WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #3

FILED
1998 SEP 19 PM 2:00
SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: WV Health Care Cost Review Authority TITLE NUMBER: 16-5F

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

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 PROPOSED: 13

TITLE OF RULE BEING PROPOSED: Financial Disclosure Rule

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

WALTER J. DALE
Chairman

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Financial Disclosure Rule

Type of Rule: x Legislative _____ Interpretive _____ Procedural

Agency: Health Care Cost Review Authority

Address: Suite 201, 100 Dee Drive
Charleston, WV 25311

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

2. Explanation of above estimates.

The program formally implemented by this rule has been operating since 1979. No new significant duties are imposed on the agency or the covered facilities by this rule.

3. Objectives of these rules:

To formally implement the provisions of the Health Care Facility Financial Disclosure Act, W. Va. Code, § 16-5F-1 et seq., by specifying the materials to be filed, the time period for doing so, and the penalties for failure to file.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None.

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

No new impact. The act has been in place and operating since 1979. Total cost for complying with the act averages about $3,000.00.

C. Economic Impact on Citizens/Public at Large.

No new economic impact. The citizens/public will benefit in making their own choice of health care providers by availing themselves of this data.

Date September 19, 1988

Signature of Agency Head or Authorized Representative

WALTER J. DALE
Chairman

DATE: September 19, 1988

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FILED

1988 SEP 19 PM 2:00

SECRETARY OF STATE

FROM: West Virginia Health Care Cost Review Authority

LEGISLATIVE RULE TITLE:

1. Authorizing statute(s) citation W. Va. Code, § 16-5F-3(a), and § 16-29B-8(a) & -16(a).

2. a. Date filed in State Register with Notice of Hearing:

July 19, 1988

b. What other notice, including advertising, did you give of the hearing?

Publication in agency newsletter.

Copies sent to hospital trade association and to nursing home trade association.

c. Date of hearing (s): September 1, 1988

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached x No comments received _____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

September 19, 1988

f. Name and phone number of agency person to contact for additional information:

John H. Kozak, General Counsel

343-3701

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

   a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

      Not applicable

   b. Date of hearing: _____

   c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

      _____

   d. Attach findings and determinations and reasons:

      Attached _____

WEST VIRGINIA LEGISLATIVE RULE
HEALTH CARE COST REVIEW AUTHORITY
CHAPTER §16-5F

SERIES XIII

Title: FINANCIAL DISCLOSURE RULE

WEST VIRGINIA LEGISLATIVE RULE
HEALTH CARE COST REVIEW AUTHORITY
CHAPTER §16-5F

SERIES XIII

Title: FINANCIAL DISCLOSURE RULE

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§ 65-13-1. General.

1.1. Scope - This legislative rule implements the provisions of the Health Care Facility Financial Disclosure Act (hereinafter referred to as "the Act"), West Virginia Code, § 16-5F-1 et seq. Pursuant to the provisions of West Virginia Code, § 16-29B-16(a), the board of the Health Care Cost Review Authority replaced the Director of the Department of Health for the administration of the Act.

1.2. Authority. - West Virginia Code, § 16-5F-3(a), § 16-29B-8(a), and -16(a).

1.3. Filing Date. - _____.

1.4. Effective Date. - _____.

§ 65-13-2. Introduction.

2.1. The purpose of this rule is to formally implement the provisions of the Act. Heretofore, the board and before it the Department of Health implemented the Act with a set of informal guidelines. This rule is intended to

bring the program into conformity with the provisions of West Virginia Code, § 29A-3-1 et seq.

2.2. It is not the purpose of this rule to replace, modify, amend, or limit in any fashion the programs implemented by the board under the provisions of West Virginia Code, § 16-29B-17 & -18 (Uniform Reporting System and Annual Wage and Salary Survey), § 16-29B-22 ("Legislative Rules To Implement Utilization And Quality Assurance Program - Phase 1", 65 C.S.R. 4 (1985)), or West Virginia Code, § 16-29B-10(b) (Professional Services Vendor Contracts). Those programs shall continue until they are specifically amended elsewhere. However, to some extent the present rule requires the submission of the same or similar information. Because the definition of "covered facility" under the Act includes a "hospital" as that term is defined at West Virginia Code, § 16-29B-3(e), certain provisions of this rule will duplicate the other filing requirements. In no event shall this rule be construed as requiring duplicate filings from any such "hospital." A single filing containing all of the required information shall be sufficient for the purpose of both statutes.

§ 65-13-3. Definitions.

3.1. The term "the Act" means the Health Care Facility Financial Disclosure Act, West Virginia Code, § 16-5F-1 et seq.

3.2. The term "annual report" means an annual financial report for the covered facility's fiscal year prepared by an accountant or the covered facility's auditor.

3.3. The term "the board" means the three-member body created by West Virginia Code, § 16-29B-5, and which is designated to administer the programs under the Act.

3.4. The term "covered facility" means any hospital or other health care facility with fifteen or more inpatient beds, whether publicly owned, operated for profit or operated as a not for profit facility and whether licensed, or unlicensed, but does not include personal care homes as the same are defined at West Virginia Code, § 16-5C-2. The term does include any facility which provides either skilled nursing care or intermediate nursing care, or both.

3.5. The term "hospital" means any health care facility licensed as such under the provisions of West Virginia Code, § 16-5B-1, and any other acute care facility operated by the state government which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons; but, does not include any federally owned or operated facility or state owned or operated mental health facilities or state owned or operated long-term care facilities. The term does include speciality hospitals such as, but not limited to, acute care psychiatric and rehabilitation hospitals.

3.6. The term "rates" means all rates, fees, or charges imposed by any covered facility for health care services.

3.7. The term "records" includes accounts, books, charts, contracts, documents, files, maps, papers, profiles, reports, annual and otherwise, schedules, and any other fiscal data, however, recorded or stored.

§ 65-13-4. Newspaper Advertisements.

4.1. Every covered facility shall cause to be published as a Class I legal advertisement, pursuant to West Virginia Code, § 59-3-2, in a qualified daily newspaper published within the county within which the covered facility is located, an annual report prepared by the covered facility's auditor or an independent accountant. The annual report shall contain only those items specified in section 4.5 of this rule and prepared in accordance with generally accepted accounting principles.

4.2. If no daily newspaper is published within the county, then the covered facility shall select a qualified newspaper which is published outside the county but which has the widest circulation within the covered facility's county.

4.3. The newspaper advertisement must be published within one hundred and twenty (120) days after the end of each covered facility's fiscal year. Upon a showing of good cause, the board may grant an extension of this time period. A copy of the advertisement must be filed with the board within thirty (30) days of its publication.

4.4. The annual report shall pertain to the individual covered facility; that is, if the covered facility is a division or a subsidiary of another entity

which owns or operates other covered facilities, then the annual report shall apply to the division or subsidiary and shall not pertain to the aggregate of the covered facilities of the other entity.

4.5. The annual report shall contain a complete statement of the following:

4.5.1. Balance sheet.

4.5.2. Income statement.

4.5.3. Statement of changes in financial position.

4.5.4. A statement of ownership for persons owning more than five percent (5%) of the capital stock outstanding and the dividends paid thereon, if any, and to whom paid for the period reported unless the covered facility is duly registered on the New York stock exchange, American stock exchange, any regional stock exchange, or its stock is traded actively over the counter. Also, the report shall state in every instance without limitation the complete ownership of a hospital (however it may be structured) where that ownership is, in whole or in part, by another entity which is not a natural person.

4.5.5. A prominent notice that the details concerning the contents of the advertisement, together with the other reports, statements and schedules required to be filed with the board shall be available for public inspection and copying at the board's office.

4.6. Under the provisions of West Virginia Code, § 59-3-2, a Class I legal advertisement must be published in only one newspaper and need not be published in two (2) newspapers of opposite politics. In selecting the newspaper

within which to publish its annual report, the covered facility shall select the one of widest, daily circulation in its county.

4.7. Further, West Virginia Code, § 59-3-2, also prohibits the use of a Sunday edition of any newspaper.

§ 65-13-5. Non-Hospital Covered Facilities.

5.1. In addition to the newspaper advertisement that must be published pursuant to section 4 of this rule, each covered facility that is not a hospital (either in whole or in part) shall file with the board annual reports, records, and other information. Except where another time period is stated, all such annual reports, records, and other information shall be filed with the board by the facility within one hundred and twenty (120) days after the end of the facility's fiscal year; except that, upon a showing of good cause, the board may grant an extension of that time period as well as any other time period stated therein.

5.2. The facility shall file an annual, audited financial report in its entirety as prepared and presented by the facility's auditor or independent accountant together with all accompanying notes, schedules, and documents as required by the American Institute of Certified Public Accountant's (AICPA) audit guides. In the event that an audited financial report is not prepared by the facility, the facility shall submit the following:

5.2.1. A statement of revenue and expenses.

5.2.2. A statement of changes in financial position.

5.2.3. A balance sheet.

5.3. The annual, audited financial report (or the substituted documents specified in subsection 5.2.1 et al.) shall pertain to the individual facility; that is, if the facility is a division or a subsidiary of another entity which owns or operates other covered facilities, then the annual, audited financial report (or its substitute) shall apply to the division or subsidiary and shall not pertain to the aggregate of the facilities of the other entity.

5.4. The facility shall file a statement of the total financial needs of the facility and the resources that are available or are expected to become available to meet such needs. The facility shall file its approved budget and its annual capital expenditures budget for the forthcoming fiscal year. The formats for the budgets may be that customarily used by the facility for its own internal purposes; except that, at a minimum the budget must state the projected patient revenue and expenses by individual cost center and the details of other anticipated revenues and expenses.

5.5 The facility shall file a statement of services available and of services rendered by completing and returning to the board a copy of its Annual Report of Nursing Homes within thirty (30) days of its receipt of the blank form.

5.6. The facility shall file a complete schedule of its then current rates for all patient services provided by the facility at the close of its fiscal year.

