

**WEST VIRGINIA**  
**SECRETARY OF STATE**  
**KEN HECHLER**  
**ADMINISTRATIVE LAW DIVISION**

Form #3

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OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

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

AGENCY: West Virginia Health Care Cost Review Authority TITLE NUMBER: 65

CITE AUTHORITY W. Va. Code 16-29B-20(k)

AMENDMENT TO AN EXISTING RULE: YES  NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: \_\_\_\_\_

TITLE OF RULE BEING AMENDED: \_\_\_\_\_

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 14

TITLE OF RULE BEING PROPOSED: Expedited Review For Rate Changes

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.



LARRY C. FIZER, Chairman

APPENDIX B

FILED

FISCAL NOTE FOR PROPOSED RULES JUL 22 3 2 40

Rule Title: Expedited Review For Rate Changes

Type of Rule:  X  Legislative             Interpretive             Procedural

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

1. Effect of Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	\$ 25,000	\$ 0	\$ 25,000	\$ 25,000	\$ 25,000
Personal Services	25,000	0	25,000	25,000	25,000
Current Expense	-	-	-	-	-
Repairs and Alterations	-	-	-	-	-
Equipment	-	-	-	-	-
Other	-	-	-	-	-

2. Explanation of above estimates. The estimate is based on additional staff needed to process this new rate request procedure. Estimate includes average salaries for one FTE for secretarial purposes and ½ FTE for a rate review analyst.

3. Objectives of these rules: To implement an expedited rate review process for hospitals licensed for more than 100 beds or that are located in a Standard Metropolitan Statistical Area as mandated by W. Va. Code 16-29B-20(k).

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None. The agency is funded with money collected from the hospitals for annual assessments and filing fees. No general revenue funds are appropriated or expended by this agency.

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

Hospitals affected by this rule may experience a slight increase in expenses associated with completing this new application. However, they are already familiar with the standard application and the new expedited form is a shortened version, therefore the expense should be minimal.

C. Economic Impact on Citizens/Public at Large.

The citizens/public will benefit in that larger hospitals and those located in Standard Metropolitan Areas will no longer be entitled to an automatic rate of inflation rate increase.

Date 6/22/89

Signature of Agency Head or Authorized Representative

  
LARRY C. FIZER, Chairman

DATE: August 14, 1989

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: West Virginia Health Care Cost Review Authority

LEGISLATIVE RULE TITLE: Expedited Review For Rate Changes

1. Authorizing statute(s) citation W. Va. Code 16-29B-20(k)

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

June 22, 1989

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

Publication in agency newsletter; copy of rule and notice of

hearing sent to all hospitals licensed for more than 100 beds

and all hospitals located in a Standard Metropolitan Area; copies

also sent to those on attached list.

c. Date of hearing (s):

August 1, 1989

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)

August 14, 1989

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

Marianne K. Stonestreet, General Counsel

Telephone: 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.

N/A

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 \_\_\_\_\_

TITLE 65  
WEST VIRGINIA LEGISLATIVE RULE  
HEALTH CARE COST REVIEW AUTHORITY

SERIES 14

Title: Expedited Review For Rate Changes

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S65-14-1 General

1.1. Scope - This legislative rule establishes an expedited review process for hospitals licensed for more than one hundred (100) beds or that are located in a Standard Metropolitan Statistical Area for rate increase requests as provided by the 1989 amendments to W. Va. Code 16-29B-20(k).

1.2. Authority - W. Va. Code 16-29B-20(k).

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

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

S65-14-2 Introduction

This legislative rule implements certain of the provisions of Enrolled Committee Substitute for Committee Substitute for Senate Bill 576 which was signed by the Governor. That bill amended W. Va. Code 16-29B-20 by adding a

HCCRA  
Leg. Rule, 165F  
Series 14, Sec. 2

new subsection. This new subsection authorizes the state agency to promulgate rules to develop an expedited review process for rate increase requests from hospitals licensed for more than one hundred (100) beds or that are located in a Standard Metropolitan Statistical Area.

§65-14-3        Definitions

As used in this rule, all terms have the same meaning as provided in the definition section of the Health Care Cost Review Authority Act, West Virginia Code, section three, article twenty-nine-b, chapter sixteen. Definitions of additional terms are set forth below and whenever those terms are used, the following definitions apply, except where the context may expressly otherwise require.

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

3.2. "DRI" refers to the inflation index for the hospital industry published by Data Resources/McGraw-Hill.

3.3. "Gross Revenue" means a hospital's gross patient revenue plus all operating and nonoperating revenues from whatever source.

3.4. "Hospital" means:

3.4.1. A facility subject to licensure as such under the provisions of West Virginia Code, article five-b, chapter sixteen; or

3.4.2. Any acute care facility operated by the state government which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons; but, ~~in either event,~~ does not include state owned or operated mental health facilities, ~~facilities primarily engaged in rendering psychiatric diagnosis, treatment and care or state owned or operated long-term care facilities, or speciality hospitals such as acute care psychiatric and rehabilitation hospitals.~~

3.5. "License" means the license issued by the state department of health pursuant to West Virginia Code, article five-b, chapter sixteen. The license is issued for a particular number by type of beds and/or type or services. The total number of beds specified on the license including non-acute beds shall determine the licensed bed capacity of the hospital.

3.6. "Standard Metropolitan Statistical Area" means metropolitan statistical area (MSA) as designated by the U.S. Office of Management and Budget and the Federal Committee on Metropolitan Statistical Areas. An MSA

HCCRA  
Leg. Rule, 165F  
Series 14, Sec. 3

is a geographical designation that represents an integrated social and economic unit with a large population ~~nucleus~~ nucleus. An area qualifies for recognition as an MSA if there is a city within the area of at least 50,000 population or an urban area of at least 50,000 with a total metropolitan population of at least 100,000.

§65-14-4      Expedited Review

Any hospital which is licensed for more than one hundred (100) beds or that is located in a Standard Metropolitan Statistical Area which wishes to change or amend any portion of its previously approved schedule of rates in an amount equal to or less than the rate of inflation as published by Data Resources/McGraw Hill shall do so in accordance with this rule.

4.1.      Application, license and budget - The hospital shall file an application with the Authority at least forty-five (45) days prior to the beginning of its fiscal year on a form to be provided by the Authority. The application submitted by the hospital shall include the following: the hospital's inpatient and outpatient utilization for the previous fiscal year, the current fiscal year and the projected inpatient and outpatient utilization for the fiscal year affected by the increase; the amount of gross inpatient and outpatient revenue received by the hospital during the previous fiscal year, the current fiscal year and the projected amount of gross inpatient and outpatient revenue for the year affected by the

HCCRA  
Leg. Rule, 165F  
Series 14, Sec. 4

increase; the amount of contractual allowances, uncollectable accounts, charity care, operating expenses, other operating revenue, non-operating revenue interest, non-operating revenue gifts, and non-operating revenue other for the previous fiscal year, the current fiscal year and the projected amount for the fiscal year affected by the increase. The hospital shall submit with its application a copy of its current license issued by the state director of health pursuant to West Virginia Code 16-5B-1 et seq. The hospital shall also submit with its application a copy of the budget approved by the hospital's board for the fiscal year affected by the increase. The budget must contain all usual information under generally accepted accounting principles for a budget and a full and specific statement of all assumptions relied upon in preparing the budget. The application shall include a certification by the chief executive officer and the chairman of the board of the hospital that the information contained therein is true and accurate.

