEETING REGISTRATION

Date of Meeting: Monday, June 13, 1988, 10:00 a.m.

Nature of Meeting: Public Hearing on Interpretive Rules

	Individual's Name:	Name of Organization:	Do you wish to speak? Y or N
1	Bob Whitler	WVHA	Y
2	Mike Spiker	Chestnut Ridge Hospital	Y
3	June Keeling	Southern Hills Western Hills	Y
4	Jeff Simmons	"	Y
5	Dr. Stephen Schuer	"	Y
6	Diana McClure	CAMC	Y
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WV HEALTH CARE COST REVIEW AUTHORITY
MEETING REGISTRATION

Date of Meeting: Monday, June 13, 1988, 10:00 a.m.

Nature of Meeting: Public Hearing on Interpretive Rules

	Individual's Name:	Name of Organization:	Do you wish to speak? Y or N
1	Janet Sherrill	HCCRA	N
2	[illegible]	Amer. Hosp. for Rehabilitation	
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WEST VIRGINIA INTERPRETIVE RULE
HEALTH CARE COST REVIEW AUTHORITY
CHAPTERS 16-5F AND 16-29B

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HEALTH CARE COST REVIEW AUTHORITY

SERIES XII

Title: COVERAGE BY FINANCIAL DISCLOSURE ACTS AND UTILIZATION REVIEW OF PSYCHIATRIC HOSPITALS AND REHABILITATION HOSPITALS

Transcript of proceedings had at a hearing held in the above-styled matter before the West Virginia Health Care Cost Review Authority on the 13th day of June, 1988, commencing at 10:00 a.m., in the offices of the Health Care Cost Review Authority, 100 Dee Drive, Charleston, West Virginia, pursuant to notice.

BEFORE: MR. JOHN H. KOZAK, General Counsel and Hearing Examiner

MR. WALTER DALE, Chairman
MR. SAM FOLIO, Executive Director
MR. LARRY FIZER, Board Member
MR. DONALD KEESLING, Board Member

APPEARANCES CONTINUED:

MS. IRENE M. KEELEY, Attorney at Law
Steptoe & Johnson
Union National Center East
Clarksburg, West Virginia 26301
Representing Southern Hills and Western Hills Regional Rehabilitation Hospitals

MR. MICHAEL I. SPIKER, Attorney at Law
Goodwin & Goodwin
1500 One Valley Square
Charleston, West Virginia 25301
Representing Chestnut Ridge Hospital

MR. ROBERT D. WHITLER
3422 Pennsylvania Avenue
Charleston, West Virginia
Representing the West Virginia Hospital Association

MS. DIANE MCCLURE
Administrative Assistant for CAMC, General Division

MR. TIMOTHY CROFTON
Chief Executive Officer of American Hospital for Rehabilitation

MR. KOZAK: The is a hearing for the proposed Interpretive Rules designated as Coverage by Financial Disclosure Acts and Utilization Review of Psychiatric Hospitals and Rehabilitation Hospitals. These rules have been filed with the Secretary of State as proposed rules. They are not now in effect, and the purpose of the hearing today is to take such comment as you wish either in the form of written documents, oral statements or both.

If you don't have a copy of the rules or have mislaid them, there a few on the corner of the table here.

What I would propose to do is go down through the list of folks who have indicated that they would like to speak and what I will ask you to do is come up here and sit at one of the chairs across from us. We do have a court reporter present to make a record of the comments that are received orally today, and I would ask each of you, as you come up, to state your name and address and who you are representing.

Beginning at the top of the list, we have Mr. Bob Whitler from the Hospital Association.

MR. WHITLER: Mr. Chairman, members of the Board, Mr. Kozak, Mr. Folio, first of all I would like to express our

appreciation for the opportunity to testify this morning. These are important issues facing us in turbulent times, and it's through thoughtful discussions like this we develop sound public policy.

Basically the West Virginia Hospital Association is strongly opposed to the proposed Interpretive Rules on Coverage by Financial Disclosure Acts and Utilization Review of Psychiatric and Rehabilitation Hospitals.

We are opposed to the rules for three principal reasons. First and foremost, we believe that this is an attempt to change the rules in the middle of the game. As you know, when the Health Care Cost Review was established it was decided at that time that free-standing psychiatric and rehabilitation hospitals were different from general acute care hospitals, and they were, therefore, exempt from the assessment on hospitals and mandatory rate settings as well as utilization review.

Partly for these exemptions, investors, both out of state investors as well as non-profit community hospitals, decided to invest in West Virginia, and they have indeed developed new, state of the art, free-standing

psychiatric and rehabilitation hospitals in West Virginia. Primarily in Parkersburg, Princeton, Huntington and Morgantown.

In terms of economic development you will notice that all the hospitals are on the Board of West Virginia.

A substantial amount of patients in those hospitals are or will be coming from out of state.

We believe that it is now unfair and a breach of faith for the State of West Virginia, after the investment has been made, to drastically change the regulatory structure under which the new facilities will be forced to operate, which will include, if these proposed rules are adopted, all of HCCRA's current regulations applicable to rate setting, including financial disclosure, utilization review, and the assessment on hospitals to one tenth of one percent of gross patient revenue, with the exception of actual rate setting itself.

We believe that if the proposed rules are adopted, you will be indeed be sending a bad signal to potential investors in the State of West Virginia, and that

the signal is namely that the regulatory system in West Virginia cannot be trusted, that it does indeed change the rules in the middle of the game.

The second principal reason we are opposed to these proposed rules is that, as you know, at the federal level a number of committees, including a Blue Chip committee for the Health Care Financing Administration, studied both rehabilitation and psychiatric hospitals. They concluded that there was no rational way of handling those hospitals under the prospective payment system. If the Health Care Financing Administration cannot develop a rational way of prospectively setting prices, we would like to know how the Health Care Cost Review Authority will use the data they collect and the assessment fees they collect. Did the Board of HCCRA have a considered and thoughtful discussion on how the data would be used in the development of public policy, or did it see a way of simply collecting additional assessment fees from hospitals?

Reading through the proposed rules the evidence I see suggests that the proposed rules are simply a means of expanding HCCRA's assessment base.

If HCCRA indeed has no plans to implement rate setting, and I think that is wise, because as we see at the federal level they can't do it, then why propose to collect data and collect assessment fees? For what purpose will hospital assessment fees be used?

I came across a publication this morning and it summarizes three major studies, all on PPS for medical rehabilitation, and all three studies have concluded that there is no way at this time to develop a prospective payment system for medical rehabilitation. I think the same thing could be said for psychiatric hospitals.

The third principal reason we are opposed to the proposed rules is that the State of West Virginia, as you know, does not provide for Medicaid reimbursement for rehabilitative services even though 36 other states do. Also there is questions of Blue Cross Blue Shield reimbursement, and as you know, PEIB is oftentimes late with payment.

In order for the hospitals, rehabilitative and psychiatric hospitals, to invest in the State of West Virginia we have to provide them maximum flexibility to adjust charges to private payors in order to compensate for the lack of

reimbursement from the State's Medicaid program.

Those are the three principal reasons why the West Virginia Hospital Association, which represents, as you know, with the exception of one, all the hospitals in West Virginia are opposed to the proposed rules.

I would like to finish by saying that for the same above reasons we also believe that distinct part rehabilitation and psychiatric units of acute care hospitals should also be exempt from the proposed rules. That includes mandatory rate setting. It includes utilization review, financial disclosure and the assessment on patient fees.

Again, I appreciate the opportunity to testify this morning. I look forward to receiving the Board's response to our comments on this very important issue. I would also like to submit for the record a letter from Highland Hospital that was addressed to Kitt Rutledge in which Highland Hospital states that they are also opposed to the proposed rules.