5.7. If the facility is certified under the federal medicare or medicaid programs, the facility shall file a complete copy of all cost reports that

are submitted by it to the medicare intermediaries and to the medicaid state agency. If such a cost report is not prepared, then the facility shall file a complete schedule of costs allocated to each category of costs, in accordance with the standards of the state medicaid office.

5.8. The facility shall file a statement of all charges, fees, or salaries (whether in cash or other species) for goods or services rendered to the facility together with the name and address of the entity which rendered the goods or services for the period reported which exceeds the sum or the equivalent of fifty-five thousand ($55,000.00) dollars. This requirement does not apply to payments made or due as a result of a patient's stay at the facility.

5.9. The facility shall file a statement of all charges, fees, or other sums (whether in cash or other species) collected by the facility and the name and address from whom collected for or on the account of any person, firm, partnership, corporation, or other entity, however structured, which shall exceed the sum of or the equivalent of fifty-five thousand ($55,000.00) dollars during the period reported. This requirement does not apply to payments made or due as a result of a patient's stay at the facility.

5.10. If specifically requested by the board, a facility shall file a trial balance for the period reported which request shall allow the facility at least fifteen (15) days to respond.

5.11. If the facility or its parent entity must file a form 10K with the federal Securities and Exchange Commission, then the facility shall file a copy

of that form 10K with the board on an annual basis and within fifteen (15) days of the filing of the form with the federal agency.

5.12. Any data or material that is furnished to the board pursuant to the provisions of section 5.7 of this rule need not be separately refiled by the facility.

§ 65-13-6. Covered Facilities That Are Hospitals.

6.1. In addition to the newspaper advertisements that must be published pursuant to section 4 of this rule, each covered facility that is a hospital (including those hospitals that have distinct part units such as skilled nursing care, intermediate nursing care, psychiatric, or rehabilitation care) shall file with the board annual reports, records, and other information. Except where another time period is stated, all such annual reports, records, and other information shall be filed with the board by the facility within one hundred and twenty (120) days after the end of the facility's fiscal year; except that, upon a showing of good cause, the board may grant an extension of that time period as well as any other time period stated herein.

6.2. The facility shall file an annual, audited financial report in its entirety as prepared and presented by the facility's auditor or independent accountant together with all accompanying notes, schedules, and documents as required by the American Institute of Certified Public Accountant's (AICPA)

audit guides. In the event that an audited financial report is not prepared by the facility, the facility shall submit the following:

6.2.1. An income statement.

6.2.2. A statement of changes in financial position.

6.2.3. A balance sheet.

6.3. The annual, audited financial report (or the substituted documents specified in subsection 6.2.1 et al.) shall pertain to the individual facility; that is, if the facility is a division or a subsidiary of another entity which owns or operates other covered facilities, then the annual, audited financial report (or its substitute) shall apply to the division or subsidiary and shall not pertain to the aggregate of the facilities of the other entity. It is noted that this section does not encompass situations such as that of Charleston Area Medical Center which operates several divisions under one corporate umbrella and which are located within one city.

6.4. The facility shall file a statement of the total financial needs of the facility and the resources that are available or are expected to become available to meet such needs. The facility shall file its approved budget and its annual capital expenditures budget for the forthcoming fiscal year at least thirty (30) days prior to the start of that fiscal year; provided that, upon a showing of good cause, the board may change that time period. The formats for the budgets may be that customarily used by the facility for its own internal purposes; except that, at a minimum the budget must state the projected patient revenue

and expenses by individual cost center and the details of anticipated other operating and non-operating revenues and expenses.

6.5. The facility shall file a statement of services available and of services rendered by completing and returning to the board a copy of its annual survey report for the American Hospital Association within fifteen (15) days of its tendering the report to that Association.

6.6. The facility shall file a complete schedule of its then current rates for all patient services provided by the facility at the close of its fiscal year.

6.7. If the facility is certified under the federal medicare or medicaid programs, the facility shall file a complete copy of all cost reports that are submitted by it to the medicare intermediaries and to the medicaid state agency. If such a cost report is not prepared, then the facility shall file a complete schedule of costs allocated to each category of costs, in accordance with the standards of the state medicaid office.

6.8. The facility shall file a statement of all charges, fees, or salaries (whether in cash or other species) for goods or services rendered to the facility together with the name and address of the entity which rendered the goods or services for the period reported which exceeds the sum or the equivalent of fifty-five thousand ($55,000.00) dollars. This requirement does not apply to payments made or due as a result of a patient's stay at the facility.

6.9. The facility shall file a statement of all charges, fees, or other sums (whether in cash or other species) collected by the facility and the name

and address from whom collected for or on the account of any person, firm, partnership, corporation, or other entity however structural, which shall exceed the sum of or the equivalent of fifty-five thousand ($55,000.00) dollars during the period reported. This requirement does not apply to payments made or due as a result of a patient's stay at the facility.

6.10. A trial balance for the period reported.

6.11. If the facility or its parent entity must file a form 10K with the federal Securities and Exchange Commission, then the facility shall file a copy of that form 10K with the board on an annual basis and within fifteen (15) days of the filing of the form with the federal agency.

6.12. If the facility (which is a hospital for the purpose of this rule) is not subject to the provisions of the Health Care Cost Review Authority Act, West Virginia Code, § 16-29B-1 et seq., and the rules promulgated thereunder, then the facility shall also make the following filings. An example of such a facility is a free-standing, rehabilitation hospital.

6.12.1. A copy of the Health Care Cost Review Authority Financial Report (otherwise known as the Uniform Reporting System) heretofore adopted pursuant to West Virginia Code, § 16-29B-17.

6.12.2. Copies of any contract that the facility enters into with any individual or group of health care providers for the provision of inpatient or outpatient services together with a schedule of rates to be charged by the health care providers for their services under the contract or charged by the hospital

for those services by the providers; except that, simple admitting privileges to the facility shall not be construed as being such a contract.

6.12.3. A complete copy of the Uniform Bill-82 (UB-82) data for each and every one of its inpatients including those that are incurred by the federal medicare and medicaid programs. If the board obtains another source for some of the data, then the board may excuse the facility of providing that portion. The UB-82 data must be submitted to the board (or its agent) on Industry Standard 1600 BPI tape or upon Wang format tape or upon similar computer tape format. If the board later chooses to specify some other format for the data, it shall issue an appropriate procedural rule specifying that format. Hard copies of the UB-82 data are not to be submitted without the prior approval of the board. It is especially directed that the board and any of its officers, employees or agents selected by it to store and manipulate the data shall maintain the confidentiality of all personal medical information personally identifiable to a purchaser. The facilities shall submit and the board's agent shall collect such confidential data from the UB-82 forms. Reference shall be made to the "Legislative Rules To Implement Utilization Review And Quality Assurance Program - Phase 1," 65 C.S.R. 4 (1985), and its successor rules in the application of this subsection 6.12.4 of this rule.

6.12.4. The provisions of this section 6.12 and its subparts are expressly based upon the provisions of West Virginia Code, § 16-5F-3(a)(2) & (3) and § 16-5F-4(b)(6).

6.13. Any data or material that is furnished to the board pursuant to the provisions of section 6.7 of this rule need not be separately refiled by the facility.

§ 65-13-7. Additional Information.

7.1. Whenever further fiscal information is deemed by the board to be necessary to verify the accuracy of any information set forth in any statement, schedule, or report filed by a covered facility under the provision of the Act or of this rule, the board shall require the production of any records necessary to verify such information.

7.2. From time to time, the board may engage in or carry-out analyses and studies relating to health care costs, the financial status of any covered facility or any other appropriate related matters, and make determinations of whether, in its opinion, the rates charged by a covered facility are economically justified.

7.3. Upon at least ten (10) days notice to the covered facility, the board may specify that the facility supply it with other reports of the costs incurred in rendering services or the board may require the filing of fiscal information by a facility relating to any matter affecting the cost of health care services in this state.

§ 65-13-8. Hearings - Pursuant to the provisions of West Virginia Code, § 16-29B-8(a)(2) and -12, the board may conduct a hearing as part of any investigation it undertakes under the Act or this rule.

§ 65-13-9. Confidentiality - The board, its officers, employees, and agents shall maintain the confidentiality of any and all medical or individual information personally identifiable to a patient or a consumer of health services, whether directly or indirectly.

§ 65-13-10. Public Access To Information - All reports, statements, and schedules filed with the board under the Act or this rule (with the exceptions stated in subsection 6.12.3 and section 9) shall be open to public inspection and shall be available for examination during regular business hours of the board. Copies of such reports, statements, and schedules shall be made available to the public upon request and the board may charge its reasonable and customary fees in making copies of such reports.

§ 65-13-11. Injunctions - Whenever it appears that any covered facility, required to file or publish such reports, statements, and schedules as are required by the Act or this rule, has failed to file or publish such items, the board's general counsel or the office of the attorney general, upon the direction or request of the board, may apply in the name of the state to, and the circuit court of the county in which such covered facility is located shall have jurisdiction for

the granting of a mandatory injunction to compel compliance with the provisions of the Act or of this rule.

§ 65-13-12. Penalties For Failure To Comply - Every covered facility failing to make and transmit to the board any of the reports required by law or failing to publish or distribute the reports as so required, shall forthwith be notified by the board by use of the certified United States mail, return receipt requested, and if such failure continues for ten days after receipt of said notice, such delinquent facility shall be subject to a penalty of one thousand dollars for each day thereafter that such failure continues, such penalty to be recovered by the board through the attorney general or its general counsel in a civil action and paid into the state treasury to the account of the general fund. Review of any final judgment or order of the circuit court shall be by appeal to the West Virginia Supreme Court of Appeals.

§ 65-13-13. Severability - If any provision or provisions of this rule or the application thereof to any entity or circumstance shall be held invalid, such invalidity shall not affect the provisions or applications of this rule which can be given effect without the invalid provision or provisions or application and to this end the provision of this rule are declared to be severable.