4.2. Eligibility standards - Upon receipt of the application, license and budget, the Authority shall determine: (1) if a minimum of 365 days have elapsed since the hospital has placed into effect its last rate increase. Temporary changes in a hospital's rates made pursuant to W. Va. Code 16-29B-21(b) are excluded from this requirement; and, (2) if the hospital has provided charity care equal to or greater than the most recent state average ~~for the previous fiscal year~~ as published by the Authority. Charity care shall be determined in accordance with the guidelines contained in the Hospital Cost

HCCRA  
Leg. Rule, 165F  
Series 14, Sec. 4

Containment Methodology - Phase I, Sections 3.4.9.1, 3.4.9.1a, 3.4.9.1b, 3.4.9.1c and 3.4.9.1d (65 C.S.R. 5) and shall not include bad debt. The Authority shall also review any or all of the following revenue limits to determine if the hospital has experienced an excess in these categories: (1) gross revenue, (2) gross patient revenue, (3) gross inpatient revenue, (4) charges per discharge; and, (5) gross outpatient revenue. No hospital will be determined ineligible to request an expedited rate increase pursuant to this rule if the data submitted indicates an excess in gross outpatient revenue or an excess in gross revenue or gross patient revenue if the excess is directly attributable to the excess in gross outpatient revenue.

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

4.3. Rate of inflation - The hospital shall determine the applicable rate of inflation for the hospital industry by referring to the most recent publication of Data Resources/McGraw-Hill. The hospital may request the Authority to provide it with the current Data Resources Index (DRI) prior to filing the application required by section 4.1 of this rule. The DRI shall be applicable for sixty (60) days from the date of the letter from the Authority notifying the hospital of said figure. The rate of inflation so reported shall not

HCCRA  
Leg. Rule, 165F  
Series 14, Sec. 4

be adjusted for the increasing costs of technology, nonsupervisory wages, malpractice premiums, new services, or any other reason.

4.4 Hearings - Upon receipt of a complete application, license and budget, the board, in its discretion, may hold a public hearing. Such hearing shall be held no later than forty-five (45) days after receipt of the complete application, license and budget. The hospital or an interested party may request a hearing which request may, in the discretion of the board, be granted. The hearing shall be conducted pursuant to 65 C.S.R. 3, section 4.3.

4.5. Review by the board - Unless a hearing is held pursuant to 4.4 of this rule, the board shall issue ~~a decision~~ an order approving or disapproving the increase requested by the hospital within forty-five (45) days of receipt of the hospital's complete application, license and budget. This forty-five (45) day period shall not begin until the Authority receives from the hospital all the information required pursuant to this rule for a complete application including the license and budget. Within 45 days of receipt by the hospital of this order, the hospital shall file with the board a revised budget and a schedule of rates, each of which shall be drafted in accordance with the revenue limits set by the board. Thereafter, the board shall issue ~~an~~ a second order setting final revenue limits, the hospital's budget and schedule of rates. The initial order shall specify the effective date of any increase, and ~~t~~The hospital is prohibited from implementing ~~the~~ any rate increase until the date specified in the order. ~~The~~ All

HCCRA  
Leg. Rule, 165F  
Series 14, Sec. 4

orders shall be sent by certified mail, return receipt requested, to the hospital. An appeal or reconsideration of ~~a final~~ an order entered pursuant to this subsection (4.5) may be requested by the hospital or an interested party pursuant to 65 C.S.R. 3, sections 4.5 and 4.8.

4.6. Notice to the community - Contemporaneously with the filing of the application, license and budget pursuant to section 4.1 of this rule, the hospital shall also cause to be published in a newspaper of general circulation in the county in which the hospital is located a legal advertisement setting forth the fact that the hospital is applying to the board for a change or amendment to its schedule of rates. The legal advertisement shall summarize the effect of the requested relief and shall further state that any person desiring to inspect the application and budget may do so at the hospital during the hospital's regular business hours and also at the offices of the board. Also, the legal advertisement shall advise the public that any person or entity who claims to be an interested party in the proceedings for the changing or amending of the schedule of rates must file with the Authority a written notice setting forth the interested parties' names, address and the facts relied upon to establish his or her interest. The legal advertisement must inform the public that interested parties must file this notice within ten (10) days of the hospital's filing of its application with the Authority or else the Authority will, except for good cause shown, deny the interested party's notice. The Authority will then send notices of all proceedings and copies of all orders to those parties deemed to be interested in the matter.

HCCRA  
Leg. Rule, 165F  
Series 14, Sec. 4

Proof of publication of the legal advertisement by the hospital must be submitted to the Authority within ten (10) days of the filing of its application, license and budget.

4.7. If the board subsequently determines that the increase requested by the hospital actually exceeded the rate of inflation as published by Data Resources/McGraw-Hill, for whatever reason, the board may institute a review and investigation of the hospital's rates and budget and take such action as it deems necessary to establish a new rate schedule and also direct a refund to the hospital's patients or a temporary decrease in the hospital's rates if any of such should prove necessary. The decision resulting from any such review and investigation may be treated as a final order and an appeal or reconsideration may be requested by the hospital or an interested party pursuant to 65 C.S.R. 3, sections 4.5 and 4.8.

4.8. This rule also applies to any hospital which seeks to increase or decrease its outpatient revenue or its nonpatient revenues from nonmedicare or nonmedicaid sources. In addition, if the hospital experiences less inpatient utilization for the twelve (12) months following the increase than it had anticipated when the expedited rate of inflation increase was obtained, the hospital's average rate per discharge shall not later be increased to compensate for the decline in gross inpatient revenue without permission of the board.

HCCRA  
Leg. Rule, 165F  
Series 14, Sec. 4

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



Gaston Caperton  
Governor

Taunja Willis Miller  
Secretary

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
**HEALTH CARE COST REVIEW AUTHORITY**

Larry C. Fizer  
Chairman

Board Members  
Walter J. Dale  
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:  
Expedited Review For Rate Changes; and  
Statement of Circumstances Requiring the Rule

DATE: August 14, 1989

The proposed legislative rule for expedited review for rate changes creates an expedited review process applicable to all hospitals licensed for more than 100 beds or that are located in a Standard Metropolitan Statistical Area for rate increase requests which is based upon a recognized inflation index for the hospital industry. The inflation index utilized in the proposed rule is denoted as "DRI" and is published by Data Resources/McGraw-Hill. Pursuant to this rule the affected hospitals may request a rate increase which is equal to or less than the inflation index published by Data Resources/McGraw-Hill if they meet certain eligibility standards. The expedited review process requires less information from the hospitals and is completed in a shorter period of time by the Authority than a standard review.

The Omnibus Health Care Act enacted by the Legislature and in effect from passage (April 8, 1989) requires the board to develop this expedited review process. Prior to the enactment of the Act all hospitals were entitled to an automatic rate increase if certain criteria were met. The automatic rate of increase is no longer available to hospitals which are licensed for more than 100 beds or that are located in a Standard Metropolitan Statistical Area pursuant to the amendment to W. Va. Code 16-29B-20(j) contained in the Omnibus Health Care Act. The Act created a new subsection [W. Va. Code §16-29B-20(k)] which not only requires the development of this expedited review process but also requires the board to adopt emergency regulations implementing the subsection within ninety (90) days from passage (July 7, 1989).

MKS/jmh



Gaston Caperton  
Governor

Taunja Willis Miller  
Secretary

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
**HEALTH CARE COST REVIEW AUTHORITY**

Larry C. Fizer  
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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: Expedited Review For Rate Changes

DATE: August 14, 1989

The proposed legislative rule establishes an expedited review process for hospitals licensed for more than 100 beds or that are located in a Standard Metropolitan Statistical Area for rate increase requests as provided by the 1989 amendments to W. Va. Code 16-29B-20(k). 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) All references within the rule to the inflation index for the hospital industry published by Data Resources were amended to Data Resources/McGraw-Hill to reflect the new name of the company which publishes the inflation index. This amendment was initiated by the Authority.

(2) The Medicon Group, Workers' Compensation Fund and the West Virginia Hospital Association commented on Section 3.4.2. of the rule. The Medicon Group and the West Virginia Hospital Association commented that free-standing rehabilitation hospitals had historically been excluded from rate review. The Workers' Compensation Fund commented that the definition contained in this section was unclear as to whether psychiatric and rehabilitation hospitals were included.