MR. KOZAK: If you could tender that to Mr. Folio.

Are there any questions, Mr. Folio?

MR. FOLIO: No.

MR. DALE: No.

MR. KEESLING: No.

MR. KOZAK: Thank you very much.

The next person on the list is Michael Spiker representing Chestnut Ridge Hospital.

MR. SPIKER: If it please the Board, my name is Michael Spiker. I'm an attorney with the law firm of Goodwin and Goodwin in Charleston, West Virginia. I appear here today as counsel for Chestnut Ridge Hospital, which is a 70-bed, free-standing hospital located in Morgantown, West Virginia. It is the psychiatric teaching and research facility that is linked with the West Virginia University School of Medicine and it provides facilities for the training of physicians, interns, and other students who go to the school of medicine and provides the resource facilities for the research in the area of behavioral health.

That institution was just opened in late November, 1987, and that institution in particular finds it ironic that they have been open less than a year and this agency is seeing fit to try to impose an assessment on them

and subject them to rules and regulations that were not within the contemplation of the Legislature when this agency was set up and rate review imposed. At the same time that this hospital in less than a year has owed more than one million dollars to the State of West Virginia, the State now seeks to impose assessments against them.

Generally, for the record, we just want to state that we incorporate by reference to comments made by the Hospital Association, and it should also be noted that with respect to psychiatric hospitals that the State of West Virginia's Medicaid program does not reimburse them for any individuals between the ages of 21 and 65. So that they are likewise in category number three mentioned by the previous speaker.

We have here today just a brief letter that we would like to file with the agency and make a part of the record and to make known that our position, the position of this hospital, that this agency has no jurisdiction within which they could impose these regulations, and if in fact they do, the interpretive regulations that they are imposing today is the improper method to impose regulations upon a hospital

for purposes of having them complete forms which would be inapplicable to a free-standing psychiatric hospital.

This agency, if it see fit to proceed against psychiatric hospitals, should at the very least confer with some representatives of those hospitals, particularly in the areas of the controllers and financial experts to determine that the forms that this agency uses at this time to have general acute care hospitals file are inappropriate for free-standing psychiatric hospitals. They are a unique creature. They have been unique creatures since free-standing psychiatric hospitals started to be constructed many years ago, and on Chestnut Ridge's behalf they find it completely ironic that they've been in existence less than a year and out of the clear blue sky after they have had their facility built, that they are now being subjected to further administrative processes and procedures that were not clearly within the contemplation of the Legislature and the drafters of this legislation a few years ago. With that I would like to tender to the agency a letter with some general comments attached to it on behalf of the hospital.

MR. KOZAK: Thank you.

Are there any questions for Mr. Spiker?

MR. FOLIO: No.

MR. DALE: No.

MR. KEESLING: No.

MR. KOZAK: Mr. Spiker, could you tell me what chapter the psychiatric hospitals are licensed under?

MR. SPIKER: No, I can't tell you that. I don't have the Code here with me.

MR. KOZAK: So you wouldn't know if it is under Chapter 16 or Chapter 27 or both?

MR. SPIKER: I'm sure the Code section speaks for itself. I knew it Friday. To be honest with you, I didn't bring it with me. I could look that up and give it to you.

MR. KOZAK: I was wondering if you could tell me off the top of your head. It has to be one or the other, or both. It's probably both.

By way of further comment, we are probably going to be changing the regulations and the forms for the Financial Disclosure Act here in the next couple months, tending to come out with a set of rules changing all that, and that will probably address the part of what your comments

were.

Thank you.

MR. SPIKER: Thank you.

MR. KOZAK: I'm going to skip down to Diane McClure of CAMC.

MS. MCCLURE: Good morning. I am Diane McClure, Administrative Assistant at CAMC General Division, and I don't know if this is the right time or not, but I wanted to make two points today. Number one, that the division of rehabilitation services went through their CON much more easily than anyone else did; and number two, that the division does get paid by Medicaid and the rest of us don't, and I don't know if this can be addressed today, but if it can't I think it should be put on the agenda for the Board in the near future.

MR. KOZAK: Thank you. Any questions?

(No response.)

MR. KOZAK: Next are three speakers listed for Southern Hills and Western Hills, and I will defer to Ms. Keeley as to how she might like to present or structure that presentation.

MR. KEELEY: Thank you, Mr. Kozak. Let me introduce myself. I'm Irene Keeley from the law firm of Steptoe and Johnson. I'm here today with Mr. Jeffrey Simmons and Doctor Steven Scheer, who will be introduced by Mr. Simmons who is here to make a presentation on behalf of American Health Enterprises Limited, operating Southern Hills Regional Rehabilitation Hospital and West Virginia Rehabilitation Services, Inc., operating as Western Hills Regional Rehabilitation Hospital. Mr. Simmons will begin our presentation.

MR. SIMMONS: Thank you. With deference to other speakers, we are going to take a little more time, and we have taken some time and energy to try to put this thing in a logical format and you have in front of you the material that we are going to cover. We are not going to read this testimony, we are going to highlight it as we go through it and also we will be prepared to stand for questions as we finish, if you would like to do that.

As Ms. Keeley has indicated, I'm Jeff Simmons. I reside in Valley Forge, Pennsylvania. I'm am the Chief Executive Officer and President of the Medicon Group. I also

serve as the president of the two operating corporations in West Virginia that own and operate the facilities in Princeton, West Virginia, known as Southern Hills, and the facility at Parkersburg, which is known as Western Hills. We weren't too creative in the names, but you will understand west and south.

Both of these are 40-bed, free-standing, level two medical rehabilitation facilities under the definition of the State health plan and are both in operation.

Irene Keeley, who we asked to help us as special counsel in this matter on the legal issues will speak in a few minutes and Doctor Steven Scheer to my right is a physiatrist from the University of Cincinnati who will speak to some of the other issues related to medicine and the operation of rehab hospitals.

Doctor Scheer is here at my request. He has no business connection or relationship to any of our companies. He is here as a special technical resource to ourselves and to you gentlemen.

Let me go back historically and tell you what has happened at our two facilities. We are, along with some

of the other rehab hospitals and psychiatric institutions here in this State, new to the State of West Virginia. The Southern Hills facility that opened in Princeton in March 11, 1987, and operated for it's first year through December, '87. I'm on page two of the testimony if you want to refer to that as we go along. Through that period of time, which was a little over ten months, we provided 195 inpatients with over 5,800 days of care and also 3,000 outpatient treatments. We lost in the start-up process, which is not unusual in these types of facilities, about $437,000. To date, May 31, 1988, this same facility has provided 1,400 patient days to 147 patients and about 1,300 outpatient visits. We are at a breakeven point to date. When I say breakeven, we have months still that we have a loss, and some months we make money. The facility clearly is not stabilized from a utilization point of view and obviously from a financial point of view at this point in time.

Western Hills at Parkersburg is about a year behind the other facility. It opened a little bit earlier in February, 1988 and through May 31 of this year has treated so far 56 inpatients with 1,200 patient days and 140 outpatient

treatments, and through the end of may on the unaudited financial statement lost about $280,000, which is slightly better than the budgeted results for the period as we have expected it.

On page three, let me just indicate the economic exposure that our two companies have in this state. One is that we have new capital investments of $18,800,000. Those two facilities both cost on a total investment basis about $9,000,000 to $9,500,000. When these facilities are fully occupied and fully operational they will generate about 220 to 240 jobs. The annual payroll combined will be about $6,000,000. The locally purchased goods and services total about $3,000,000, and the state and local taxes on an annual basis will be about $500,000.