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

MEMORANDUM

TO: Legislative Rule-Making Review Committee

FROM: West Virginia Health Care Cost Review Authority

RE: Brief Summary of Proposed Legislative Rule: Financial Disclosure Rule; and Statement of Circumstances Requiring The Rule

The West Virginia Health Care Facility Financial Disclosure Act, West Virginia Code, § 16-5F-1 et seq., was enacted in 1979 for the purpose of requiring covered facilities to "make a public disclosure of their financial position and to bring about a review as to the reasonableness of the costs of health care services." Id., at section 1. The facilities affected by the act are the state's nursing homes and hospitals. Following the enactment, the Director of the Department of Health issued a set of "Guidelines" for the implementation of the act. Although never promulgated as a regulation or rule, in effect, the "Guidelines" were regulations. From 1979 until the summer of 1988, the covered facilities complied with the act and the "Guidelines" without significant problems. However, in the summer of 1988, a number of nursing homes indicated that in the absence of lawful regulations or rules, they would not comply with the full requirements of the act. Hence, it is now necessary to issue the proposed rule to rectify this problem and to keep the program functioning. Pursuant to West Virginia Code, § 16-29B-16(a), 1983 the Authority replaced the director of the Department of Health as administrator of this program.

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

The proposed rule largely repeats the language of the act itself. Additionally, guidance is given regarding the publication of a financial report in the facilities' local areas by means of a legal advertisement. The rule also details the various types of financial reports and documents that must be filed with the agency and states when the various items must be filed. In addition to the items provided for by the act, the rule utilizes the authority given to the agency under section 3(a)(2) and requires the hospitals to file their yearly trial balances. The nursing homes are only required to file trial balances if specifically requested by the agency to do so. Moreover, both types of facilities are required to file copies of their Forms 10K from the federal Securities and Exchange Commission if they have a parent company and if the parent is required to file that form. Thus, both new filing requirements concern copies of items that are already being required of the facility by other authorities and are not items that will have to be prepared especially for this rule.

Finally, the rule addresses hospitals, such as rehabilitation facilities, that are covered by this act but which do not make filings under the West Virginia Health Care Cost Review Authority Act, West Virginia Code, § 16-29B-1 et seq. The rule requires such hospitals to file additional financial documents so that they will be filing all of the same items that other hospitals are required to do under the HCCRA Act. See Section 6.12 of the proposed rules.

JHK/jmh

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

MEMORANDUM

TO: Legislative Rule-Making Review Committee

FROM: West Virginia Health Care Cost Review Authority

RE: Amendments and Reasons For Amendments To Proposed Legislative Rule: Financial Disclosure Rule

The proposed legislative rule concerns the West Virginia Health Care Facility Financial Disclosure Act, West Virginia Code, § 16-5F-1 et seq. This memorandum will address the written and oral comments made regarding the proposed rule and will explain the reasons for accepting some of the suggestions and for rejecting others. Consequent changes in the language of the proposed rule will also be addressed.

(1) . Both the West Virginia Health Care Association, Inc., by its Executive Vice President, Edwin J. Foss, and the Glenwood Park United Methodist Home, Inc., by its President, Daniel W. Farley, commented upon section 5.4 of the proposed rule. Section 5.4 requires nursing homes to file a "budget and annual capital expenditures budget for the forthcoming fiscal year at least thirty (30) days prior to the start of that fiscal year." Both commentors note that nursing homes ordinarily do not complete their budgets until well after the start of their fiscal years due to problems associated with the state's medicaid program. Both suggest that this filing date be delayed.

The agency agrees to the comment and will change the filing date to 120 days after the start of the fiscal year which will be the same date as in most of the other requirements.

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

(2) The West Virginia Chapter of the Healthcare Financial Management Association (HFMA) by its President, Ronald D. Anspaugh, filed a written comment and also submitted oral comments to the agency's staff. HFMA suggests that sections 6.8 and 6.9 be amended to make clear that neither section applies to insurance or other third-party payments and patient payments. Section 6.8 and 6.9 concern the identification of parties who do business with the hospital in excess of $55,000.00 per year as is required by section 4(b)(5) of the act. The agency agrees that the act does not intend this requirement to apply to insurance or other third-party payments or other patient payments. Thus, these sections will be amended to reflect that intention. Similar changes will be made to sections 5.8 and 5.9 of the proposed rule since those sections complement for nursing homes sections 6.8 and 6.9 which apply to hospitals.

HFMA also suggests that the $55,000.00 limit used by sections 6.8 and 6.9 (as well as by section 5.8 and 5.9) be adjusted for inflation. The agency must reject this request since the act does not grant the agency either the power or discretion to make such adjustments.

HFMA suggests that section 7.2 of the proposed rule be deleted because the agency's rate setting methodology already addresses whether or not a hospital's rate structure is economically justified. The agency must reject this suggestion. Initially, the agency notes that section 7.2 of the proposed rule merely repeats the language of section 4(f) of the act. Thus, no new or additional power or duty is being created by this section. The agency believes that this proposed rule should state the full requirements of the act and should not state only some items and, thus, force a concerned person to have to search out both the rule and the act. By reading the rule, such a concerned person will have all requirements of the program before him or her in one place. In addition,

the agency notes that section 7.2 of the proposed rule also applies to nursing homes which are not covered by the agency's hospital rate setting program.

HFMA also commented on section 4.1 of the proposed rule. This section concerns the requirement of section 4(a) of the act that a covered facility publish as a legal advertisement an annual financial report. Specifically, HFMA is concerned that the use of the phrase "the covered facility's auditor or an independent accountant" would require the publication of an extensive and multi-page financial statement with all of the accountant's notes rather than the very short statement that is presently required. The agency notes that the complained of phrase is taken directly from section 4(a) of the act. However, the agency does not believe that the phrase was intended to require the publication of an extensive financial report. Rather, the agency believes that section 4.1 of the proposed rule merely follows prior practice. In order to clarify this intention, section 4.1 has been amended.

HFMA is also concerned that section 6.12 would cause hospitals to duplicate filings that they are already making under the Health Care Cost Review Authority Act, West Virginia Code, § 16-29B-1 et seq. This concern is misplaced. Section 6.12 applies only to those few facilities which are hospitals for purposes of this rule and this act, but which are not treated as hospitals under the HCCRA act. At the moment, section 6.12 applies only to free-standing rehabilitation hospitals. Thus, it is only they, at this time, to which section 6.12 is applicable. However, in the interests of clarity, section 6.12 has been amended by adding an illustrative, example statement. In addition, the agency is deleting the former provisions of subsection 6.12.2 concerning the agency's Annual Wage and Salary Survey since that report is now included within the Uniform Reporting System. See subsection 6.12.1. Former subsections

6.12.3 through 6.12.5 have been renumbered to reflect this deletion and are now numbered as subsections 6.12.2 through 6.12.4 respectively.

(3) The Charleston Area Medical Center (CAMC) by its Vice President for Finance, Stephen Z. Bell, filed written comments. CAMC initially objects to the requirements of sections 4.4 and 6.3 that each individual facility file an annual, audited financial report. That is, if the facility is a division or a subsidiary of another entity which owns or operates other covered facilities, the separate reports must be made for each facility and they may not be lumped together.

The agency believes that CAMC is misreading these sections. CAMC operates within the city of Charleston as three divisions. However, it is not these types of divisions that are affected by these sections. Rather, sections 4.4 and 6.3 are addressed to facilities such as Humana-St. Luke's and Humana-Greenbrier Valley or to facilities such as Beckley Appalachian Regional Hospital and Man Appalachian Regional Hospital. In such circumstances, the hospitals are individual entities located in different towns. Each serves a discrete population. It is the intention of the agency that section 6.3 for hospitals and section 4.4 for nursing homes apply in these circumstances. CAMC is the only facility --nursing home or hospital -- known to the agency that is structured into divisions within one city. Hence, section 6.3 will be amended to account for this unique situation.

CAMC also suggests that section 6.4 concerning the filing of its budgets not less than thirty (30) days prior to the start of each fiscal year be amended so that the agency may grant extensions upon a showing of good cause. The agency concurs and will amend sections 5.1 and 6.1 to so note.

CAMC also comments that subsection 6.12.3 (which will be renumbered to be subsection 6.12.2 as a result of changes noted above) should be amended to provide for keeping confidential the required copies of contracts between a hospital and any individual or group of health care providers. Public disclosure of such contracts will, CAMC fears, defeat its ability to negotiate with other providers.

Initially, the state agency notes that section 4(d) of the act (as well as sections 9 and 10 of this proposed rule) provide that all information and documents -- with one exception -- that are filed under this program are to be open to the public. The exception concerns patient identifiable information. Thus, section 4(d) of the act defeats CAMC's request. In addition, the agency notes that subsection 6.12.3 does not apply to CAMC, but applies only to hospitals not covered by the HCCRA act. CAMC's obligation to file similar information is controlled by West Virginia Code, § 16-29B-19(b), and rules promulgated thereunder.

(4) Wheeling Hospital by its Assistant Administrator, John J. Yeager, filed written comments. Initially, Wheeling Hospital objects that under section 3.4 of the proposed rule, the definition of the term "covered facility" is broad enough to "include all nursing homes which were not included in the original Act." The agency notes that the first sentence of section 3.4 is taken directly from section 2(4) of the act which has not been amended since the original enactment in 1979. The program has always been applied to nursing homes and such facilities have regularly reported under the act. Thus, section 3.4 is not a change from prior practice.