The agency agrees with these comments and has specifically excluded speciality hospitals such as acute care psychiatric and rehabilitation hospitals from the expedited rate review process pursuant to section 3.4.2. of the rule.

(3) The Workers' Compensation Fund commented that section 3.5. should be amended to expressly include non-acute beds within the total number of beds specified in the license. The agency agrees with this comment and has amended the rule to specifically include non-acute beds.

Memorandum to Legislative  
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(4) Several entities commented regarding the use of the inflation index published by Data Resources/McGraw-Hill. Princeton Community Hospital specifically comments that the Data Resources index is not an equitable inflation index for use for the hospital industry. Steptoe & Johnson comments that the use of the DRI is a deviation from prior norms. The West Virginia Hospital Association and the West Virginia Chapter of Healthcare Financial Management Association (HFMA) on the other hand do not object to the use of the DRI inflation factor, however, they suggest a technology increase of 2 percentage points.

The agency disagrees with these comments and did not amend the rule to reflect these suggested changes. The agency notes that one of the major reasons W. Va. Code 16-29B-20(k) was enacted was to enable HCCRA to apply a lower and more reasonable rate of inflation to hospital rate increases. The hospital component of the consumer price index which was utilized in the automatic rate increase cases for the hospitals affected by this proposed rule was too high, at approximately 11.0%. The agency further notes in regards to the comments received from Steptoe & Johnson the DRI inflation factor is not a deviation from the norm. The agency has in the past and continues to use the DRI as a guideline in standard rate review cases. Finally, the agency notes that although a 1.0% allowance for technology is considered in standard rate review cases, an adjustment for increased costs of technology, new services, etc., has never been permitted in the automatic rate review process nor is it appropriate for the expedited review process.

(5) The agency received many written and oral comments regarding the charity care provisions contained in section 4.2. of the rule. Oral comments on this topic were received from Monte Ward, Chief Financial Officer, Cabell-Huntington Hospital and William Iseman, VP of Finance at Thomas Memorial Hospital. Mr. Ward believes that charity care is an issue that should be addressed separately from the expedited review process; Mr. Iseman believes that the charity care eligibility standard contained in section 4.2. of the proposed rule is unfair to hospitals without emergency rooms as they provide less charity care. Written comments on this issue were received from Steptoe & Johnson which believes that the requisite data-base does not exist to establish a state average for charity care; Weirton Medical Center which believes that the charity care eligibility standard is inequitable to community hospitals; Princeton Community Hospital which comments are similar to those provided by Cabell-Huntington Hospital in that each facility believes that charity care should be treated separately as an incentive rather than an eligibility standard; HFMA, St. Joseph's Hospital-Parkersburg and The West Virginia Hospital Association all commented to the effect that the method of classifying charity care is unclear and that there is a need for universal method. In addition to these comments, written remarks were also received from Blue Cross and Workers' Compensation to the effect that these entities wanted a more stringent eligibility standard in regards to charity care. The agency has reviewed these comments carefully and has amended the proposed rule in section 4.2. to more clearly define charity care

Memorandum to Legislative  
Rule-Making Review Committee  
August 14, 1989  
Page Three

and the relevant data-base from which the state average will be determined. The agency is aware that some entities believe the standard to be too stringent and others believe it to be too lax. However, the agency believes that the requirement that a hospital provide charity care equal to or greater than the most recent state average as published by the Authority is the most equitable standard.

(6) Many comments were also received concerning the requirement contained in section 4.2. of the proposed rule that a hospital may not experience an excess in certain revenue categories. St. Joseph's Hospital-Parkersburg, HFMA, Weirton Medical Center, The West Virginia Hospital Association, and Princeton Community Hospital all submitted written comments objecting to the use of these screens.

The agency has carefully reviewed these comments and agrees that an amendment is needed. The agency has amended the rule to state that an excess in gross outpatient revenue or an excess in gross revenue or gross patient revenue if the excess is directly attributable to the excess in gross outpatient revenue shall not prohibit the hospital from applying for an expedited review.

(7) A written comment was received from the Workers' Compensation Fund concerning section 4.5. of the proposed rule which states that the rule is not clear as to which order shall be used to specify the effective date of the increase.

The agency agrees with this comment and has amended the proposed rule to clearly state that the initial order shall specify the effective date of the increase. The order which sets final revenue limits, the hospital's budget and schedule of rates is more clearly defined in the amendment as the second order.

(8) Oral comments were received from Gayle Wright, VP of Finance at Camden-Clark Hospital concerning the use of gross revenues as opposed to net revenue as a basis for determining eligibility for this expedited review. Written comments to this effect were also received from HFMA, The West Virginia Hospital Association and Princeton Community Hospital. These comments urge the agency to adopt a methodology which utilizes net revenues as opposed to gross revenues.

The agency has carefully considered these comments; however, current statutes and regulations require the use of gross revenue rather than net revenue. Consequently, the proposed rule for expedited review for rate changes must also utilize gross revenues as its basis for determining eligibility.

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August 14, 1989  
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(9) Finally, a written comment was received from Doak, Cuppett & Poling, Certified Public Accountants, requesting that the proposed rule for expedited rate changes use the same criteria which is currently applicable to small facilities. Specifically, it requests that the same inflation factor be used for both the automatic and the expedited applications. As stated previously, one of the primary purposes for the enactment of W. Va. Code 16-29B-20(k) was to enable the agency to utilize a lower rate of inflation for rate increases. The CPI which is currently used in automatic applications for small hospitals is considerably higher than the DRI, consequently the agency rejects this comment.

MKS/jmh

WV HEALTH CARE COST REVIEW AUTHORITY  
MEETING REGISTRATION

Date of Meeting: August 1, 1989

Nature of Meeting: Public Hearing - Expedited Review for Rate Changes

	Individual's Name:	Name of Organization:	Do you wish to speak? Y or N
1	William L. Sheppard	Princeton Com. Hosp	Yes
2	Monte Ward	Cabell Huntington Hosp.	Yes
3	Norma Good	Action Reporting	
4	Bob Whitten	WVHA	Yes
5	CON ANSPAUGH	HFMA / ST. JOSEPH'S HOSP	YES
6	CHRIS KOCH	WHEELING HOSP.	NO
7	Ann Vroom	Stapton + Johnson	NO
8	DOUG YARBROUGH	WVHA	NO
9	James L. Backus	St. Joseph's Hospital	YES
10	William J. Dumm	THOMAS MEMORIAL HOSP	YES
11	Sam White	Berkeley County	NO
12	David H. Hester	HCCRA	N
13	Gregg Pitt	HCCRA	
14	Blair Smith	Party, Inc	N
15	Taylor D. Dwyer	Condon-Craig Mem. Hospital	Y
16	David E. Owen	Weston Medical Center	
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Blue Cross  
Blue Shield  
of West Virginia, Inc.



200 Kanawha Boulevard, E. 12th St.  
P. O. Box 1353  
Charleston, WV 25325

100 JUN 28 AM 11:56

Writer's Direct Dial Number  
347-7705

*cc: [unclear]  
Boyer  
Raley  
Marionne*

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

Dear Mr. Fizer:

Thank you for the opportunity to review the HCCRA regulations (Section 65-14-1) dealing with expedited review for hospital rate changes. These regulations implementing Section 1629B-20(K) of the West Virginia Code pursuant to the recently passed Ombius Health Care Act will hopefully provide some relief from the automatic approval of eleven plus percent rate hikes by hospitals. The automatic approval of rate increases based upon the spiraling inflation in health care charges was not providing our state businesses with the necessary protection against unaffordable health care cost. The regulations allowing for an expedited review and approval for qualified hospitals seeking rate increases of approximately six and one half percent (6½%) appear to be a valid effort to control health care prices without over regulating the hospital industry.

The following are a series of specific comments relative to the regulations.