So as you can see from these introductory comments, we have a very high stake in West Virginia. The investors in these companies have a high stake in this, and I would just say as we start for the record that we consider the proposed HCCRA rule making as contrary to existing law, which Ms. Keeley will talk about, and certainly in addition to that we believe it is clearly ill-timed from a state policy

standpoint. Now, on that basis, I would like to move into some of the discussion of these points and we will tie it all up and come back to questions in a few minutes.

So let me turn the matter over now to Ms. Keeley and she will discuss the legal aspects of our objections.

MS. KEELEY: Thank you. Southern Hills and Western Hills believe that the Authority has overreached in it's attempt to subject rehabilitation facilities operating in West Virginia to the provisions of West Virginia Code 16-29B-1. Because we believe, first of all, on procedural grounds that it is not proper to use an interpretive rule to determine the private rights, privileges or interests of these facilities by subjecting them to regulation and assessment scheme under 29B.

Even if this Authority were to hold that use of an interpretive rule were procedurally correct, we believe there is no substantive basis for the attempted regulation of rehabilitation facilities and I would refer you to the discussion in the public statement beginning on page five.

Under West Virginia Code 16-29B there is an

initial statement of legislative findings about the purpose of 29B, which states that the article is "to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate acute care hospital services." The linchpin of our argument is that rehabilitation services are not acute care services and are not, therefore, in contemplation of 29B.

We believe that additional support for the proposition of 29B is limited to acute care services as found in HCCRA's own rules, 65-5-2, which states in pertinent parts that the Authority's primary responsibilities are to (1) develop a rate-setting system for hospital acute care services; (2) develop a uniform system of reporting hospital data; and (3) ensure the continuation of appropriate acute care hospital services in West Virginia.

We believe the Authority has specifically recognized that the breadth of 29B is limited to acute care facilities. Now, apparently for the promulgation of this rule HCCRA is relying on the broad definitions of hospital found under 29B-3 and 16-5B-1, and I would like to address those.

Under 29B-3 a hospital is defined as a facility subject to licensure as such under the provisions of Article Five-B of this chapter and any acute care facility operated by the state government and does not include state mental health care facilities or state long-term care facilities. So you have to refer to 5B-1 to find out what the definition of hospital is that is relied on under 29B.

Under 5-B-1 hospital is defined as any institution, place, building or agency in which an accommodation of five or more beds is maintained, furnished or offered for the hospitalization of the sick or injured. Importantly, that broad definition continues to specifically exclude extended care facilities not operated in connection with a hospital.

We believe that this definition clearly contemplates the exclusion of rehabilitation facilities.

At the time that 5B-1 was drafted by the Legislature in 1947, and as it was subsequently amended in 1963 and 1977, there were no rehabilitation facilities operating in West Virginia. Rehabilitation facilities were not existent until 1986 in West Virginia. There were,

however, other facilities which were providing a basic level of care on a continuum beyond the acute, and these are recognized as, among others, extended care facilities. So if you take the initial assumption that the Legislature presumed a difference between acute care and other levels of care on a continuum, and then you look at what the Legislature did in 1988 during the most recent Legislative session, under 5B 5(a), I think you find specific recognition in addition to that found in the state health plan for the concept that rehab is not acute care. Section 5(a) exempts from periodic license inspection all hospitals, as defined by 5B-1, which are accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association. These accrediting agencies are specific agencies for the accreditation of acute care hospitals, and what the Legislature said was that if you are accredited by either one of these, you don't have to undergo our annual licensure inspection.

By reference to the State Health Plan, however, we find that rehabilitation facilities are by mandate to be accredited not by JCAHO or AOA, but by CARF, the

Commission on Accreditation of Rehabilitation Facilities, which is the only national organization which specifically accredits rehabilitation facilities. Thus, to be in compliance with the State Health Plan, a rehabilitation facility could not come within the purview of Section 5(a) and we submit that that is clear indication of the Legislative intent by adoption of the State Health Plan and by adoption of 5(a) to exclude rehabilitation facilities from the definition of hospital under Section 16-5B-1 of the Code.

Now, Southern Hills and Western Hills concede that they are presently licensed as acute care hospitals in West Virginia, but it is important for the Authority to look at why that has occurred. That has occurred because the Department of Health has failed to recognize and implement the changes that occurred when the State Health Plan was rewritten to include Chapter 15, the rehabilitation facility section, which as we will talk about in the next few minutes, does not recognize rehabilitation facilities as acute care hospitals.

Unfortunately, the categories under Section 15-B, as implemented by the Department of Health classification system, only include acute care hospitals and

nursing homes, so when Southern Hills and Western Hills were approved by this Authority and began operations they had only two choices; to be either licensed as acute care hospitals or nursing homes. They are neither. They are extended care facilities, rehabilitation facilities, which fall outside the acute end of the continuum and the nursing home end of the continuum. Other states surrounding West Virginia, Pennsylvania, Ohio, Kentucky, Maryland, recognize this distinction and License rehabilitation facilities separately. They are not acute care hospitals in any of those states. I think that is of great significance in recognizing how the State Health Plan approaches this type of care, how the Legislature has addressed it, and how this Authority itself has addressed it's limitations under regulation, and therefore, to conclude that rehabilitation facilities are not acute care facilities, are not within the purview of article 29B and subject to the interpretive rule as proposed by the Authority.

I have referred on several occasions to the State Health Plan. Beginning on page eight of our prepared remarks is an extensive discussion of the content of Chapter

15 of the State Health Plan as it relates to rehabilitation facilities.

Chapter 15 presents a comprehensive medical rehabilitation services plan. The Legislature appropriated $150,000 in order to develop this plan which has been recognized by providers of rehabilitation services as among the best that there is in this country, and I believe that Doctor Scheer will be addressing that more specifically. But it is important to note that one of the fundamental principles of the system created by Chapter 15 is the identification and clarification of rehabilitation services as being separate and distinct from those usually found in an acute care hospital setting.

Without reading from these public remarks, I would nevertheless refer you to specific sections so that you may review them. In the State Health Plan, on page nine, we discuss Appendix G, which recognizes that rehabilitation services are usually chronic rather than acute, and that the policy recognizes that patients have the best chance of rehabilitation when the institution in which they are hospitalized, that is the acute care institutions, provides

preventative and rehabilitative services to the full extent of its capabilities and, recognizing its limitations, has accepted its limitations, has accepted its responsibility to refer patients to other facilities. So the Chapter recognizes that rehabilitation will not be provided in the acute care setting.

Again, at page 50, line 42 of Chapter 15, the Plan recognizes that there is a difference between chronically ill and disabled individuals from acute and long-term patients. This Appendix G Policy is incorporated into the Chapter in its introduction, and therefore, we conclude that the Chapter not only defines rehabilitation services facilities as post acute services and settings, but it also describes rehabilitation patients as disabled or chronic patients whose acute medical diagnosis, treatment or management is no longer the primary concern.

Now, in the Problem Overview Section of Chapter 15, the Medical Rehabilitation Plan begins by drawing a distinction between morbidity and disability as a health status indicator, and it says that acute care hospitals provide some components of physical rehabilitation, but are

not geared to a coordinated comprehensive effort, which is what rehabilitation facilities are to provide.

In Section 2 of Chapter 15, Scope and Organization of Physical Rehabilitation Services, the Chapter recognizes that the rehabilitation facility brings together specialists, know as physiatrists, in a different setting. The rehabilitation hospital does not look like an acute care hospital, and as Doctor Scheer will address, many of the services, surgery, OV, your typical diagnostic equipment, is not present in a rehabilitation facility. That is because it is post acute and is devoted to achieving the maximum physical and vocational improvement of the patient.