Wheeling Hospital also asserts that subsection 4.5.4 "requires disclosure of 'ownership by any parent company or subsidiary.' This should be clarified to

ensure that a covered facility is not required to disclose ownership of noncovered subsidiaries, but is required to disclose ownership of the covered facility itself." The agency notes that subsection 4.5.4 of the proposed rule uses the exact language of section 4(a)(4) of the act. Thus, this requirement is not new. By its terms, subsection 4.5.4 applies to privately held companies the stock for which is not traded publicly. The agency is of the opinion that subsection 4.5.4 concerns ownership of the hospital company and directs disclosure of that ownership. It is not directed to ownership by the hospital company, itself, of any other non-hospital entity. The last part of the final sentence is perhaps the cause of Wheeling Hospital's concern. That sentence states: "Such statement shall further contain a disclosure of ownership by any parent corporation or subsidiary, if applicable." In the agency's opinion, this sentence requires, in every instance, the disclosure of the ownership of a hospital company by some other entity where that other entity is not a natural person. The reference to "subsidiary" in the sentence is taken to mean a subsidiary of still another entity, but where the ownership of the hospital company rests with the subsidiary. The sentence is not taken to mean the disclosure of ownership by a hospital company of other non-hospital entities. The agency has rewritten the final sentence of subsection 4.5.4 to clarify the intention of the sentence.

Wheeling Hospital also urges that section 5.4 and 6.4 be amended to eliminate the requirement that annual budgets be submitted at least thirty (30) days prior to the start of a facilities fiscal year. The hospital also urges that a definition of the word "other" is needed in the final sentences of the two sections where they require disclosure of "the details of other anticipated revenues and expenses." As indicated above, the agency has amended section 5.4 so that

nursing homes may file their budgets not more than 120 days after the pertinent fical year begins.

As to section 6.4 which concerns hospitals, the agency notes that it receives a proposed budget and later a final budget from each hospital covered by the HCCRA act. In most of these instances, the submittal of the budgets will be made without regard to the beginning of a new fiscal year. Hence, section 6.4 will apply only to hospitals not covered by the HCCRA act and to facilities not requesting a rate change at a time proximate to the beginning of a fiscal year. The agency believes that the thirty (30) day period prior to the start of a fiscal year is reasonable. However, in order to accommodate unexpected situations, this requirement will be modified to explicitly state that, upon a showing of good cause, the agency may grant a waiver of the time period.

As to the use of the phrase "other anticipated revenues and expenses," the agency is aware that for the hospital industry the proper terminology is "other operating and non-operating revenues." Since the terms are equivalent, the agency shall amend section 6.4. However, section 5.4 will not be so amended as the agency believes the more generic phrase is better suited for nursing homes.

Wheeling Hospital also objects to sections 5.9 and 6.9 because they might be construed to require patient identifiable information. As noted above, both of these sections have been amended to eliminate this concern.

The hospital also objects to section 6.10 by stating: "The proposed rule also requires filing of a trial balance which was not under the original financial disclosure law. The trial balance contains detailed revenue and expense by cost center. This information could be incorrectly used by vendors, third parties, and labor unions." The agency agrees that the section 6.10 requirement of filing a yearly trial balance was not previously included in the act or the guidelines. The

agency, however, has previously requested each of the state's hospitals to file that document beginning about January 1988. This requirement is added to the others under the authority given to the agency by sections 3(a)(2) & (3) and 4(b)(6). The trial balance is a document which is prepared in the usual course of compiling the hospital's formal financial statements. Thus, in most instances the hospitals will merely need to make an extra photocopy of the document for submission under the proposed rule. The agency notes that the Legislature has found that "[t]he public has a right to know the financial position of hospitals and related facilities." The Legislature did not place any limits on what members of the public has this "right to know." Thus, the use any member of the public makes of the information disclosed is not a basis for limiting the disclosure in the first place.

Wheeling Hospital also objects to subsection 6.12.3 (which has been renumbered to 6.12.2 as discussed above). This section concerns the filing of copies of contracts between a hospital and health care providers that amount to more than simple admitting privileges. The classic examples are exclusive contracts for radiologists and pathologists. The hospital notes that section 6.12 and its subparts only applies to hospitals not covered by the HCCRA act; but, it also objects to what it sees as change under the HCCRA act as well so as to obtain similar copies from all state hospitals. The objection voiced is that the "provision would eliminate the ability of any hospital to negotiate contracts as competitors and payers would have access to existing contracts."

Hospitals that are covered by the HCCRA act have been under obligation to provide copies of these types of contracts since May 1985. Subsection 3.4.3 of the legislative rule "Hospital Cost Containment Methodology - Phase 1," 65 C.S.R. 5(1985), states:

> Hospital-based physicians -- The Authority will consider hospital-based physicians' fees as a separate expense classification. Hospitals will provide annually a copy of the contract, with a schedule of fees, for all contracted physicians or physician groups, mid-level practioners and any contracted technical staff....

The quoted provision effectuates section 19(b) of the HCCRA act, W. Va. Code, § 16-29B-10(b). Thus, this requirement as it affects HCCRA act covered hospitals has been in effect since 1985 and is not new. Through subsection 6.12.3 of the proposed rule, the same requirement (based upon the disclosure act, however) is merely extended to other types of hospitals.

As to the disagreement with the substance of the requirement, the hospital neglects to consider the impact upon patients of these contractual relations. When a patient is forced to deal with a health care provider who is the exclusive provider for his or her type of services as a result of one of these contracts, then the patient has no bargaining power of his or her own regarding that provider and its services. It goes without saying that physicians are an essential component of hospital based health services. The contractual rights given by the hospital to a provider are highly significant to the costs of the services and to their availability. Thus, it appears to the agency that these contracts are well within the scope of the findings and purposes of the act as expressed in section one. Hence, the agency declines to eliminate this provision.

Finally, Wheeling Hospital complains that sections 7.1, 7.2, and 7.3 impose additional filing requirements whenever the agency deems it necessary and that these sections can be used in a discriminatory fashion against a hospital. The agency notes that sections 7.1 and 7.2 appear in the "Guidelines" as Section H and Section I. The provisions are also in the act as sections 5(e) and 5(f). Hence, neither requirement is new and both have been available for use by the Director

of the Department of Health from 1979 to 1983 and by this agency from 1983 to date. While almost any statutory enactment potentially can be abused by the agency administering it, mere potential is not sufficient to block the implementation of a program. Arbitrary, capricious, or irrational behavior of any governmental entity can be controlled. Further, this agency notes that in the five years it has administered the financial disclosure program, it has had available to it the statutory authority of these same provisions and has not abused them.

As to section 7.3, this section merely puts into regulatory form the general authority provided for by section 4(b)(6) of the act which allows the agency to require "[s]uch other reports of the costs incurred in rendering services as the [agency] may prescribe." The proposed rule adds to the protection afforded to covered facilities by requiring at least a ten (10) day notice period before the additional documentation must be filed. Thus, it will not be possible to demand the immediate filing of additional information. Because these three sections of the proposed rule merely restate powers given to the agency by the statute itself, the agency declines the hospital's request that they be eliminated.

(5) The public accounting firm of Doak, Cuppett & Poling by one of its partners, E. Mark Doak, C.P.A., also filed written comments. Initially, Mr. Doak repeats the complaint that section 4.1 would require the publication of a lengthy financial report. This comment has been addressed and, as noted, section 4.1 has been amended to clarify what is intended here.

Mr. Doak also notes that the requirements of subsection 4.5.2 and 4.5.3 are for the same financial statement. He suggests that one of them be deleted. The agency notes that subsections 4.5.2 and 4.5.3 merely repeat the statutory language found at subsections 4(a)(2) & (3) of the act. However, both of these

sections of the proposed rule as well as subsection 4.5.1 have been amended to be more specific and so as not to duplicate each other.

Mr. Doak next complains that subsection 4.5.4 concerning disclosure of ownership of a hospital (which has been addressed above) has also been expanded to include the amount of dividends paid for hospital stock. Mr. Doak believes this to be a new requirement. The agency notes that subsection 4.5.4 appears as Section E, paragraph 3 of the "Guidelines" and is also found in the act. Thus, this provision is not new. Since the section merely restates the language of the act, the agency declines to change it.

Mr. Doak also complains that section 5.4's requirement for the filing of a budget is contrary to the agency's general program of collecting historical data. Thus, he believes that the budgets (which are projected documents) should not be required. Section 5.4 of the proposed rule finds its origin in section 4(b)(2) of the act which states that the facility must file: "A statement of the total financial needs of such covered facility and the resources available or expected to become available to meet such needs...." Thus, it is the act itself which requires the filing of budgets. Hence, this provision is not new and was formerly found at Section F, paragraph 3 of the "Guidelines."

Mr. Doak next comments that section 5.10 (which concerns the possibility of a special request for trial balances from nursing homes) is subsumed by section 7.1 which permits the agency to request additional information. Thus, he believes section 5.10 should be eliminated. The agency agrees that section 5.10 is subsumed by section 7.1. Thus, the agency could request a nursing home to file its trial balance on the basis of section 7.1. However, the agency believes that it should give a specific notice to the nursing homes that they might have to

file copies of their trial balances. Because section 5.10 provides this specific notice, the agency declines the suggestion to delete it.

Mr. Doak repeats his comments concerning section 5.4 as they apply to the similar provision for section 6.4. Again, the act itself imposes the requirement for filing budget information and section 6.4 merely restates that requirement.

Mr. Doak next comments regarding section 6.6 that since the hospitals already have on file schedules of their rates under the requirements of the HCCRA act, then section 6.6 is merely duplicating that requirement. The agency notes that the act itself requires the filing of a complete schedule of rates. See section 4(b)(3) of the act. This requirement was stated in the "Guidelines," Section F, paragraph 4, as well. To the extent that a hospital has filed its schedule of rates under either the proposed rule or the HCCRA act, that one filing satisfies both requirements. Thus, duplicate filings need not be made. In addition, the agency notes that section 6.6 also applies to hospitals that are not covered by the HCCRA act. Thus, section 6.6 alone will apply to them.

Next, Mr. Doak comments regarding section 6.10 that it is subsumed by section 7.1. Mr. Doak views section 6.10 as being a special request by the agency for the trial balance. Unlike section 5.10 where the filing of a trial balance by a nursing home depends upon a specific request by the agency, section 6.10 requires the annual filing of a trial balance by the hospitals. Thus, imposition of section 6.10 is a mandatory directive to file, on an annual basis, a hospital's trial balance. Hence, section 6.10 is not subsumed by section 7.1.