- 1) The specific inflation index which is to be utilized should be more clearly defined in the regulations. The Data Resource Institute has published a number of inflation indices applicable to the hospital industry some of which exclude professional fees and capital cost. The regulation should provide that HCCRA will publish an approved rate of increase (based upon information obtained for Data Resource Institute) on a monthly basis which could be used in hospital applications. Section 4.3 of the regulations indicates that the hospital shall determine "an applicable rate of inflation" but do not make clear if the rate to be used is a historical rate or the projected rate of increase in the hospital cost index published by the Data Resource Institute.
- 2) Section 4.1 should be reworded to clearly state that the utilization, revenue contractual allowance, and operating expenses for the previous, current, and projected fiscal year be separately identified for Medicare, Medicaid, PEIA, and "All Others" in addition to the totals. This breakdown would be entirely consistent with the current "R Series" reports except that the PEIA would now be separately identified since the Ombius Health Care Act has apparently eliminated a hospital's revenues generated from the PEIA from HCCRA control. The information by payor category, to include separate information on PEIA activity, should prove useful in the analysis of hospital rates and for overall analysis of health care utilization, cost, and charges for our state. We strongly urge that this information be required on a timely and projected basis.

7-28-89 *[initials]*

Mr. Larry Fizer  
July 26, 1989  
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- 3) The standard in Section 4.2 requiring all hospitals to provide the "state average" amount of charity care as a condition of eligibility for expedited review does not appear to be sound policy. Economic conditions vary considerably around our state and not all hospital service areas have the same requirements for charity care. Encouraging some hospitals to relax charity care eligibility standards may discourage some people from seeking health care coverage thus increasing the burden on those who pay their own way. If the intent is to discourage some hospitals from dumping charity care on other hospitals, a better approach may be to specify that a hospital must provide some percentage (e.g. 1.0%) of charity care and/or that the hospital must provide some percentage (e.g. 90%) of the amount of charity care which they provided in the proceeding year in the projected year.
- 4) We would suggest the following as an additional eligibility standard for hospitals seeking an expedited review of an inflationary price increase: "The hospital's diagnosis related group (DRG) conversion factor for non-government patients is less than one hundred five percent (105%) of the state average conversion factor. The DRG conversion factor is the average charge per case divided by the case mix index associated with the diagnosis related groups into which the cases used in calculating the average charge per case have been grouped. The HCCRA UB82 data collection and analysis system for the preceding calendar year will be used as the basis for this calculation."

This additional standard is designed to preclude high priced hospitals, high priced after taking into account case mix, from perpetrating their high prices through inflationary price increases based upon the DRI. The use of a case mix index in comparing a hospitals charge per day to the state average will give considerable recognition to those hospitals which treat patients requiring expensive modes of care.

- 5) We would suggest that the last sentence of Section 4.2 be modified to read as follows:  
"No hospital shall be determined ineligible to request an expedited rate increase pursuant to this rule if the data submitted indicates an excess in gross patient revenue of less than one percent (1%) of total gross patient revenue."

We hope that the authority finds these comments to be appropriate and useful in their deliberations regarding these regulations. We are hopeful that these regulations reflect a beginning of renewed efforts on the part of HCCRA to assure affordable health care for West Virginia.

Sincerely,

*William E. Gavin*

William E. Gavin  
Vice President  
Health Care Services

WEG/bls



# WORKERS' COMPENSATION FUND

601 MORRIS STREET  
CHARLESTON, WEST VIRGINIA 25301

GASTON CAPERTON  
Governor

EMILY A. SPIELER  
Commissioner

July 14, 1989

cc: Bd  
Bob  
Ralph  
Marianne

Larry C. Fizer  
Chairman, Health Care  
Cost Review Authority  
Suite 201, 100 Dee Drive  
Charleston, W.Va. 25311

Dear Mr. Fizer:

Re: Proposed Rule - Title 65, Series 14,  
"Expedited Review For Rate Changes"

On behalf of Commissioner Emily A. Spielers, thank you for sending us a copy of the Authority's proposed rule and affording us an opportunity for comment.

Regarding specific matters first, please note the following matters.

1) In section 3.4 for the definition of a hospital, we would suggest that the definition either exclude psychiatric and rehabilitation hospitals or contain a reference to the Authority's interpretative rule excluding such facilities from the rate review program. This would eliminate some possible confusion since the proposed rule is later in time than the interpretive rule. However, we would also urge the Authority to reconsider its general exclusion of those hospital's and to place them under the rate review system.

2) At page 3, line 1 up from the bottom, the word "necleus" appears. Should this read "nucleus"?

3) In section 3.5, we would suggest that the definition of "license" be clarified to expressly include non-acute beds within the count to determine if the hospital has 100 or more beds. Long term care beds, rehabilitative beds, and others contribute to a hospital's operating costs and revenues, staffing needs, future capital costs and needs, and overhead expense in the same manner as do acute care beds - the difference is one of degree and there is not a qualitative difference from a cost containment perspective.

4) In section 4.1, is the expedited process available for only beginning of a fiscal year changes? The section does not expressly exclude mid-year changes. Such an omission has caused the Authority difficulty in the past in terms of processing repeated applications and is generally disruptive to coherent planning incentives for hospitals. If an emergency arises in mid-year, then the section 21 temporary rate increase is available to a hospital. We would suggest expressly limiting a hospital's ability to use the expedited process to beginning fiscal year changes and not allow the expedited process during the course of a fiscal year.

5) The Workers' Compensation Fund endorses the Authority's separation of charity care from bad debts in section 4.2. This change will ensure an appropriate accounting of whether the state's non-profit hospitals are living up to their eleemosynary reasons for existing. In addition, it will allow the Authority to review the charity care patient population of each hospital to ensure that each is caring for its appropriate number of such patients and that not only a few hospitals are unfairly carrying their fellow hospitals' burdens.

6) Also on the issue of charity care, section 4.2 specifies that a comparison will be made of each hospital's charity care to the state average for the past fiscal year. We think this is a commendable idea, but have some questions. Given the incomplete nature of the Authority's data base on charity care since for so long many hospitals combined charity care and bad debts in their reporting, we would suggest that the rule specify how the comparison will be made in the interim until complete information is received. What data will be used to compose the state's average during this period? We would also suggest that the Authority consider making the comparison against an average of other 100 plus bed and MSA hospitals and exclude from that average the smaller hospitals. The proposed rule affects only the 100 plus bed hospitals and MSA hospitals and comparison between them alone would be informative.

7) Section 4.2 should also specify the consequences of the comparison review. Will the expedited application be denied if the hospital is below the average? Or must it be significantly below the average? Will the comparison be used at all in deciding whether the expedited application will be approved or modified? We believe that both the standard to be applied and the consequences of failure to meet that standard should be addressed.

8) In section 4.1, we would suggest that the application's factual assertions be verified under oath and not be merely certified by the hospital's officers. Verification will enable the Authority to take corrective action in the event of deliberate evasions. A certificate is a matter of ethical

obligations rather than legal obligation and cannot be readily enforced.

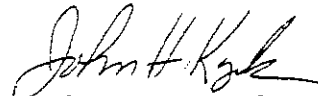
9) In section 4.5, line 11 down on page 7, which order will be used to specify the effective date of the increase? The section reads as if only the final order after the submission of a revised budget and schedule of rates will specify the date. However, the Authority's practice has been to allow hospitals to place an increase into effect following the interim order. If this alteration from past practice is intended, then the change should be more explicitly stated. We do not disagree with such a change as it would give hospital's incentive to complete the application process by submitting the later material promptly which has often not been the case in the past.

10) The rule does not specify how the DRI inflation factor is to be applied nor to which revenue limits it will be applied. A clearer explanation of the calculation that will be made would be helpful to understanding future decisions.