Now, under the Benefits of Physical Rehabilitation discussion in the Chapter, it is pointed out that as more sophisticated techniques and equipment become available medicine is able to treat, in an acute sense, those diseases or injuries that previously would have killed. Rehabilitation is the overall process of improving the quality of life by reducing the long-term effects of disability and the costs of dependency. So, again, the Chapter recognizes the separation between acute care and post acute care, which

is rehabilitation.

The Chapter also locates the kind of goals and objectives that rehabilitation seeks to achieve under Class Four Rehabilitation and Maintenance Goals, rather than under the Acute Goals, which are diagnosis and treatment. So the Taxonomy is very important to an understanding of how the Chapter views rehabilitation.

The Chapter also recognizes that level two facilities, such as Southern Hills and Western Hills, provide therapeutic care for post acute patients, and the Chapter also recognizes that even a skilled nursing facility may serve as a second tier rehabilitation unit if it has followed the established State Health Plan and, significantly here, the CARF, or Commission on Accreditation of Rehabilitation Facilities' guidelines; not JCAHO; not AOA.

Another discussion is found under Recommended Action 3, wherein it is required that an application for a third tier facility include a draft agreement with a medical school affiliated hospital. Showing that there is a contemplated transfer of patients from acute care facilities, such as medical school affiliated facilities to rehabilitation

facilities.

Finally, Goal RM-3, which is on page 19 of the Plan says that the average length of stay in any physical rehabilitation unit or facility in West Virginia should not exceed 40 days in any one year. Doctor Scheer will point out that there is a very clear difference between the average length of stay in an acute care facility and that contemplated in a rehabilitation facility. Then, in the elaboration on that objective, the Plan states that because physical rehabilitation is essentially different from acute care, different standards must be used to determine appropriateness of services and the length of stay.

I will conclude my remarks by referring you now to Doctor Steven Scheer from the University of Cincinnati, who is a physiatrist, who is a recognized national expert in this field, who will discuss in detail the differences between the services and the team approach to acute care and rehabilitation.

DOCTOR SCHEER: Thank you, Ms. Keeley; Mr. Simmons.

My purpose here, as I understand it, is to perform an educated function and will begin, if you refer to

pages 15 through 19 and also the appendix at the very end of the handout, but we are going to start on page 15.

Let me just mention briefly that my reason for being here relates to the fact as Ms. Keeley alluded to, my experience, my background in rehabilitation medicine, since I've been practicing ten years after my residency, but also the fact that I have been a CARF surveyor for over four years, CARF being the recognized agency that performs an accreditation function for rehabilitation facilities across the country.

The things I'm going to do are discuss the nature of rehabilitation, a rehabilitation facility, the people who practice in a rehabilitation facility, and the nature of the patient population, and also I'm going to discuss a little bit more about what CARF is all about and what it does in a rehabilitation hospital.

You have a definition of medical rehabilitation on page 15, and it refers to disabling injuries or diseases, being the reasons that people end up in a rehabilitation facility. Typically, those disabling conditions may be in three large categories. They may be

chronic diseases, such as stroke, arthritis, chronic back pain. That's one category, which tends to be an older age population. A second category is a younger population who have experienced trauma. That may be a car accident. It may be a gunshot wound. Those are typically people who have either a spinal cord injury or brain injury. The third category -- and these are generic and large and not inclusive of all those who may be in a rehabilitation hospital, but three big ones -- a third category is those individuals who have had congenital birth-related defects, which may all of their lives, suffer from some disabling condition.

Now, we are going to refer to several of the generic differences between what takes place in a rehabilitation facility and what happens in an acute care hospital. Starting on page 15 at the bottom, the complicated and physical impairment category relates to the fact that the individuals who are needing rehabilitation have functional problems. We also refer to that in the definition. Functional means that which relates to everyday activities. It may be function in mobility. It may be function in self-care, how you brush your teeth, wash your face, wipe yourself.

It may be function in communication. Finally, it may be function in the way you work, vocational status. So these are four big areas of functions that rehabilitation facilities typically deal with, and at least two of them are usually involved when a person needs an inpatient rehabilitation stay.

The second important criterion is that in a rehabilitation facility case mix is significantly, drastically different from what is commonly seen in an acute care hospital. You have your statistics indicating that, at least a large survey that over half the rehabilitation or units of hospitals in the United States, four diagnoses, stroke, spinal cord injury, traumatic brain injury and amputation, which represent 75 percent of the patients in rehabilitation facilities, correspond to only a few percent, less than five percent of the patients you see in an acute hospitals. So we've got a different patient populations we are dealing with here. Obviously those who have functional problems, those with neurologic or orthopedic or cardiovascular concerns, which disable them functionally in those ways I mentioned, are not necessarily represented in the acute care hospital population; people who come in for totally different kinds of

things.

A third, and one other thing I should mention to further amplify on the case mix, is that in a study performed by Coopers and Lybrand, the accounting firm, a majority of rehabilitation patients could be classified within eight of the Medicare 467 DRG groups. But only two of those eight were in the leading DRGs in acute hospitals. So, again, we are talking about different patient populations in these two places.

Length of stay is also very interesting to compare when you see these two populations. Comparing national rehabilitation facilities, the average length of stay all across the country, is approximately 30 days. In one study it was 29.3 and in another 31.2, so we are going to call it 30 days as an average. The average length of stay in acute hospitals is 7.5 days. I refer to my statistics at the University of Cincinnati, which I was able to get for the year 1987, and again, I found a 7.5 average length of stay for all diagnoses, but birth, I should mention, again, compared to a 30 day average length of stay.

In the appendix variant you see the diagnoses

broken down by length of stay. This is also very interesting to refer to. The box refers to 25 to 75 percent of patients. The plus is the mean length of stay. Unfortunately, the staples took away for you the ordinate here, so you are going to have to write in with each of those cross-hashes, 20, 40, 60, 80, 100 days. At least in my margin, I can't quite get it. So, the mean length of stay for a stroke, for example, is a little more than 30 days. For a traumatic brain injury, the mean length of stay at the plus is roughly 40 days. The comparable length of stay average, I used the University of Cincinnati, and I had very large numbers, several hundreds, for a particular year to refer to. The average length of stay for a stroke, for example, is 11.7 days, comparing to what you see here as an average of over 30. For a brain injury the average length of stay was 9.8 days, where here you see the average length of stay at the plus is 40. So we are talking about significantly different lengths of stay here, and the reasons are quite clear. When you come to an acute hospital with an acute condition that has to be dealt with, the emphasis is on diagnosing and treating quickly, making the person stable. As soon as that stability is achieved, the

person is no longer kept in the hospital. In fact, the emphasis now with the DRG movement is to get that person out of the acute hospital as fast as possible. In the rehabilitation facility, on the other hand, it is a completely different emphasis, where function is what is worked for, and then entire team mobilizes to improve function. We are going to talk a little bit more about that, but for that reason, function, which can take much longer to achieve, to return a person to the ability of a level of care that makes them more dependent, is a much lengthier process. That's why the length of stay is so much more drastic in rehabilitation facilities.

Under the category of Medical Stability on page 16, again, we are talking about different types of patients in the acute facility, and as mentioned, people are very often not stable. They are there because they are not stable. In the rehabilitation facility they must be stable in order to promote a return to function. There can't be a situation where the patient and the family is dwelling on an acute instability, because they cannot then try to better themselves functionally. If the emphasis is more on the medical, very often the patient doesn't belong there. The

patient belongs in the acute hospital, rather than the rehabilitation facility. And the nature of the physician population in these two places, the acute hospital versus the rehabilitation facility, is quite different.