Mr. Doak also criticizes subsection 6.12.4 which requires the filing of copies of a hospital's Uniform Bill-82 (UB-82) on computer tape. He notes that many hospitals do not have computer tape capacity. The agency is aware of this problem and has noted in subsection 6.12.4 that the agency may waive the

computer tape filing requirement if asked to do so. In fact, the agency has granted this waiver to many hospitals because it recognizes the additional costs that would be imposed upon hospitals without computer tape capacity.

Finally, Mr. Doak contends that section 7.2 duplicates provisions in the HCCRA act regarding a determination of whether the rates charged by a facility are economically justified. Mr. Doak is correct to the extent of the hospitals covered by the HCCRA act. However, section 7.2 also applies to other hospitals not subject to the HCCRA act as well as to nursing homes. Thus, it does not duplicate other provisions in that regard. Also, section 7.2 merely restates the language of section 4(f) of the act.

(6) St. Joseph's Hospital of Parkersburg by its Senior Vice President and Chief Financial Officer, James L. Backus, also filed written comments. Each of the comments made by this hospital were raised by others and have been addressed above.

(7) The Medicon Group by its President, H.J. Simmons, III, and its attorney, Irene Keeley, Esquire, also filed written comments and also presented oral comments. Initially, the agency notes that Medicon objected to the filing of this proposed rule as an emergency rule. For the reasons filed with the emergency rule, the agency does not agree with Medicon. In addition, the agency notes that the Secretary of State has rendered his judgement in accordance with West Virginia code, § 26A-3-15a, and has approved the filing. See "State Register," Vol. V, Issue 36, at page 1131 (September 2, 1988).

Medicon also noted that section 6.12 and its subparts appear to be directed at the new rehabilitation hospitals. Further, as new entities the rehabilitation facilities, in Medicon's view, should not be subject to the burdens of financial

disclosure. Thus, Medicon asserts that the rehabilitation hospitals should be exempted from financial disclosure.

Initially, the agency notes that Medicon has previously asserted that rehabilitation hospitals should not be subject to the HCCRA act. While the agency disagrees with Medicon's position, it has chosen not to exert its authority under the HCCRA act against these facilities. However, there is no doubt that rehabilitation hospitals are included within the statutory definition of a "covered facility." Section 2(4) of the act defines a covered facility as "any hospital or other health care facility with fifteen or more inpatient beds, whether public owned, operated for profit or operated as a not for profit facility and whether licensed, or unlicensed...." The two existing rehabilitation facilities have in excess of 15 inpatient beds and they are clearly a health care facility. It is this definition which gives the act a much greater scope than the HCCRA act has. It is the agency's view that the Legislature decided the issue of balancing the cost of financial disclosure to the facilities against the value of public disclosure. The Legislature has sided with public disclosure. Hence, the agency finds no reason to create an exemption (if it could even do so) for the rehabilitation hospitals. Finally, the agency acknowledges that at the present time section 6.12 applies only to the rehabilitation hospitals. There are not now any similar entitites that are exempt from the HCCRA act, but which are covered by this act. However, the future may see the development of others for whom section 6.12 would then be applicable.

(8) Finally, the Mountain State Health Care Campaign by its steering committee member, Florette Angel, offered oral comments to the proposed rule. The Campaign did not suggest any changes to the proposed rule. Rather, the Campaign urged the agency to utilize the authority given to it by the act in the

most thorough and efficient manner possible. The speaker suggested that many members of the public viewed health care facilities with a great deal of suspicion and uncertainty. This is especially true, the speaker urged, with regard to possible conflicts of interest by hospital board members and hospital employees who may be doing other business with the hospital and receiving lucrative reimbursement for those goods and services.

The agency is aware that the general public often views the complicated financial dealings of health care facilities with a skeptical and suspicious eye. The agency believes that the provisions of the proposed rule require the filing of adequate information upon the facilities to allow informal members of the public to learn and understand the financial affairs of those facilities. Especially with the addition of mandatory filing by the hospitals of their trial balances as well as the discretionary authority to request trial balance from nursing homes, the proposed rule will allow a much greater degree of scrutiny. The agency concludes that this proposed rule together with the several other programs and acts affecting the health care industry will lead to adequate surveilance of that industry.

WV HEALTH CARE COST REVIEW AUTHORITY
MEETING REGISTRATION

Date of Meeting: Thursday, September 1, 1988, 2:00 p.m.

Nature of Meeting: PUBLIC HEARING 1. CON Forms 2. Financial Disclosure

	Individual's Name:	Name of Organization:	Do you wish to speak? Y or N
1	N.J. [illegible] (H.J. Simmons	[illegible] American Health Enterprises, Ltd.	YES (2) - Fin. Disc.
2	Kathleen [illegible]	West Virginia University Hospitals	No
3	[illegible]	WVHA	N
4	Janet Harrell	HCCRA	N
5	Irene M. Keeley	Steptoe & Johnson	Y
6	[illegible]	[illegible]	
7	Edwin J. Foss	WVHCA	Y
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WV HEALTH CARE COST REVIEW AUTHORITY
MEETING REGISTRATION

Date of Meeting: Thursday, September 1, 1988, 2:00 p.m.

Nature of Meeting: PUBLIC HEARING
1. CON Forms 2. Financial Disclosure

	Individual's Name:	Name of Organization:	Do you wish to speak? Y or N
1	Florette Cingel #2	Nat State Health Care Camp	Y
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Glenwood Park United Methodist Home, Inc.

Route 1, Box 464
Princeton, West Virginia 24740
(304) 425-8128
(304) 325-8164

August 19, 1988

Mr. Robert F. Parker, II
Director, Certificate of Need
Health Care Cost Review Authority
100 Dee Drive
Charleston, WV 25311

Dear Mr. Parker:

I am writing in reference to the proposed legislative rule which will implement requirements of the Health Care Facility Financial Disclosure Act. It is my intent to be present for the public hearing scheduled for September 1, 1988, in the Authority's large conference room. However, I wanted to place in writing specific comment concerning one section of the proposed rule. If something should occur and I would be unable to be in attendance, I would appreciate your taking steps to see my view is given consideration.

Moving now to comments, reference should be made to page 7, section 5.4. Therein, attention is given facility budgets, both operational and capital, being submitted thirty days prior to the start of a fiscal year. My recommendation would be to change the approach from submission thirty days prior to, to thirty days following the start of fiscal years.

Rationale for this recommendation relates to the West Virginia Medicaid Program as the primary source of funding for long term care facilities (nursing homes). Recognizing the fact facilities are subject to two rate changes annually (April and October), it is very likely projecting income thirteen or more months could be tricky and in reality could create an almost impossible situation as far as supplying reliable data. This circumstance, I am sure, will vary widely, depending upon the source of authority for particular long term care facilities be they single owner operations, multi-corporate organizations, etc. However, narrowing the period of time which must be considered prior to planning for given fiscal years should enhance worth of data submitted to comply with the statute.

If after review, I have confused the situation or not made clear rationale for requesting consideration for change, please let me know.

Sincerely,

Daniel W. Farley, ACSW-CFACHCA
President/Chief Executive Office

rdw

xc: Ed Foss

Doak, Cuppett & Poling
Certified Public Accountants

August 22, 1988

Mr. Walter Dale, Chairman
Health Care Cost Review Authority
100 Dee Drive
Charleston, West Virginia 25311

Dear Mr. Dale:

Recently the Authority has issued proposed regulations regarding Financial Disclosure. It is in response to these regulations that the attached comments have been prepared.

Respectfully,

DOAK, CUPPETT & POLING

E. Mark Doak, CPA
Partner

Enclosures

Drawer 1626 Waldo Complex • Clarksburg, West Virginia 26301 • (304) 622-0804

FINANCIAL DISCLOSURE RULE

Comments

Section 4.1

Whenever a Certified Public Accountant is associated with financial information, certain disclosures must be made. These include an opinion as to the level of service which was performed and notes to the financial statements. For a Certified Public Accountant to be associated with information placed in a legal advertisement, all of the disclosures required by the CPA would also have to be published. Annual hospital audit reports are often 10 to 15 pages long. This is not realistic.

It is my suggestion the Section be amended to simply state that the hospital publish an annual report which had been prepared in accordance with generally accepted accounting principles.

Section 4.5.2 and 4.5.3

A statement of 'income and expenses' and a statement of 'Profit or loss for the period reported' will be the same statement. I would recommend Section 4.5.2 be removed.

Section 4.5.4

The prior disclosures have required the publication of stock ownership. This Financial Disclosure Rule expands the publication to include dividends paid. A private corporation is already disclosing its income statement, balance sheet and salaries in excess of $55,000. To require disclosure of dividends paid may be the straw which keeps investors from investing in the West Virginia healthcare system.

It is my recommendation the requirement of dividend disclosure be removed.

Section 5.4

If the Authority is collecting historical information from Non-Hospital covered facilities, why is the annual budget being collected which is projected data. This is an unnecessary filing requirement which should be removed.

Section 5.10

Section 7.1 allows the Authority to request additional information. Section 5.10 would fall under a special request by the Authority for additional information. It is my recommendation Section 5.10 should be removed as it is part of Section 7.1.

Section 6.4

If the Authority is collecting historical information from Hospital covered facilities, why is the annual budget being collected which is projected data. This data will be submitted as part of any rate change request. It is my recommendation the filing of a budget should be done in conjunction with rate requests and should be removed from the Financial Disclosure filing requirements.

Section 6.6

Hospital can only change rates with the approval of the Authority. Therefore a current file of charges is always on file and it is not necessary to file a rate schedule at the close of the fiscal year.

Section 6.10

Section 7.1 allows the Authority to request additional information. Section 6.10 would fall under a special request by the Authority for additional information. It is my recommendation Section 6.10 should be removed as it is part of Section 7.1.