As a more general matter, the Fund would encourage the Authority to develop a rate setting methodology for out-patient care. The proposed rule continues the Authority's practice of encouraging hospitals to shift care to the out-patient setting by excluding out-patient revenue limits from being binding. While such a practice has been useful in the past, the Fund would suggest that it has outlived its usefulness. A review of most hospitals' rates over the last few years for out-patient charges will indicate that most have been increasing their charges with no apparent relationship to the costs of providing those services. Thus, the problems originally confined to inpatient charges at the time the Authority was created in 1983 are now well established on the out-patient side as well. Either this rule or a modification of prior rules should address the need to curb the rise in out-patient charges.

Thank you again for the opportunity to comment on this proposed rule.

Sincerely,




John H. Kozak  
Executive Secretary

cc: David Lambert, Esquire

**United Steelworkers of America**  
**AFL—CIO—CLC**

*cc: Maxanne*

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JIM BOWEN  
DIRECTOR  
  
July 25, 1989



Mr. Larry Fizer, Chairman  
Health Care Cost Review Authority,  
State of West Virginia  
100 Dee Drive, Suite 201  
Charleston, WV 25311

RE: TITLE 65 EMERGENCY WEST VIRGINIA LEGISLATIVE RULE  
HEALTH CARE COST REVIEW AUTHORITY - EXPEDITED REVIEW  
FOR RATE CHANGES

Dear Larry:

I have reviewed the above referenced Series 14 and  
see nothing wrong with it.

I would propose that you go ahead with it.

Very truly yours,

Larry Ratliff, Sub Director  
UNITED STEELWORKERS OF AMERICA  
District 23

LR:nlw

cc: Jim Bowen, Director, District 23, USWA

7-27-89 *st*

THE MEDICON GROUP

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July 31, 1989 AUG 1 1989

HEALTH CARE COST REVIEW AUTHORITY

Mr. Larry C. Fizer  
Chairman  
Health Care Cost Review Authority  
100 Dee Drive  
Charleston, WV 25311

Re: Expedited Review for Rate Changes

Dear Mr. Fizer:

Three Radnor Corporate Center  
100 Matsonford Road, Suite 200  
Radnor, PA 19087  
215/687-6900  
An Integrated Health  
Care Company

I am writing to you as the President of the Board of Directors of two medical rehabilitation hospitals licensed in West Virginia, namely

Southern Hills Regional Rehabilitation Hospital  
Princeton, WV

Western Hills Regional Rehabilitation Hospital  
Parkersburg, WV

Senate Bill 576 amended West Virginia Code S 16-29B-1 et seq. and authorized the Health Care Cost Review Authority (HCCRA) to promulgate rules establishing a new expedited rate review process for certain hospitals in the State of West Virginia. The authority is currently considering such a proposal.

The proposed rulemaking exempts some hospitals from rate review, but free-standing rehabilitation hospitals are not included on this list of exempted hospitals. It is this omission which I am addressing by this letter.

Historically, the HCCRA has consistently maintained that it does not wish nor intend to bring free-standing rehabilitation hospitals under the rate review provisions of S 16-29B-1 et seq. As recently as June 27, 1988, HCCRA issued an interpretive rule which disclaimed the application of the provisions of the rate setting act on free-standing rehabilitation hospitals. (See S 7.2 of the interpretive rule.)

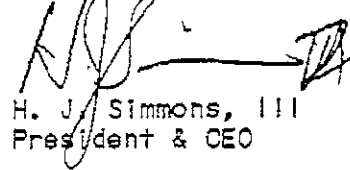
July 31, 1989

Given HOCRA's prior actions and current policy, the omission of free-standing rehabilitation hospitals from the list of exempted hospitals under the proposed rules for establishing a new expedited rate review process appears to be an oversight on the part of staff.

It is requested that free-standing rehabilitation hospitals continue to be excluded from rate setting under S 16-29B-1 et seq. and that this policy be appropriately reflected in the drafting of the proposed rule under consideration by the HOCRA Board.

Respectfully submitted,

THE MEDIGON GROUP



H. J. Simmons, III  
President & CEO

/Jpk

cc: Robert D. Whitler (WVHA)

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EXPEDITED REVIEW FOR RATE CHANGES

West Virginia Legislative Rule  
Health Care Cost Review Authority

AUG 1 1959

HEALTH CARE COST REVIEW AUTHORITY

Mr. Chairman, Members of the Board, I am Bob Whitler, Vice President/Public Policy Development, West Virginia Hospital Association. I appreciate the opportunity to testify on behalf of the Hospital Association and its 63 member hospitals concerning the legislative rule establishing a new expedited review process for hospitals licensed for more than one hundred (100) beds or that are located in a metropolitan statistical area (MSA).

Senate Bill 576 amended West Virginia Code §16-29B-20 by authorizing the Health Care Cost Review Authority to promulgate rules establishing a new expedited rate review process for hospitals licensed for more than one hundred (100) beds or that are located in a metropolitan statistical area. This particular provision was included in Senate Bill 576 because of the perception among some legislators that the inflation factor used in evaluating automatic rate increase applications - the hospital component of the consumer price index - was too high, at approximately 11 percent. We believe that there was considerable misunderstanding and confusion concerning this particular inflation factor during the legislative session since it allows hospitals to increase only gross revenues by that percentage.

Following deductions for charity care and bad debt, as well as Medicare and Medicaid shortfalls and contractual allowances, an 11 percent increase in gross revenues could very well result in only a 4 or 5 percent increase in net revenues. Fully 60.2 percent of West Virginia hospitals gross patient revenues (43.6 percent Medicare, 9.2 percent Medicaid and 7.4 percent charity

and bad debt) are not controlled by HCCRA and are, therefore, not affected by HCCRA approved rate increases.

The new inflation factor proposed by the Health Care Cost Review Authority - the DRI - is currently at 6.9 percent or 40 percent below the most recently published CPI inflation factor of 11.3 percent. Again, the inflation factor, as proposed, is based on gross revenues so that, in reality, it will allow a hospital to increase its net revenues on average only about one half that amount. The West Virginia Hospital Association, strongly recommends that in the near future a new rate review system be developed which will include an automatic inflation factor based on net revenue as opposed to gross revenue.

The Health Care Cost Review Authority proposes not only to reduce the automatic inflation factor by 40 percent, but to also put in place additional screens on individual hospital access to that lowered index. The West Virginia Hospital Association is totally opposed to the additional screens called for in the proposed rules in order to take advantage of the expedited review process, including the provision of charity care (not including bad debt) equal to or greater than the state average for the previous fiscal year and the requirement that a hospital not exceed any revenue limits. Each is discussed below.

Presently, hospitals use different methods for classifying charity care and bad debt and are now in the process of revising charity care policies and reporting procedures in order to comply with the State Tax Department's new ad valorem tax rules. To impose such a screen when hospitals do not have common reporting criteria would create confusion and unnecessarily complicate what should be a simple expedited review process. If the reported level of charity

care is used as a screen, there would be only 9 hospitals still eligible for the expedited review process out of a total of 33 potential hospitals.

Additionally, to utilize a charity care screen to access an inadequate automatic inflationary adjustment is hardly a "reward" for providing charity care. Instead, perhaps a hospital should be allowed an extra increase above the index as an incentive to provide such care.

Next, the authority proposes to review revenue limits in the following categories: (1) gross revenue, (2) gross patient revenue, (3) gross inpatient revenue, (4) charges per discharge and (5) gross outpatient revenue. Except for gross outpatient revenue, if any hospital has exceeded these limits, it would be ineligible for the expedited review process. Because of the nature of the revenue caps, many hospitals, even those hospitals with net operating losses, exceed at least one of the caps. Therefore, this screen will effectively eliminate from the expedited review process those hospitals that may pass the charity care screen. A review of the data by Hospital Association staff indicates that only 1 or 2 out of a total of 33 hospitals would be able to pass both the charity care and the revenue caps screen. Essentially, then, the HCCRA has created a non-process and which we would argue fails to recognize legislative intent which was to reduce the automatic inflation factor for larger hospitals, but also to keep in place an automatic rate increase mechanism to reduce unnecessary paper work and recognize management efficiencies."