The generic training that all of us go through, including myself, for medical school and residency, tends to promote the development of many different specialties, being in the acute hospital. In the rehabilitation facility, while there are specialists who are consult, the primary physician who practices is a physiatrist, like myself, where our training is involving disabilities; medical treatment that is pharmaceutical and sometimes light surgical application, but also a very preponderant amount of our training deals with the non-medical approaches to promoting function. So that we don't discount the psychological, the vocational, the social issues, we make that very much a part of our training and what we are trying to provide patients with is a rounded holistic approach. The whole human being is addressed in a rehabilitation facility, but returned to a quality of life involving the family in the care and the education process, and that the patient and the

family are very active participants in that program is crucial in the rehabilitation facility. On the contrary, as you are probably aware, I hope not personally, the experience in the acute hospital is one where you are a passive participant. Everything is done to you. You are in and out, and there is not nearly as much emphasis, nearly as much emphasis, in the area of education of you or family as is in the case of a rehabilitation facility.

On services provided, it is a very interesting comparison. We don't have the statistics. I have them, but we don't have them in a graph form to show you, but the relationship of the number of therapists, allied health specialists, psychologists, vocational counsellors, in a rehabilitation facility per patient, is roughly one to one. All of those specialists who are specializing in the non-medical areas of function correspond in number to the number of patients in the hospital at that time, as opposed to in the acute care hospital where you may have ten to 25 therapists for 400 to 700 patients and the emphasis here also, even in the way that those therapists function in the acute care facility, is a very quick return of whatever can be gotten in

as few days as possible, again, driven by the DRG situation as compared to what happens in rehabilitation facilities nationally where there is much more time given to development of this function. But the number of service providers in the acute care facility is drastically different, much lower than what you would find in rehabilitation.

Finally, inter-disciplinary team approach, the nature of rehabilitation, since it is holistic, dealing with the whole human being, the nature of the art, not just the skill, but the art, requires a teamwork approach. Everybody has to work together, frequent meetings of the entire staff dealing with each patient, frequent meetings of the staff with the patient and families to describe the process, where we are, what are the likely ramifications of home situations that will occur as a result of functional problems this person has. "We will do the best we can with function, but whatever we can't do we want you to understand that you are going to have to try to deal with after the fact." So a lot of teamwork is involved. Now, that's totally different from hierarchic nature of medical care in the acute facility. There is a doctor, very often a kingpin, and decisions are made, sort of

passed on down the line of the hierarchy to the patient, ultimately who receives this information.

I think it is important to mention that the ultimate goal in a rehabilitation program is independence, the maximization of function so that the patient can be independent after they finish the whole program.

In the acute hospital, of course, this is an entirely different approach. For that reason anytime a patient comes who is ultimately going to be able to go home, that is considered a victory because a large number of people who come in to rehabilitation facilities would have gone to a nursing home had they not the opportunity, the exposure, to rehabilitation. This is an extremely important fact to realize how useful, how important that function is, that rehabilitation process, to the restoration of the quality of life, a sense of dignity, to that person who would have otherwise ended up in a custodial care facility.

I'm going to quickly go through, on page 18, anything we haven't already mentioned to highlight two things that I haven't described. I've referred to some of these items already in the discussion previously, but let me

mention first of all, that what wasn't mentioned on your original list here, is that an indicator of quality as a characteristic distinguishing acute care hospitals from medical rehabilitation facilities is that in the acute care hospital accreditation is commonly done by the JCAHO. That is considered a standard that the industry of hospitals recognizes, but in rehabilitation facilities CARF is considered the national authority. CARF is an organization, Commission of Accreditation of Rehabilitation Facilities, established in 1966. Interestingly, it was a splitter from the JCAHO at the time it was the JCH and it was some people who felt very discouraged by the lack of rehabilitation relatedness of the JCH which caused the CARF people to break off from JCH. CARF is composed of a group of people who are chosen by peers, people who have been in practice a long time, established the standards, there are field studies to determine the field standards applicability, and a book is published, which I have here, a Standards Manual that is put out each year. It is modified in two to three years so that the standards are really state of the art.

I participated in the most recent review and

rewriting of Standards for Inpatient Rehabilitation, as a matter of fact, and that just took place a few months ago for the 1989 manual. So this is a process which is constantly reviewed. You should be very proud of the fact that your State Health Plan recognized CARF as the standard of quality for the rehabilitation facilities which will take place in West Virginia because CARF is really, as I say, the nation's recognized expert as a quality control intermediary.

The other thing I wanted to mention about page 18 is that it is so important that the misprint I feel I have to correct, but third of the way down it should say patient and family participation in the left as a characteristic, and then on the right patient and family are active participants. That's very important in rehabilitation, and so much so that I felt that that was an oversight here.

The very last thing that I'm going to refer to relates to the nature of the service consumption, the resource consumption in rehabilitation facilities, which I've mentioned several times earlier in my report. A very important study was done by the RAM Corporation. It was commissioned by HFMA of the Health and Human Services Department and it was

concluded that a prospective payment system for rehabilitation based on diagnostic indicators, which is now at the core of the PPS by Medicare, would not result in a reliable system for rehabilitation, and the reasons are quite clearly that the nature of the person who comes into a rehabilitation facility who needs to be in that system is not necessarily a nature that relates to the diagnosis. Although there are very common diagnoses you can see in a rehabilitation facility, they are not there because they have had a stroke. A large number of people who have had a stroke may not need to be in a rehabilitation facility unless they have functional problems. It is the function or the limitation in function which demands that a person go into a rehabilitation facility. So that if there are functional indicators, that is another consideration if functional indicators could be developed, but the fact is, using diagnosis is not going to tell you the length of stay and again referring to the appendix we have handed out at the end of the handout, you can see why using diagnosis is not going to be useful because of the wide disparity, the wide variation of time that a person will need to be in a rehabilitation facility. If you are using--

diagnosis as the key indicator, you can't say how long a person will have to be in the hospital to maximize their function.

Let me stop at this point.

MR. SIMMONS: Let me try to reiterate where we are before I move into this next section. Another point I would like to add for the record is that the beds, the medical rehabilitation beds in this state, are not currently licensed as acute care beds as part of the State Health Plan and the bed inventory.

What we are trying to suggest to HCCRA is that we believe that the definition under which you are attempting to extend the reporting requirements are not applicable to medical rehabilitation facilities, and what we've tried to do through the presentation of Ms. Keeley and Doctor Scheer is to demonstrate that there is a clear difference between an acute care hospital around which the HCCRA rule making was intended and a rehabilitation hospital, and we are officially putting that on the record today.

Now, setting that argument aside, which I'm sure Mr. Kozak may have interest in, I think there are some

other issues that the West Virginia Hospital Association spoke to and we would just like to put on the record, because we think it is important to a public policy body such as this to consider when they start thinking about additional regulatory activity. I'm on page 19. I think the first group of reasons we would talk about for the exclusion of the rehab system from this rule making is the fact that there are some very strong economic reasons that ought to be addressed.

The first one of these is the fact that at full operation, at least on the basis of our judgment of our facilities, the assessment of one tenth of one percent of gross revenues when these facilities come up to speed, which will be somewhere within a year to two on each one of them, those fees will be roughly $7,000 a year and I think one of the earlier people here testified that it doesn't make any sense when you are losing money to additionally burden a facility to the tune of $7,000 a year, which is not a one time charge, but an ongoing cost. It is clear that as long as the reimbursement system stays the way it is, both in the state as well as nationally, that that cost is going to be passed on to the patients that utilize the facility. That is the way you

recover the costs.

The second point I would make is that there are certain compliance requirements in terms of reporting that require additional data collection and handling that we think will significantly exceed, when I say significant, in terms of the multiple that we are talking about of $2,500 estimated in the fiscal note, we believe that the time and energy required to do that on an annual basis will probably run closer to $5,000 or $6,000, and again, that is certainly going to be passed on to the patients through increased costs of the operation of the facility.