Section 6.12.4

The Authority has requested UB-82 data from hospitals in a computer format. It should be realized that many facilities may not have the computer capabilities. Therefore while the Authority may save funds by having computer ready data, the hospitals will pay to have this service and the cost will be passed on to the consumers.

Section 7.2

The Authority has a Hospital Rate Setting Methodology to determine if rates charged by a facility are economically justified. For this reason I do not see the need for Section 7.2 in the financial disclosure law and I would recommend it be removed.

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 be determinative of any issue affecting private rights, privileges or interest (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, Administrative Law in West Virginia, the legitimacy of an interpretative rule turns on its consistency with legislative intent. Id. 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 Ye Olde Apothecary v. McClellan, 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. See also Mason County Board of Education v. State Superintendent, 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 et seq. 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. This 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, in 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 and the services and facilities in which these patients are served.

In Section 2, Scope and Organization of Physical Rehabilitation Services, 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 Benefits of Physical Rehabilitation. 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.

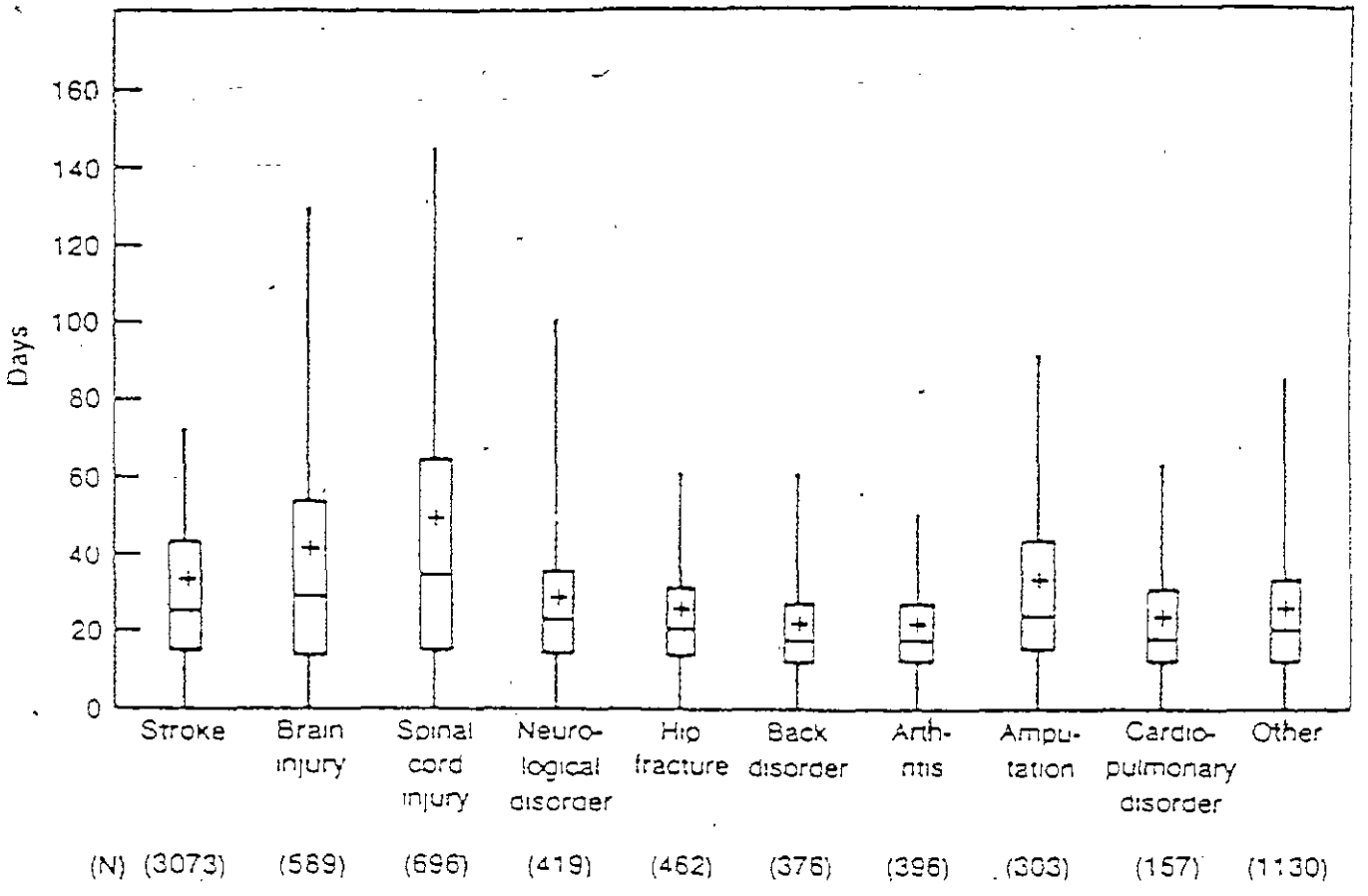

Fig. 1--Distribution of lengths of stay by diagnostic category

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.

WHEELING HOSPITAL

September 1, 1988

Mr. Walter J. Dale, Chairman
Health Care Cost Review Authority
State of West Virginia
100 Dee Drive, Suite 201
Charleston, West Virginia 25311

Dear Mr. Dale:

We have reviewed the proposed financial disclosure rule, and have comments as identified on the attached schedules.

If you have any questions, please call either myself at 243-3680 or Ms. Carol Marsh at 243-3990.

Sincerely,

John J. Yeager
Assistant Administrator

JJY/ma

Enclosure

c: Sam G. Nazzaro

WHEELING HOSPITAL
POSITION PAPER ON THE
PROPOSED FINANCIAL DISCLOSURE RULE

Section Number	Topic	Comments
3.4	Covered Facility	The proposed rule indicates that any hospital or other health care facility with fifteen or more inpatient beds is covered by these rules. By definition, this would include all nursing homes which were not included in the original Act.
4.5.4	Disclosure of Ownership	The proposed rule requires newspaper disclosure of "ownership by any parent company or subsidiary." This should be clarified to ensure that a covered facility is not required to disclose ownership of noncovered subsidiaries, but is required to disclose ownership of the covered facility itself.
5.4 and 6.4	Annual Budget	The proposed rule requires that a budget be submitted 30 days prior to the beginning of the fiscal year. Given the logistics of preparing a budget, the rule should be amended to require filing prior to the beginning of the fiscal year. The proposed rule also requires detailed line budget disclosure of other anticipated revenues and expenses. This needs a definition of "other" to be included as other operating or nonoperating revenues and expenses.
5.9 and 6.9	Disclosure of Collections	The proposed rule requires disclosure of all collections in excess of $55,000 during a reporting period. Potentially, this amount could be from a single patient, in which case disclosure would violate confidentiality.
6.10	Trial Balance	The proposed rule also requires filing of a trial balance which was not under the original financial disclosure law. The trial balance contains detailed revenue and expense by cost center. This information could be incorrectly used by vendors, third parties, and labor unions.

Section Number	Topic	Comments
6.12.3	Disclosure of Reimbursement Contracts	The proposed rule requires disclosure of all contracts in excess of $55,000 for payment of services. While this section only applies to hospitals not covered by the HCCRA Act, it is our understanding that all hospitals will be required to submit this. This provision would eliminate the ability of any hospital to negotiate contracts as competitors and payers would have access to existing contracts.
7.1 to 7.3	Additional Information	This section would allow the authority to accumulate any financial information it deems necessary. This could become a disclosure discrimination law by HCCRA earmarking certain facilities for additional information. This represents additional filing requirements under the disguise of further analysis.

West Virginia Health Care Association, Inc.

"Serving West Virginia's Professional Long-term Care Facilities"

1115 Quarrier Street

Charleston, West Virginia 25301

304-346-4575

SEPTEMBER 1, 1988

COMMENTS RE: LEGISLATIVE RULE TO IMPLEMENT REQUIREMENTS OF THE HEALTH CARE FACILITY FINANCIAL DISCLOSURE ACT

PAGE 7, SECTION 5.4: RECOMMEND CHANGING DEADLINE FOR SUBMISSION OF FACILITY BUDGETS FROM 30 DAYS PRIOR TO THIRTY DAYS FOLLOWING THE START OF FISCAL YEARS.

REASON: BUDGET PROJECTIONS MADE 30-DAYS IN ADVANCE ARE STILL SUBJECT TO LAST MINUTE CHANGES; BUDGET FIGURES LOCKED IN AS OF THE BEGINNING OF THE FISCAL YEAR ARE APT TO HAVE FEWER AND LESS DRAMATIC CHANGES, AND THEREFORE WILL BE MORE MENANINGFUL TO HCCRA IN ITS DATA GATHERING EFFORTS!

Submitted by: Edwin J. Foss
Executive Vice-President, WVHCA

HFMA
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
WEST VIRGINIA CHAPTER

August 31, 1988

Walter J. Dale, Chairman
Health Care Cost Review Authority
State of West Virginia
100 Dee Drive
Charleston, WV 25311

Dear Walter:

On behalf of the West Virginia Chapter of the Healthcare Financial Management Association (HFMA), I appreciate the opportunity to express our comments regarding the revised Financial Disclosure rules and Certificate of Need requirements.

Our detailed comments on the Financial Disclosure revisions have been provided as a part of the HCCRA/HFMA task force.

A summary of key concerns would include:

- Financial Disclosure Rules

  Section 6.8/6.9

  We recommend exempting patient account payments, such as insurance or other third party payments and patient payments from Sections 6.8/6.9.

  Consideration should be given to adjusting the reporting limit of $55,000 by an annual inflation factor. The $55,000 limit has been in place since the inception of the law. Presently, the limit is artificially low, resulting in additional paperwork and reporting cost not intended by the legislation.

  Section 7.2

  The HCCRA has the Hospital Rate Setting Methodology to determine if a hospital's rate structure is economically justified. Consequently, Section 7.2 is unneeded.