The issue should simply be this: "Is the hospital proposing to keep rate increases due to inflation at or below the DRI." If yes, then the rate increase should be automatic.

The Connecticut legislature recently repealed their state's DRG system and replaced it with a cost containment mechanism based on revenue caps. During a transition year that will begin on October 1, 1989, hospitals will be able to avoid detailed budget review by the state's Commission on Hospitals and Health Care Providers where increases in net revenue do not exceed 8 percent and increases in gross revenue do not exceed 13 percent. In the fiscal year that begins October 1, 1990, a new threshold will be created that permits hospital net revenue to increase by the rate of inflation, as measured by the DRI, plus two percentage points.

The West Virginia Hospital Association urges the Health Care Cost Review Authority to drop its reliance on the relatively meaningless gross revenue caps and move, like Connecticut, toward caps on net revenue.

Finally, the West Virginia Hospital Association would like to point out that those hospitals exempted from rate review under 3.4.2., medical rehabilitation facilities are not included. We understand that this was simply an oversight on the part of staff and that rehabilitation facilities will, indeed, be exempted from rate review in the revised rules.

We appreciate the opportunity to express our views and would like to offer you our assistance as you move toward more reasoned rate setting methodology.

EXPEDITED REVIEW FOR RATE CHANGES

SUBJECT: COMMENTS REGARDING THE EMERGENCY RULE ON EXPEDITED REVIEW FOR RATE CHANGES
FROM: WILLIAM L. SHEPPARD, CEO, PRINCETON COMMUNITY HOSPITAL
FOR: THE RECORD OF PUBLIC HEARING CONCERNING THE EMERGENCY RULE HELD AUGUST 1, 1989

This legislative rule was established under the authority of the amendments made to West Virginia Code 16-29B-20 by Senate Bill 576. I offer the following comments regarding the particular sections of this legislative rule as outlined below.

Section 65.14-4 Expedited Review - "...rates in an amount equal to or less than the rate of inflation as published by Data Resources..."

Comment - The Data Resources Index is not an equitable or accurate inflation index to use for the hospital industry. Consider the wage component of the calculation of this index. The wage component in the calculation of the DRI is itself based on ten components. Only one of the ten components is a wage inflation factor for the hospital industry. The other nine components are wage inflation factors from non-hospital industry occupations. This wage component is obviously an important component of a hospital inflation index since personnel costs are a hospital's single largest expense item, yet only one tenth of the DRI wage component is based on hospital industry experience. I therefore, have to seriously question the equitability and accuracy of using the DRI as a measure of inflation in the West Virginia hospital industry.

Section 4.1 Application, License, & Budget - "The hospital shall file an application with the Authority at least 45 days prior to the beginning of its fiscal year on a form to be provided by the Authority".

Comment - The above sentence, if taken literally, would preclude those hospitals with a July 1 fiscal year start date from filing an application for an expedited rate review until next year, since this legislative rule was not received by these hospitals until a few days before the beginning of their present fiscal year.

Section 4.2 Eligibility Standards - "...(2) if the hospital has provided charity care equal to or greater than the State average for the previous fiscal year...."

Comment - Assuming the State's objective is to have hospitals not only provide an adequate level of charity care, but hopefully increase their levels of charity care, providing incentives to do so would be the most effective way of accomplishing this. The use of a charity care standard to help determine

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HEALTH CARE COST REVIEW AUTHORITY

Eligibility for what is an inequitable inflationary adjustment is not an incentive for providing charity care. In addition, the job of developing common reporting standards for charity care to assure comparability of hospital data, would seem to add an unnecessary burden to HCRRA and to what should be a simple expedited review process.

Section 4.2 Eligibility Standards - "... if the hospital fails to meet these standards (such as the standard of not exceeding any previous revenue cap), the hospital may not request the rate increase pursuant to this rule."

Comment - Each year's rate request should stand on its own. A number of West Virginia hospitals have exceeded certain revenue caps in the past, but for good reasons which have been accepted by HCCRA, for instance, exceeding a charges-per-stay cap because of an increase in length of stay. It is clearly totally arbitrary to use that past history (which should be completed and closed business) as a standard for a present rate request.

Section 4.3 Rate of Inflation- "The rate of inflation so reported (by DRI) shall not be adjusted for the increasing cost of technology, non-supervisory wages, malpractice premiums, new services, or any other reason."

Comment - A new service or project with an approved CON can obviously significantly impact on the hospitals expenses, but yet not be taken into account by a general inflation index such as DRI. It is clearly inequitable to not adjust the rate of inflation for such new services or projects. In addition, the increasing cost of technology impacts on hospitals every year, and has previously been recognized as a necessary adjustment to an inflation factor by HCCRA. The cost impact of technology on hospitals will continue in the future change and therefore should continue to be recognized as a legitimate adjustment to the rate of inflation.

Final Comments:

1. The rate review process in our State has traditionally used gross revenues as the key measure of the review process. I recommend that HCCRA seriously consider developing a new rate review system based on net revenue as opposed to gross revenue, for the two reasons outlined.
  - a. Given that the primary objective of rate review is to control the amount of non-federal health care dollars paid to hospitals, hospital gross revenues is not an accurate measure because net revenue rather than gross revenue is the amount of dollars actually paid to hospitals.
  - b. Applying an inflation factor to gross revenue is misleading because of revenue deductions such as contractual allowances, charity care, and bad debts. Again, therefore, net revenues would be a more accurate measure to use in the rate review process.

2. Finally, although it is not unusual to find some degree of adversarial relationship between a rate review agency and the organizations it reviews, we strongly feel that it is important that a good working relationship rather than an adversarial working relationship should be developed between hospitals and HCCRA. A good expedited rate review should contribute to a good working relationship by accomplishing the rate review objective while simplifying and decreasing the work involved for both HCCRA and hospitals. It concerns us that the additional eligibility screens significantly complicate the expedited review process, create significant work for both parties, and have the potential for contributing to an adversarial relationship. We strongly recommend that HCCRA eliminate the additional screens called for in the proposed rules and continue to use an appropriately adjusted inflation factor as the standard for expedited rate approval. We feel that this will help contribute to a continued good working relationship between HCCRA and the hospitals.



HEALTHCARE  
FINANCIAL  
MANAGEMENT  
ASSOCIATION

WEST VIRGINIA  
CHAPTER

WEST VIRGINIA CHAPTER  
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

POSITION PAPER ON:  
EXPEDITED REVIEW FOR RATE CHANGES  
FOR HOSPITALS >100 BEDS OR IN A MSA

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WEST VIRGINIA CHAPTER

I. CHANGE FROM CONSUMER PRICE INDEX TO THE DATA RESOURCES INDEX

The DRI inflation factor proposed by the Health Care Cost Review Authority is currently at 6.9% or approximately 40% below the most recently published CPI rate of 11.3%. The proposed DRI rate when applied to gross revenue could only yield an increase in net revenue on the average of about one half of that amount.

The West Virginia Chapter of the Healthcare Financial Management Association (WVHFMA) believes that the use of the DRI by itself without the addition of one or two percent for the increasing costs of technology is unduly penalizing providers in the state. These same facilities are the ones bringing new technology and service to the state to provide better and up-to-date care to the people of West Virginia.

Recent data provided by the state of West Virginia clearly shows that more than 20% of PEIA patient dollars go to out-of-state providers. Since most of the surrounding states healthcare costs are higher than many West Virginia providers, West Virginia residents could receive healthcare services closer to their homes at less expense pending the technology being available in our own state.

For similar reasons, Connecticut has recently repealed their DRG system for hospitals and will be implementing on October 1, 1990, a new system that permits hospitals' net revenue to increase by the DRI plus two percentage points.