We would only argue and suggest that in the absence of any desire, expressed desire on the part of HCCRA to regulate, that this is really primarily a reporting process that adds additional financial burden to the facilities and is really a cumulative data process more than anything else. We are not comfortable with the stated position of the Commission at this point that you won't move into regulation, but we understand the purpose of the rule making today is for reporting as opposed to regulation, rate regulation per se.

We would also suggest that there are a number

of other economic issues that as you began to rate regulate, if that's where you end up with this, these medical rehabilitation facilities, that clearly that may well end up putting some of these at a disadvantage to the point where other people or the patients may tend to travel to other neighboring states, to other facilities. That clearly has an adverse economic and financial impact on this segment of the health care industry in West Virginia, and obviously on the economics of West Virginia itself.

The last point I would make is at the bottom of page 21 and the top of page 24, these are not financially stable facilities and I can't speak for the other people that are in this room today, but I would submit to you that the rehab facility in CAMC, the psychiatric hospital up in Morgantown, the rehab facility that is under construction down in Huntington, as well as our two facilities, are still in a very early stage of growth and development, and they are not going to be economically stable. One reason why is that they are small facilities. They are 40 bed facilities. Although the psychiatric hospital is 70 beds. These are very economically unstable units at this point and it is going to

take quite a while to settle into an operating pattern that is going to give some reliability to their financial performance. I think that it doesn't serve any financial, beneficial or public purpose to begin to threaten, even if remotely, the financial stability of this particular segment of health care industry in this state.

The last area I would like to spend a couple of seconds on is on page 22, the policy reasons. I know this is essentially variant for West Virginians, and as a native West Virginian going back many years I can understand that. However, I must say that having left this state and in coming back as somebody who brought an investment back to this state, we did that because we thought West Virginia had real potential to yield the kind of economic benefits and would be a business environment that investors and people would want to come to the state. We are clearly a minority in that regard in many cases around the country, and I would only point out that if you recognize a recent Wall Street Journal, and I would just refer to this briefly, they indicated that only two states, Louisiana and West Virginia, rank in the bottom of the 15 states listed in both these surveys in some of these

factors that represented a poor business environment. These are not my words. These are articles and studies published in the Wall Street Journal. West Virginia was noted as having a high tax base, lack of skilled labor, and overregulation. I don't want to discuss the first two of those. All I want to do is focus on the issue of overregulation, and we would only argue and suggest to you that this type of regulatory effort only stultifies the business environment and the economic prospects of this state, and you are talking about people that are already here, that just came in on this basis, and it seems to me that that reflects a very poor public policy on the part of this state.

I would point out that four neighboring states abutting West Virginia, Kentucky, Maryland, Ohio, Pennsylvania, of all those states only one is opposed to rate review/rate control system on rehabilitation facilities, and that is in the State of Maryland, if you follow the industry.

We believe that the absence of rate regulation in those other states has probably served their economic growth and benefit. There are a lot of development of facilities in these neighboring states that are medical

rehabilitation facilities. For that matter, maybe psychiatric facilities. I'm not as knowledgeable in those areas.

I would point out, and if you have any question about this you can certainly have your staff check this out, our company does a lot of work, and I'm talking about our company in this case, being Medicon, a lot of work in Maryland and that heavily regulated state down there has resulted in an seriously underdeveloped medical rehabilitation system in that state, and they will be the first to admit that. So there is a state that is contrast. If West Virginia moves in that direction, whether that will blow any of the current prospective opportunities in this state remains the question, but there is a development effort still underway up in Morgantown alone that may well be threatened by this type of proposed rule making.

Finally, I would like to talk again about the Health Plan and the implied commitments. When you're into a CON process, you are required by that process to address the State Health Plan and to meet those commitments, both in your application and once that application is approved, you must fulfill those obligations and commitments as a sponsor and as

a provider as the facility comes up and comes on stream.

Our two facilities are attempting to meet all those obligations. We haven't met them all yet because we are new. We are in the process now of beginning to look and focus on CARF accreditation and other things such as that, but we understand that we are obligated to do that and we will do that. The problem is that the State of West Virginia, in our opinion, has not addressed all of its implied commitments in that plan, and I would address three of those. First of all, it has been talked about by the West Virginia Hospital Association that the state has yet to fund and pay for medical rehabilitation services to its Medicaid beneficiaries. I'm not going to dwell on the reason for that, and the fiscal instability of the Medicaid program in this state. It is a fact, but the question is that here are people that probably in the economic spectrum of the public have a greater need for medical rehabilitation than maybe other segments of this state, yet these people are by and large unable to achieve these services, and West Virginia has to address that problem. These patients are not going to be cared for in these facilities, any of these facilities in this state

potentially.

The State of West Virginia has yet to mandate rehabilitation benefits under private insurance plans. Blue Cross in this state has yet to recognize medical rehabilitation as a covered service in the State of West Virginia. Again, they've got to answer for that in terms of their own beneficiaries, their own insurance plan people, but the lack of mandated benefits exposes a very large segment of the population of this state to inadequate medical rehabilitation services.

Finally, your own Workers' Compensation plan, and we are putting this on record. I'm not sure that this is a commonly know fact, but they, they being Workers' Comp refer almost all the cases to rehab facilities outside this state currently. These are state tax dollars that are being paid for by companies and industries in this state into the plan for medical rehabilitation services that are being spent in out of state facilities when there aren't qualified facilities and programs and beds available in the State of West Virginia. Nobody yet in Workers' Comp has addressed that issue and therefore, some of these patients that need these services

either because they don't want to travel or can't afford to travel can get these services under that plan. So the summary of that would be that the State of West Virginia really, in our opinion, ought to focus on trying to meet these public policy commitments rather than be looking at attempting to regulate these facilities at an early stage and putting addition financial burdens on them for adverse economic reasons to the facilities.

Well, let me close by saying that we appreciate the opportunity to appear before you. We know that this has been a little long, a little tortured maybe, for you. We think it is a very important public issue. Certainly it is an important issue to our facilities and our reasons for investing and operating in this state and I thank you for the opportunity to do this and we will certainly stand for whatever questions you have.

MR. KOZAK: Thank you all. Mr. Folio?

MR. FOLIO: Yes. Part of this agency's job is to collect patient data information, including the kinds of illnesses that patients might have, the kinds of problems they might have, but also patient origin data. You are opposed to

us collecting that data, is that correct?

MR. SIMMONS: Let's be specific about the data, Mr. Folio. I'm not sure I understand.

MR. FOLIO: Well, we have uniform billing discharge data. It's a good planning tool for us.

MR. SIMMONS: That data that is required to be reported as part of the Health Department's requirements, we are not arguing against. We are not taking a position in opposition to. In fact, we have and will continue to provide that data information.

MR. FOLIO: You are opposed to providing us any financial information as opposed to salaries, wages, profit, losses, gross income, those kinds of data?

MR. SIMMONS: We have taken the opportunity to publish locally in Princeton, which is the only facility right now that would fall under the requirement and regulation, we have published that information and have submitted that in the reporting process to the State of West Virginia within the context of the Department of Health's requirements, so we are not taking exception to that. What we are taking exception to is the additional information that you are requiring under the

HCCRA part of the reporting requirements. Is that a fair statement, counsel?

MS. KEELEY: Yes, it is the 29B requirements we object to, not the Financial Disclosure Act.

MR. SIMMONS: I think we need to distinguish between those two.

MR. FOLIO: Do you all belong to the West Virginia Hospital Association?

MR. SIMMONS: Yes, we do.