  We recommend deletion of this section.

  Certificate of Need

  While the HFMA/HCCRA task force has not reviewed the Certificate of Need requirements in detail, it is apparent that much of the data requested either does not pertain to justifying the project or is data provided as a part of the Methodology or Financial Disclosure.

HFMA recommends that data required as a part of a CON application pertain to justifying the project and not burdening the facility with duplicative paper and labor costs.

As always, should you have any questions, please do not hesitate to phone (424-4220).

Sincerely,

Ronald D. Anspaugh
President
HFMA - West Virginia

CHARLESTON AREA MEDICAL CENTER

Administrative Office
Financial Services

• Post Office Box 1547
Charleston, WV 25326

• 503 Morris Street
Charleston, WV 25301

August 31, 1988

Mr. Walter J. Dale, Chairman
West Virginia Health Care
Cost Review Authority
100 Dee Drive, Suite 201
Charleston, West Virginia 25311

RE: Proposed Health Care Cost Review Authority Regulations on Financial Disclosure Rule

Dear Mr. Dale:

I am writing to provide the West Virginia Health Care Cost Review Authority (WVHCCRA) with Charleston Area Medical Center's (CAMC) comments on the above referenced proposed rule. For the sake of clarity, I have set forth CAMC's comments identified to the related sections.

SECTION 4.4 AND 6.3

Each of these sections specify that the annual report required under the Financial Disclosure Rule shall pertain to an individual covered facility if said covered facility is a division or a subsidiary of another entity which owns or operates other covered facilities. CAMC owns and operates three separate divisions in Charleston, West Virginia. However, none of these three divisions operate independently of the other and all three share common services. CAMC also maintains one provider number for all three operating divisions which adds additional support to the fact that CAMC is basically one hospital facility. As has been the case in the past, CAMC would anticipate that aggregation of the three operating divisions would continue under these proposed rules.

SECTION 6.4

Section 6.4 requires a facility to file its approved budget and its annual capital expenditures budget for the forthcoming fiscal year at least thirty days prior to the start of that fiscal year. There are a number of reasons

why a facility may not be in a position to have a Board approved budget available thirty days prior to the start of its fiscal year. Accordingly, CAMC is of the opinion that the WVHCCRA should include a provision in this Section which would allow the WVHCCRA to grant an extension of time for the submission of this data upon showing of good cause.

SECTION 6.12.3

This Section of the rule requires that hospitals submit copies of contracts with individuals or groups of healthcare providers for the provision of inpatient and outpatient services. CAMC is concerned that the general availability of such contractual information may affect its ability to negotiate contracts on terms favorable to CAMC. If such contracts are to be provided, CAMC is of the opinion that they should be provided under seal and not available for general review.

CAMC appreciates the opportunity to provide these comments to the proposed Legislative Rule 16-5F. Should there be any questions concerning these comments, the WVHCCRA may feel free to contact me at its earliest convenience.

Sincerely,

Stephen Z. Bell

Stephen Z. Bell
Vice President for Finance

jem

ST.
JOSEPH'S
HOSPITAL

August 31, 1988

Walter J. Dale, Chairman
Health Care Cost Review Authority
State of West Virginia
100 Dee Drive
Charleston, West Virginia 25311

Dear Mr. Dale:

St. Joseph's Hospital appreciates the opportunity to comment on the proposed revisions to the revised Financial Disclosure Rules.

There are a number of concerns and/or questions that we have noted as follows:

Section 4.1

Reference is made to HCCRA requesting that "an annual report prepared by the covered facility's auditor or an independent accountant" be published in a local newspaper. Such a report could be 10-15 pages or more in length.

It is our suggestion that Section 4.1 be amended to simply state that the hospital publish an annual report which has been prepared in accordance with generally accepted accounting principles.

Section 4.5.1/4.5.2/4.5.3

A statement of "Income and Expenses" and a statement of "Profit or loss for the period reported" will be the same statement. Suggestion is made to delete 4.5.3 and restate 4.5.1 as the "Balance Sheet" and 4.5.2 as the "Income Statement", using present terminology.

19th Street and Murdoch Ave. Parkersburg, WV 26101 1-304-424-4111

Section 4.5.4

Prior disclosures have required the publication of stock ownership. Section 4.5.4 expands the publication to include dividends paid. Private corporations are already disclosing their balance sheet, income statement, and salaries in excess of $55,000. To require disclosure of dividends paid may prevent investors from investing in West Virginia healthcare.

It is our suggestion that the requirement of dividend disclosure be deleted.

Section 6.8/6.9

We recommend that sections 6.8/6.9 be clarified so as not to include patient account payments such as third party payers, insurance companies, and patients.

St. Joseph's Hospital also suggests that consideration be given to annually increase the reporting limit (currently $55,000) by an annual inflation factor. The present limit has not been corrected for inflation since adoption.

Section 6.10

It would appear that Section 7.1 allows HCCRA to request additional information. Section 6.10 would usually be a special request item by the Authority for additional information. It is our recommendation that Section 6.10 be deleted.

Section 7.2

The Health Care Cost Review Authority has the Hospital Rate Setting Methodology to determine if rates are economically justified. For this reason there appears to be no justification for Section 7.2 in the Financial Disclosure law. We recommend deletion of this section.

Should you have any questions regarding St. Joseph's Hospital's response, please feel free to call 424 4713.

Sincerely,

James L. Backus
Senior Vice President and
Chief Financial Officer

BEFORE THE HEALTH CARE COST REVIEW AUTHORITY

In Re:

Proposed Rules Regarding the Health Care Facility Financial Disclosure Act and Proposed Procedural Rules Under the Certificate of Need Program.

Transcript of proceedings had or testimony adduced in the above-styled case before the Health Care Cost Review Authority, 100 Dee Street, Charleston, Kanawha County, West Virginia, at 2:00 p.m., on the 1st day of September, 1988, pursuant to order issued by the Authority.

BEFORE: JOHN KOZAK, General Counsel
LARRY FIZER, Board Member
DON KEESLILNG, Board Member
WALTER DALE, Director

MR. KOZAK: This is a public hearing held pursuant to West Virginia Code, Article 3, Chapter 29(A), for the purpose of taking public comments on proposed rules. We have before us today a proposed set of legislative rules regarding the Health Care Facility Financial Disclosure Act as well as the proposed procedural rule under the Certificate of Need Program.

For the record, my name is John Kozak, general counsel for the Authority. Also in attendance today are two of the board members of the Authority: Mr. Larry Fizer and Mr. Don Keesling, as well as the Executive Director and other members of the staff.

We have had a number of written comments filed, which will be responded to in the ordinary course of putting the rule-making package together. I'd also note that there has been an oral discussion for which I have notes with the subcommittee of the Hospital Financial Management Association. Those comments will also be responded to. About an hour ago I had a call from Mr. Mark Doth from Clarksburg, who indicated he had some comments on the Certificate of Need. He asked if it was necessary to fax those down here to get them today, and I told him no, we'd take them by mail, so when they're here, they will be admitted as well.

We only have a few people who have indicated that they want to talk. i'll just mention -- we will take both sets of rules together. They are sufficiently dissimilar that I'm sure we can sort the comments out through the transcript. We'll start with Mr. H. J. Simmons.

If you come up and have a seat and just put on the record who you are representing, you can go ahead and make your comments here.

MR. SIMMONS: Mr. Kozak, I'm Jeff Simmons. As you know from previous testimony, I am a resident of Valley Forge, Pennsylvania. I am President and CEO of the Medi-Con Group, based in suburban Philadelphia. I am here representing two organizations doing business in this state, one of them being West Virginia Rehab Services, Inc., which is the company that owns and operates the rehab facility in Parkersburg, West Virginia, known as Western Hills Regional Rehabilitation Hospital. I am the President of that particular Board of Directors. I am also representing American Health Enterprises, Ltd., which is the owner and operator of Southern Hills Regional Rehabilitation Hospital in Princeton, West Virginia. I also serve as the President of that particular Board of Directors, also.

With me is Mrs. Irene Keeling from Steptoe and Johnson, who has been retained to serve us on this matter before the Commission. I appreciate the opportunity to speak before you.

Let me open my comments and we're speaking -- at least I am speaking -- and Mrs. Keeling, while she is with me here, will be speaking strictly to the financial disclosure matter. None of it is related to the other issue.

As you know, we appeared before this Commission back in July -- excuse me, June -- over a similarly

related matter, which later then there was a decision issued relative to that matter. I would like, for the purposes of this record, to introduce that testimony again.

MR. KOZAK: Do you have a copy of that?

MR. SIMMONS: Yes, I do have a copy of it. Let me hand that to you, when I get through here in just a second, in case there are any questions you may have and I need to refer to it.

Our understanding of our original testimony here, plus the decision of the Commission was that there would be regulatory reporting under Section 5(f) of the Code, and we have obviously agreed with that and will certainly abide and respond to that requirement. However, I think that as we start to look through the proposed rule-making here, we get some questions raised that go beyond some of the reasons why we may have opposed the earlier proposed rule-making. To get into the details on this, I think I would just point out a couple of things.

As far as our concern, and I think, based on our analysis, this current proposal in front of us is really directed to trying to bring rehab hospitals back under the earlier proposal that was being considered by the Commission. I would also point out that, right now, the only two operating rehab hospitals that would be subject to this are owned by the same -- majority owned by the same company. We do recognize that there is at least one other rehab hospital in the state that is under construction, although I understand they are having problems down in Huntington,

as well as the recently issued CON.

So, in terms of the magnitude of the state of this industry being addressed, it is not particularly significant in terms of numbers of beds or potential financial involvement. To get specific, in our two facilities, I again want to emphasize that these are two facilities that were financed and constructed and started operations within a year of each other, beginning a year ago last February. These are not mature organizations, nor will the two organizations that are currently under consideration in Huntington and Morgantown going to mature for some period of time.