The WVHFMA strongly urges the Health Care Cost Review Authority to add a one or two percent adjustment for technology to the DRI inflation factor.

II. ELIGIBILITY STANDARDS - SCREENS TO ELIMINATE THE USE OF EXPEDITED REVIEW:

The WVHFMA believes that the intent of the 1989 legislature was to modify the prior expedited review process only to the point of reducing the eligibility standard to what was in their mind, a more reasonable level (i.e. 7% vs. 11%). A process that provides cost containment goals for healthcare providers while not overly increasing the level of review and burdening the bureaucratic process at a time of limited state funds and limited state manpower.

Developing stringent eligibility standards, in addition to reducing the inflation factor, will serve only to increase healthcare cost by forcing providers to complete the expensive and time consuming rate request

application when, in fact, that provider may be doing an excellent job in otherwise maintaining healthcare costs.

In addition, reliance upon a charity care screen to qualify hospitals for the expedited review process may appear to favor some providers as a result of exceeding a state "average" when, in fact, a provider may be providing a substantial amount of charitable healthcare service to its community - yet remain below the state average. The reasons for such could range from the economic condition of the community to the method a provider chooses to record charitable service. Accurate charity care guidelines can not be developed until such time that all providers and state agencies develop a universal method of classifying charity care, uncompensated care, and bad debt - a process that is currently underway with the State Tax Department, the West Virginia Hospital Association, The West Virginia Chapter - HFMA, and hopefully, the HCCRA staff.

The proposed screen on revenue limits could arbitrarily disqualify a hospital provider from expedited review even if the hospital could reasonably justify the increase and/or was operating at a net loss. Because of the nature and variety of the revenue caps, as well as circumstances, such as an increase in patient acuity, a change in physician referral or admission pattern, new high cost products, or even the addition of a new physician (such as a specialist) to a community hospital's staff, a hospital can exceed a cap for very just circumstances.

Finally, the HCCRA proposed screen that a minimum of 365 days must have elapsed prior to the hospital placing into effect its last approved rate increase. Hospitals could be unduly penalized for delays in the bureaucratic process - particularly if full review will become reality as a result of the proposed emergency rules. A hospital submitting a completed rate request two or three months prior to its fiscal year may not receive final approval until three or four months into its fiscal year. Consideration should be given to permit expedited review request based on a provider's fiscal year.

### III. SUMMATION

Recent data prepared by the West Virginia Hospital Association clearly indicates that only 1 or 2 hospitals would qualify for the expedited review process as a result of the proposed emergency rules and the change from the Consumer Price Index (CPI) to the Data Resources Index (DRI) for hospital providers larger than 100 beds or those that are located within a metropolitan statistical area.

The West Virginia Chapter Healthcare Financial Management Association (WVHFMA) believes that expedited review process allows those providers maintaining healthcare costs at a reasonable level - now established at the lower DRI level - to continue providing low cost healthcare to their community while not burdening them with costly and time consuming reporting and paper processing.

In addition, it provides HCCRA with the mechanism to concentrate on those providers appearing to require the agency's attention - at a reasonable staffing level and cost to the state and, in particular, to the taxpayer at a time when resources are limited.

Therefore, WVHFMA strongly urges compliance with the expedited review process as intended by the legislature and elimination of the proposed additional screens.

Also, suggestion is made to consider a new rate review methodology that is based upon net revenue and provides a technology increase of two percentage points. As stated earlier, the latter would allow West Virginians access to healthcare technology now being provided in other states at higher cost to West Virginia - both in terms of much higher cost in most surrounding states and the much needed out flow of millions of dollars in lost revenues to West Virginia healthcare providers.

The West Virginia Chapter HFMA, in conjunction with the WVHA, is available to assist HCCRA wherever possible in implementing a workable healthcare cost methodology and review process.

ST. JOSEPH'S HOSPITAL  
PARKERSBURG, WV

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POSITION PAPER ON:  
EXPEDITED REVIEW FOR RATE CHANGES  
FOR HOSPITALS >100 BEDS OR IN A MSA HEALTH CARE COST REVIEW AUTHORITY

ELIGIBILITY STANDARDS

Screens have been established so as to effectively eliminate the expedited review process for the state's larger hospitals and/or hospitals in a SMSA.

The first screen requires that 365 days have elapsed since the hospital has placed into effect its last rate increase. While the regulations state that HCCRA has 45 days to issue an order after receipt of a hospital's application, there are loopholes that would allow HCCRA to go beyond that time frame.

The potential effect of this eligibility standard is that hospitals would not be able to implement a rate increase at the start of its fiscal year and, because of the 365 day time limit, the affect would be permanent.

The second screen requires that each hospital has provided charity care equal to or greater than the state average. Again, this screen would effectively eliminate hospital's from the expedited review process. The problem with using an average is that one or two hospitals with a large charity care provision could skew the average up, making it difficult for the majority of hospitals to reach. The provision of charity care should not be used as a way to screen out hospitals. Hospital's with a higher than average provision of charity care should be allowed to use a higher rate of inflation than those hospitals that are at or below the average.

In addition to the two above-mentioned screens, hospitals would also be excluded from an expedited review if they exceeded their limit for any of the following: 1) gross revenue, 2) gross patient revenue, 3) gross inpatient, <sup>revenue</sup> and 4) charges per discharge.

While a hospital would not be ineligible due to an excess in gross outpatient revenue, an increase in gross outpatient revenue could cause an excess in gross patient revenue which would eliminate a hospital from an expedited review.

Presently, there are only penalties for when a hospital has exceeded its revenue limits. There should be some incentive or reward for when a hospital has stayed within its limits.

The inclusion of these screens would effectively eliminate the expedited review process which we feel was not the intent of the legislature. We feel the intent was to still allow for an expedited review process but with a lower inflation rate index. This is accomplished by using the Data Resource Index (DRI) rather than the Medical Consumer Price Index (CPI).

# STEPTOE & JOHNSON

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August 1, 1989

Larry C. Fizer

Chairman

The West Virginia Health Care Cost Review Authority

100 Dee Drive, Suite 201

Charleston, West Virginia 25311

Dear Mr. Fizer:

In response to the opportunity to submit written comments regarding the West Virginia Health Care Cost Review Authority's ("HCCRA's) proposed legislative rule "Expedited Review For Rate Changes", we respectfully submit the following comments.

## BACKGROUND

Effective April 9, 1989, the West Virginia Legislature made the following additions [additions underlined] to W.Va. Code § 16-29B-20 governing rate determinations by HCCRA:

(j) Notwithstanding any other provision of this article, the board [HCCRA] shall approve all requests for rate increases by hospitals which are licensed for one hundred beds or less and which are not located in a Standard Metropolitan Statistical Area where the rate of increase in the hospital's gross inpatient revenues per discharge for nonmedicare and nonmedicaid payors is equal to or less than the rate of inflation for the hospital industry nationally as measured by the most recent hospital market basket component of the consumer price index as reported by the United States Bureau of Labor Statistics applicable to the hospital's fiscal year. The board may, by regulation, impose reporting

requirements to ensure that a hospital does not exceed the rate of increases permitted herein.

(k) Notwithstanding any other provision of this article, the board shall develop an expedited review process applicable to all hospitals licensed for more than one hundred beds or that are located in a Standard Metropolitan Statistical Area for rate increase requests which may be based upon a recognized inflation index for the national or regional hospital industry. The board shall adopt emergency regulations implementing this subsection within ninety days after the effective date of this subsection [April 8, 1989] and shall thereafter submit a proposed legislative rule to the Legislature for consideration at its regular session in the year [1990].

HCCRA's implementing regulations for the former W.Va. Code § 16-29B-20 (j) are found at the W. Va. Code of State Rules ("CSR") §65-3-5, "Automatic Rate of Inflation Increases." (Attached hereto as Exhibit 1 for reference.)