MR. FOLIO: Do you pay an assessment fee?

MR. SIMMONS: Yes, we would pay the assessment requirements. Yes.

MR. FOLIO: Thank you.

MR. KOZAK: Mr. Keesling?

MR. KEESLING: No questions.

MR. DALE: When you were quoting the Wall Street Journal on the Louisiana and West Virginia, would you just go a little further there?

MR. SIMMONS: Well, I have to dig that out, Mr. Dale.

MR. DALE: Take your time.

MR. SIMMONS: The Wall Street Journal was -- this was an article --

MR. DALE: I understand the Wall Street Journal.

MR. SIMMONS: Well, I'm glad you do because sometimes I don't. The Wall Street Journal, this article was published on Tuesday, May 30, 1988, this year, and the subject of it is, "Rating Business Climates Becomes A Confusing And Nasty Game." There were two studies that they reported on there. One by the company by the name of Grant-Thornton and another one, Corporation For Enterprise Development. They ranked the best and the worst of the states. They ranked West Virginia and Louisiana in the bottom five. They didn't rate the two states of Alaska and Hawaii, only the contiguous 48 states. West Virginia in that one was ranked 43rd out of 48. In the Corporation For Enterprise Development, the worst states listed included, again, the only commonality was Louisiana, West Virginia. These were ranked alphabetically. I don't know where West Virginia ranked in that bottom 15 because they were put in alphabetical order. What they did, they identified what constituted good and bad economic characteristics and three of the ones that they noted in West

Virginia in this case are the ones of those I've mentioned, one of those being "overregulation", whatever definition you want to put on that, and that type of thing we are talking about here today.

MR. DALE: One of the lower 15, not last or second to last?

MR. SIMMONS: No, I didn't say that. I said they were in the bottom 15 percent, which I think represents the bottom nine in the case of that second study.

MS. KEELEY: I think one of the things we recognize in our public statement is that West Virginia has taken very serious steps to correct that public perception, and that public perception may indeed lag behind with what the facts may be in West Virginia with the aggressive business development program in the state. But our point is to impose regulation upon a group of facilities which were led to believe that that would not occur, is detrimental to development further, successful invitations to these kinds of facilities to come into the state, as well as to the growth and development of existing facilities in the state.

MR. SIMMONS: I want to go back and make a point.

When we looked at the opportunity to come into West Virginia in 1983 and 1984, the environment was whatever it was in those days, we still felt that coming into the state, and I must say there was a great deal of discussion at our Board level as to whether we wanted to come to West Virginia or not, and I said that I thought that this state was a diamond in the rough and was an opportunity to get in at a time when this state has no place to go but to improve in the situation. That's why we made the investment, and we don't apologize for that. We still think that is the situation. We are bullish on West Virginia, and it's hard sometimes frankly as a West Virginia to find people bullish on West Virginia. We think it is still going to be a good place to be. We just think that this is an ill-timed, ill-advised step in the wrong direction and sends the wrong message. That may not necessarily auger or predict how this whole discussion or debate between us is going to come out, but from a public policy and public perception point of view, we think it is very poorly timed, and it doesn't help me in the board room because I get the fingers pointed to me and, "I told you so." That's what they pay me for, I guess.

MR. KOZAK: Mr. Fizer?

MR. FIZER: Yes. Mr. Simmons, I don't know whether you recall me or not.

MR. SIMMONS: Yes, sir, I do.

MR. FIZER: I do apologize for my scratchy voice this morning. I've been standing in the rear and listening to the comments very enthusiastically this morning. I have a couple of questions for you. As you proceeded along with your Certificate of Need process in the development of your rehab facilities within this state, was it ever indicated to you that those facilities may be exempted from rate setting review or financial disclosures?

MR. SIMMONS: Well, yes, sir. Now, let me be very specific about this. When we were having our feasibility studies done by Ernst and Whinney, which we used to finance the bond issue, the people in Pittsburgh in different feasibility studies in that office of E&W wrote and received or asked for a letter from a member of the state, and I believe the letter was from John Kozak, who is here and I'm sure he remembers this, writing to Jill Beatty. That letter was dated November 20, 1986, and they indicated that their intent was not to regulate the hospitals. Then, subsequent to

that on December 21, 1987, last December, one of our financial officers at one of our facilities wrote to get additional confirmation to that fact and got a letter back from Walter J. Dale, Larry Fizer, and Don Keesling, that there was no intention of rate regulating these facilities.

We understand that we are not here debating rate regulation per se. What you are asking for and what you are proposing to do is initiate a collection of data under the reporting system, underneath HCCRA rules and not regulation per se. We believe that that will only inevitably lead to regulation and we also believe that in addition to that that you don't have the legal right to do that under the definition of how you are trying to apply it, and that's what we are here to debate today.

MR. FIZER: Well, I think it is a recognized point that has been made by you, your counsel, and the professor from the University of Cincinnati. In recognizing that it is a special and distinct service within this state, and I think HFMA and the folks at the federal level also, have they not recognized the fact that there is a lack of adequate data to do a determination of what the costs and so forth are?

So if we are ever going to look at some reasonable or rational way in costing out what those services are going to be, do we not need that type of data?

MR. SIMMONS: Possibly.

MR. FIZER: You mentioned another point that is very dear to my heart also, in the limited number of people that do pay for rehab services that indicates that most of the rehab services may be paid out of an individual's pocket due to the lack of the insurance coverages and so forth. Is it not also a reasonable state policy to look at those costs that are associated with that to ensure all their citizens that they are paying a reasonable cost that is associated with providing the service, since they do not have the insurance and so forth to pay for it?

MR. SIMMONS: Well, I'd make a couple of points. First of all, I think I would have to cite specific data coming out of the facility, which we will be glad to collect if you want us to. I don't believe there have been many, if any, patients in either one of our facilities to date that have paid anything out of pocket. Most of this have been insurance coverages where there are deductibles or co-

insurance provisions of private insurance payments. Obviously those people have to pay those costs. I don't think the burden has been directly out of pocket to any great extent in either facility. I can only speak to our two, but the fact of the matter is if significant segments of the paying or the payors are unwilling to underwrite the costs, then the only logical answer is that you have to cost shift to some of these other payors. I mean, that has been the tradition in the retrospective reimbursement system in this country for many, many years, and for certain parts of the industry to remain that way, and I guess the point I would make about that is that I think there is concern that one segment of the insured public may pay more than their share because the state won't absorb its rightful obligation, either under Medicaid or Workers' Comp, as well as Blue Cross. So I think your point is well taken. I can't give you any comfort about that because I think the facts are what they are and you have to operate these -- the financial requirements being what they are, you have to operate them that way.

MR. FIZER: This point that I'm trying to make, sir, in the development of these regulations, I think our

intent is very clear that we are not, as the letter has indicated, we are not moving in with the rate setting at this time, but if you will also look at the rate setting program that is in being that was put in together very loosely, if you'll pardon the expression, in gathering historical data and so forth, there has been tremendous adjustment made to that in the future years, and that was due to a lack of a data base that accurately reflected the costs, and I think that is the thing that we are seeing, that we do need this type of data to be provided on these patients to where we can look at the costs and so forth. Who knows, we may wind up in the same boat in the future, the same as HFMA and they are seeing right now. We can't establish it, but I think if you are ever going to look at it, and some people are suggesting that you are an acute care facility, then we need to look at it.

MR. SIMMONS: Well, I think that is part of the debate that will have to be discussed, and my response to you would be that if that's what you want and that's what you need, this is not the forum and the way to get it. It ought to be done through another public policy approach.

MR. KOZAK: Any further questions?

MR. FIZER: Not at this time, John.