Financial requirements - financial disclosure requirements being placed on these facilities during this startup period is going to be extremely difficult for these facilities, which I will point out to you in a minute, but these are new organizations. They have new people; they have new procedures. They are trying to develop a patient care program that can be balanced off against the financial requirements of the organization, and to tell you the truth, these are day-to-day management operations going on in these facilities. These are not ongoing facilities that have been around ten or fifteen years, some of whom in this state are doing well financially; others are not doing well. These are very high-risk ventures that are coming up out of the ground, that are getting started, that are refining their patient care programs, and that are basically limping along

until they can get into a profitable position. I think the timing of this particular proposal couldn't be worse for facilities like this.

The systems that we have for financial reporting in this facility are, at best, nominal, just for our own internal needs. We have a staff down there that, while they are qualified and well-trained, nevertheless, in a startup mode, to give you an example, down in Princeton, it takes us fifteen days after the close of the month just to get a financial statement out of those facilities. Now, those statements, when they are issued, are good statements, and we rely on them, but that's a lot of time. Then when you start imposing additional requirements, both from here and from other sources, it gets to be a very difficult problem down there.

I think that the systems we have in there are modest. They certainly are not the types of systems that I think this regulatory process anticipates a hospital to have in terms of some of the tape requirements that you want and everything, and it just would be almost impossible, at least for the foreseeable future, to try to get into the level of sophistication and computerization that some of this is going to require.

So, I would express to you that we consider some of this to be extremely onerous on a new facility. Now, down the road two, three years, when you have a mature organization that's well-oiled and running along, different issue, no question

about it, but we take great exception to this at this point in time.

Now, to finish up my comments, I'd like to refer you to the proposed rule -- I assume you have that in front of you -- page 12. I want to make a couple of comments about two or three specific sections to give you an example of the concerns that we have. The first one would be Section 6.12, and we read that precisely to mean that you are directing this exclusively at the rehab industry, and in this case, the two existing rehab hospitals in this state, recognizing that there is a facility in Huntington, and perhaps one in Morgantown when they implement it, will also fall under this particular provision. We see this as being specifically applied to those two hospitals.

Under Section 6.12.1, Uniform Reporting System, we just simply are not prepared at this point to report under this. I mean, if we are required to do it, we'll have to find a out a way to do it, but we haven't given any thought to this reporting requirement, frankly, because we're busy trying to put a hospital up and make sure we can provide good care and meet the financial requirements of the organization.

On 6.12.2, the Health Care Cost Review Authority Annual Wage and Salary Survey, we addressed this in our testimony earlier in the summer. We believe and continue to believe that this is not a Section 5(f) requirement but a Section 29(b), and our only question is, if you're now proposing this again,

as we made the point earlier this summer, is this not just purely in anticipation of rate regulation, which at this point I think the Commission has conceded is not the intent of the rule-making.

Skipping one more, finally, to give you a detailed example of 6.12.4, on page 13, it gets into the UB 82 information, the patient care information. We were surprised at the detail about which you are requesting this information. You want taped format, and I would tell you -- and I don't have this verified -- but based on Mrs. Keeling and others that we have talked to in this state, we are of the opinion that only maybe five or six of the existing hospitals, acute care hospitals, in the state could meet this requirement today. So that leaves a good number of hospitals around the state that can't, and now you're talking about two brand new startup hospitals that you're expecting to come onstream.

I will tell you candidly there is no way we could meet that requirement today. If you impose this, and it, in fact, was in place, and we had to abide by it, we couldn't do it. We would be immediately in nonconformance with this requirement. We recognize in here that hard copies could be provided, but the way that is written alone would suggest, because it is put in the negative, you are at the mercy of the Board as to whether it would even let you provide hard copies of this information.

So, I guess, to close off our part of this, we believe that this requirement is going to be difficult to meet.

We think it's onerous at this point in time to the rehab hospitals that we think this is directed to.

I'd like to turn to Mrs. Keeling for some additional comments.

MRS. KEELING: Thank you. My comments will be very brief, and they are directed at the procedural method by which the Board has chosen to promulgate the rules. Frankly, we see no reason why these are emergency rules. We can't fathom that there is any emergency in the state affecting two rehab hospitals which amount to very few beds and a very small number of dollars in terms of the total health care delivery system in the state that could be characterized as an emergency. So we do not believe that the requirements of Section 29(A) 315 have been met with the promulgation of the rule.

We'll just close by saying that, again, Section 6.12 appears to be directly focused at rehab hospitals, since, for some reason, the nursing homes are not required to report under that section. We question whether it's arbitrary and capricious in that singling out of the rehab hospitals, and whether or not it is directed at attempting to begin, through 5(f) to attempt to prepare to regulate under 29(b), which according to the decision in June, is not appropriate at this time, at least. Thank you.

MR. KOZAK: Any questions from the staff?

(All give negative response.)

MR. KOZAK: Thank you very much.

MR. KEESLING: I do have a question. You mentioned the startup of these new facilities. How long have you been involved in this rehab hospital climate?

MR. SIMMONS: Here in this state?

MR. KEESLING: No, overall.

MR. SIMMONS: Well, as a company, we have been involved in rehab probably for, extensively, for five or seven years. In terms of ownership and startup facilities, these are the first two we've been involved with.

MR. KEESLING: At present, how many other institutions do you have?

MR. SIMMONS: The only two we have.

MR. KEESLING: I'm not talking about just in West Virginia.

MR. SIMMONS: The only two we have currently. Now, there are obviously some planned or acquisitions on the way, but we don't have any others that we are working with.

MR. KEESLING: Okay. Thank you very much.

MR. SIMMONS: Yes, sir.

MR. KOZAK: The next name I have on the list is Edwin Foss.

MR. FOSS: My name is Ed Foss, Executive Vice President of the West Virginia Health Care Association. We have just one observation or comment to offer regarding the proposed

regulations. On page 7, Section 5.4, we would recommend changing the deadline for submission of facility budgets from 30 days prior to 30 days following the start of the fiscal year, and the reason for that, quite simply, is that the budget projections made 30 days in advance are still subject to last-minute changes. The budget figures locked in as of the beginning of the fiscal year are apt to have fewer and less dramatic changes, and the information that you receive will be more meaningful to you.

Thank you.

MR. KOZAK: Any questions?

(Negative response from attendees.)

MR. KOZAK: Thank you, Mr. Foss. That concludes the names on the list I have here. Does anyone else care to comment?

MR. BELL: I don't have any verbal comments to make right now, but I do have a few written comments on behalf of the Charleston Area Medical Center that I'd like to submit.

MR. KOZAK: If you would hand those to Mr. Folio, perhaps Mr. Folio would give me the list on the table back there, please.

MR. FOLIO: We have one name on the other list -- Ms. Florette Angel.

MS. ANGEL: I'm Florette Angel, representing the Mountain State Health care Campaign, based in Charleston, but representing consumers and consumer organizations across the state.

I am here to respond very briefly to the proposed regulations on financial disclosure. I want to commend that concretizing what has been demanded by Code and to have it in a form to be dealt with and to also commend for the effort to get data which is representing a consumer organization, I think will long term, prove to be very vital as there is staffing to study and others to study for terms of strengths and weaknesses in our health care system, so that remedies to address those weaknesses can be proposed.

The concern I want to express, again with each of us coming from a particular bent of representation, deals with what I believe was the legislated intent in forming HCCRA and the intent that is referred to in the findings dealing both with financial disclosure and in the previous rules dealing with the methodology. It deals with the public's interest in health care, its vitalness to us as our citizens, the intent of the legislature to try to see that an affordable system of health care is in place in West Virginia accessible to all of its citizens. Since we have started in this campaign, I have to share with you that the types of calls and concerns that have come to the offices of those involved in the steering committee deal perhaps with perceptions, but perceptions are things that need to be addressed. There is a perception by many citizens that there is the possibility of conflict of interest occurring between staff and board members of our health providers and that this sometimes leads to decisions being made which are not in the financial best interest of the

ultimate consumer, driving the cost of health care even further up than it is, or would need to be.

I do not know -- by the sound of financial disclosure, it would appear that semantically this would be the proper place, but perhaps the other sections dealing with methodology is to address this, but would suggest and would ask your attention to -- there appears to be no existence of any regulations calling for the filing of conflict of interest statements on behalf of the health care providers, either their board or of their key staff, nor does there appear to be any regulations that demand that hospitals and other providers adopt policy that is filed that shows that decisions are made to assure cost effectiveness, and I raise this in that sometimes I think that good decisions are made but because the decision-making process is hidden, that there then gives the appearance of conflict which may in fact not exist. I would cite as an example a fictitious hospital which makes a purchase of hospital beds, and there is the belief that those hospital beds that the company stock is owned by board or staff. There is nothing on file to say that a conflict of interest has been filed. There is the belief then in the public or consumer's mind that a higher price was paid for those beds, that there was not a competitive bidding process, and then it is felt that bad decisions have been made. If there was a kind of information on file and there was reason to believe a bad decision had been made, agrees at least to investigate, if such

information were on file with this body, an investigation could occur, and it either could be corroborated or denied, and would ask, wherever it is proper, that you consider very strongly addressing these types of consumer concerns within your regulations.

Thank you.

MR. KOZAK: Any questions?

(Negative response from attendees)

MR. KOZAK: Is there anyone else present who wishes to speak or submit written comments? If not, we will call the public hearing to a close and thank you all very much for coming.

REPORTER'S CERTIFICATE

STATE OF WEST VIRGINIA,
HEALTH CARE COST REVIEW AUTHORITY, to wit:

I, the undersigned, Debra L. Skidmore, Staff Reporter for Phyllis Edens, Official Reporter, do hereby certify that the foregoing is, to the best of my skill and ability, a true and accurate transcript of the proceedings in the aforesaid matter and that the witnesses were first duly sworn by me to testify the truth in relation to the matters about which they were interrogated in the hearing held on September 2, 1988.

Given under my hand this 15th day of September. 1988.

Debra L. Skidmore
Reporter