MR. KOZAK: I have a couple. As I recollect my conversations with Ms. Beatty and others, as well as those letters, having reserved a specific statement that the policy stated in the letters, that that was what was in effect at that time and was subject to change through the rule making process, which is what we are all about here. The letters, of course, can speak for themselves, but that is my recollection.

MR. KEELEY: John, we don't disagree with that. Up until this point in time, because there was no assertion of any authority that it was not incumbent upon either Southern Hills or Western Hills to take the position that they have adopted here today, which is that when you look at the regulations and the statute, it is in our mind clear that Article 29B is limited to acute care facilities and not to other facilities such as nursing homes or extended care facilities such as rehabilitation facilities. I would, in the course of those recognized -- I don't know what Mr. Dale has been looking at in connection with various statutes that he has in front of him, but I would recognize that if you are looking at the CON definition of hospitals, it does recognize

rehabilitation facilities as a hospital, but keep in mind that different code section is not 29B and these facilities went through Certificate of Need review as do nursing homes and everything else. The breadth of the CON law and definitions are very different from the breadth of the definitions under 29B, so we draw that distinction very clearly.

MR. KOZAK: You mentioned, Mr. Simmons, the fact that Maryland's rate setting agency does oversee the rehabilitation facilities. As a caveat I'll mention that it is my understanding that our statute was based upon that in Maryland, and as a matter of fact, the Maryland people assisted the Legislature in the writing of our statute.

I was interested to pursue further what the other three major rate setting states do, if you know, New York, New Jersey.

MR. SIMMONS: Well, let me think a minute. New Jersey is -- well, wait a minute. I do have that, as a matter of fact. Give me a few seconds to dig that out, get the survey on that.

I can give you, at least, New Jersey. New Jersey's inpatient rehabilitation is under the aegis of the

share program, which is the predecessor of the current DRG program in that state, which, as you know, is exempted out by the feds at this point, is wavered out. New York, I don't have any data on. I can get that for you if you'd like me to. Was there another state you had in mind, Mr. Kozak?

MR. KOZAK: Massachusetts.

MR. SIMMONS: I don't know. I cannot answer Massachusetts. Again, I can dig that out for you if you want me to.

MR. KOZAK: I think we have that on file here.

MR. SIMMONS: But I must point out, the share program is a completely different method for reimbursement of rehab hospitals in that state than the DRG system is in the State of New Jersey.

MR. KOZAK: We do not use the DRG system in this state either.

MR. SIMMONS: I understand that.

MR. KOZAK: I guess this question is more for Ms. Keeley. I was going to ask you about the application despite your arguments of 5F, the Financial Disclosure Statute. As I recall that statute it has basically an empowering section in

it that such other reports as the Director of Health may require, I think I read something paraphrased to that extent. We, of course, replaced the Director of Health to administer that statute. What I was thinking from listening to this is that very little possibly UB-82 data. I haven't thought that through yet.

MS. KEELEY: The wage and salary survey?

MR. KOZAK: But there is very little that goes into what is purely 29B that couldn't also be collected under the Financial Disclosure Statute.

MS. KEELEY: I think that is why we took the position that this regulation is cumulative and unnecessary because you are already getting from the facilities basically all the information you need, and the additional information is for purposes of an assessment and the wage and salary survey which is a preliminary to rate review is unnecessary if, in fact, there is no intention to regulate by rates, these facilities.

MR. KOZAK: My point though is that it would seem that we could issue a set of legislative rules under the Facilities Disclosure Statute that would require the

collection of the annual wage and salary surveys for hospitals as well as nursing homes, the annual financial reports that hospitals have to do could be slid into that statute. I can make a fast argument here about the UB-82 data, but I haven't thought that one through yet.

Also under 5F, as opposed to 29B, since they are all in some fashion connected with financial disclosure, I guess was just basically interested in hearing your response to that. As I mentioned to Mr. Spiker, we are in the process of rethinking that program fundamentally and will be issuing rules for it. I don't see why we couldn't slide most of the stuff under 5F.

MS. KEELEY: I think if it were, as you use the term, slide it under 5F, which we have acknowledged here today that we are subject to, that much of the fear as to what this is a precursor of would be eliminated. I have not discussed that with Mr. Simmons and I have not reviewed that statute, so I don't want to stand on what I'm saying. I reserve the lawyer's right to change my mind. Also the woman's right, but I think if the breadth of that statute is, in fact as you say it is, that that may be a more appropriate location for the

information that is being sought.

MR. KOZAK: Are there any further questions?

MR. FIZER: I have one I would like to follow-up with Mr. Simmons again. I have heard it mentioned on several occasions including Ms. Keeley today in regards to the $7,000 assessments. I also heard your response to the question by Mr. Folio that you are a member of the Hospital Association, and thinking along those lines, are you familiar with the position that was advocated by that association during the recent Legislative sessions to expand that assessment to all health care providers in this state to lower the amount of assessment on individual facilities?

MR. SIMMONS: I have not heard that specifically. I'm not that current on the whole matter, Mr. Fizer.

MR. FIZER: You are also aware by being familiar with the statute that this agency cannot spend any more money than is appropriated by the Governor or the Legislature, so it is not a matter of collecting more money.

MS. KEELEY: I think our point was that assessment given the economic fragility of these institutions might be more burdensome than the actual dollars themselves would

indicate since the facilities are losing money.

MR. KOZAK: Thank you all very much.

That ends the list that I have in front of me. Is there anyone else that wishes to make a presentation?

MR. CROFTON: My name is Tim Crofton and I'm the CEO for the American Hospital for Rehabilitation that we are building over in Huntington. I'll be very brief, but I would like to say that our organization has invested a considerable amount of money and we hope to provide quality service to the citizens of Huntington and across the two rivers.

We support the comments that were made by my colleagues and also the West Virginia Hospital Association. We are opposed to data collection through an extra effort rather than through the means that are now available. I'm not familiar enough to know the differences between what is available through the cost reports that we file with the Medicare folks and what the Health Care Review organization is interested in, but I suggest that maybe the information is available through some other channel than to ask the hospital to absorb another cost.

Fundamentally, then, we are opposed based on

cost. We are very fiscally conservative. We have a very small hospital, 40 beds, and as you've heard earlier, we work on a very narrow kind of margin. It would be very difficult for us to absorb an added cost.

MR. KOZAK: Thank you, sir. Are there any questions?

MR. DALE: In your last statement, did you have a negative or a positive bottom line?

MR. CROFTON: No, sir. We haven't opened yet. We hope to have a positive bottom line, but we have not opened yet.

MR. KOZAK: Thank you, Mr. Crofton.

Is there anyone else present who would like to make a comment on these rules?

(No response.)

MR. KOZAK: Hearing no further comments, we will declare the public hearing ended, and thank you all for coming.

MR. SIMMONS: Mr. Kozak, do you have an idea when you are going to issue your decision on this?

MR. KOZAK: I did mean to mention that the Board

has scheduled a public meeting on June 27, which is a Monday at 2:00 in this room at which we expect the Board will deal with these rules in some version after they've had time to study these comments and reflect upon them. That action will take place at that time, so if anyone is interested they can be here then or check with one of us later.

Thank you.

(WHEREUPON, the hearing was concluded at 11:28 a.m.)

REPORTER'S CERTIFICATE

STATE OF WEST VIRGINIA,

COUNTY OF KANAWHA, to-wit:

I, the undersigned, Donna J. Whiting, Court Reporter, do certify that the foregoing is, to the best of my skill and ability, a true and accurate transcript of all the testimony adduced or proceedings had in the aforementioned case as set forth in the caption hereof.

Given under my hand this 20th day of June, 1988.

Donna J. Whiting
Court Reporter