#### DISCUSSION OF PROPOSED LEGISLATIVE RULE

It is well-established that administrative agencies have only such powers as have expressly or impliedly been conferred upon them by law. Walters v. Ritchie, 156 W.Va. 98, 191 S.E.2d 275 (1972). Pursuant to an administrative agency's authority to promulgate rules and regulations implementing statutory mandates, such rules must not be in conflict with, or alter or limit, the statute and cannot supply omissions of the statute. See, e.g., Tulley v. State Farm Mut. Auto. Ins. Co., 345 F.Supp. 1123 (D.C.W.Va. 1972); Ney v. State Workmen's Compensation Com'r., 297 S.E.2d 212 (W. Va. 1982); Anderson & Anderson Contractors, Inc. v. Latimer, 162 W. Va. 803, 257 S.E.2d 878 (1979). In determining an administrative agency's scope of authority it must be presumed that the lawmakers intended to place no greater restraint on the liberties of a citizen than was clearly and unmistakably indicated by language they used. Walters v. Ritchie. Finally, when an administrative agency reverses course from its precedents, it must give reasonable notice and supporting rationale before it changes its standards, or its actions appear arbitrary and capricious. C & P Telephone Co. of W. Va. v. Public Service Com'n. of W. Va., 301 S.E.2d 793 (W. Va. 1983).

Here the Legislature has specified that proposed rate changes by hospitals of 100 beds or more located in Standard Metropolitan Statistical Areas - that are no greater than the hospital industry rate of inflation - undergo an expedited review. This new review requirement, however, is actually a limitation of the previous right to an automatic rate increase pursuant to the prior W.Va. Code § 16-29B-20 (j) 87) and §65 CSR 3-5. In interpreting the Legislature's underlying intent in this regard it is helpful to review the legislative findings expressed at the time HCCRA was established, which are set forth at W. Va. Code § 16-29B-1 as follows:

The legislature hereby finds and declares that the health and welfare of the citizens of this state is being threatened by unreasonable increases in the cost of acute care hospital services. In order to alleviate this threat, information on hospital cost must be gathered, a system of cost control must be developed and an entity of state government must be given authority to ensure the containment of acute care hospital costs. Therefore, the purpose of this 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].

Clearly, rate increases that are no greater or less than a national or regional hospital industry rate of inflation are per se "reasonable" and this explains the rationale underlying the right to an automatic rate of inflation increase heretofore accorded all hospitals pursuant to the prior W.Va. Code § 16-29B-20 (j). Thus, it is a reasonable conclusion that the amendment to W.Va. Code § 16-29B-20 (j) and addition of paragraph (k), supra, reflects a concern that, due to the naturally greater costs of the larger hospitals, rate of inflation increases should be given some level of scrutiny prior to automatic approval in order to assure that such increases are indeed limited to the specified industry rate of inflation. The language of paragraph (k) - referring to "rate increase requests which may be based upon a recognized inflation index for the national or regional hospital industry" (emphasis added) - supports this interpretation.

Given this legislative background as context, any rule promulgated by HCCRA should provide for a most narrowly drawn review limited to, in effect, a certification of a given hospital's proposed rate of inflation increase. In certain key respects, however, the proposed rules significantly exceed such a limited review.

First, § 65 CSR 14-4.2 of the proposed rules set forth "eligibility standards". Specifically, this section posits, inter alia, the following requirements:

4.2. Eligibility Standards - Upon receipt of the application, license and budget, the Authority shall determine: (1) if a minimum of 365 days have elapsed since the hospital has placed into effect its last rate increase. Temporary changes in a hospital's rates made pursuant to W. Va. Code 16-29B-21(b) are excluded from this requirement; and, (2) if the hospital has provided charity care equal to or greater than the state average for the previous fiscal year. Charity care shall not include bad debt ... (Emphasis added)

... If the hospital fails to meet these standards, the hospital may not request a rate increase pursuant to this rule.

The 1989 amendment to W. Va. Code § 16-29B-20 (j) and added paragraph (k) do not, however, authorize HCCRA to impose any sort of charity care "eligibility standard". As stated in the present CON regulations, "[c]harity care poses a unique problem for the hospital industry in West Virginia." 65 CSR 5-3.4.9.1. Under the current reporting rules and regulations, charity care is defined only by "guidelines" and as a component of the larger category of "uncompensated care". 65 CSR 5-3.4.9. et seq. Thus, there does not now exist the requisite database of comparable reported information about "charity care" upon which to equitably determine a "state average" for charity care, in line with the over-arching legislative intent expressed in W. Va. Code § 16-29B-1. supra. Furthermore, inherent in HCCRA's approach to cost and rate review has been the grouping together of like hospitals variously by size, region, or type of service for purposes of equitable comparison; a "state average" is at variance with this better-reasoned approach, and cannot produce a fair result for the broad range of hospitals affected by W. Va. Code § 16-29B-20 (k).

Second, Paragraph 4.3 of the proposed rules adopts a new measure of inflation. This provision states:

4.3. Rate of Inflation - The hospital shall determine the applicable rate of inflation for the hospital industry by referring to the most recent publication of Data Resources. The hospital may request the Authority to provide it with the current Data Resources Index (DRI) prior to filing the application required by section 4.1 of this rule. The DRI shall be applicable for sixty (60) days from the date of the letter from the Authority notifying the hospital of said figure. The rate of inflation so reported shall not be adjusted for the increasing costs of technology, nonsupervisory wages, malpractice premiums, new services, or any other reason.

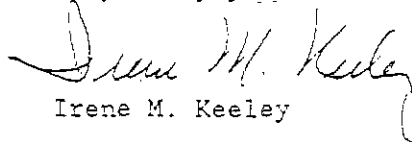
As a matter of administrative law this unexplained designation of the "DRI" as the standard for determination of the allowable rate of inflation increases is clearly an administrative agency action that "reverses course from precedents". Heretofore, the widely recognized consumer price index as reported by the United States Bureau of Labor Statistics ("CPI") has been primarily used as the "recognized inflation index for the national or regional hospital industry." At a minimum, a reasoned explanation for the departure from established policy in this regard should be established. See, e.g., Atchison, Topeka & Santa Fe Railroad Co. v. Wichita Board of Trade, 412 U.S. 800, 808 (1973) ("There is ... at least a presumption that those policies will be carried out best if the settled rule is adhered to. From this presumption flows the agency's duty to explain its departure from prior norms. (emphasis added)) In addition, the final sentence of this paragraph is another major departure from the limited scope of authority provided for by W. Va. Code §16-29B-20 (k). The admonition that "[t]he rate of inflation so reported shall not be adjusted for the increasing costs of technology, nonsupervisory wages, malpractice premiums, new services, or any other reason" is again, as in the case of the charity care

provision, not called for by the statutory language. This provision as presently stated can only have a chilling effect on the hospitals' exercise of the limited right provided by the newly-legislated expedited review.

Finally, with respect to sections 4.4, 4.5, and 4.6 of the proposed rule - dealing with "Hearings", "Review by the Board" and "Notice to the Community" - we note that section 4.5 fails to specify any timeframe in which "the board shall issue an order setting final revenue limits" including "the effective date of any increase. This is at variance with the present full review procedure, §65-CSR 3-4.4., that provides: "The final order on any proposed change or amendment shall not be issued more than one hundred eighty (180) days from the date of filing of the application and proposed budget with the board. If the board fails to complete its review of the proposed change within the time period specified for the review, the proposed changes shall be deemed to have been approved by the board."

Thank you for the opportunity to provide you with these comments.

Very truly yours,

  
Irene M. Keeley

  
J. Robert Gwynne

  
M. Ann Vroom

proved by the board

4.5 Appeals from board's final order. Should the hospital or an interested party wish to contest the board's final order, the hospital or interested party shall file its appeal pursuant to the provisions of West Virginia Code, section thirteen, article twenty-nine-b, chapter sixteen . . .

4.6 Rates during hearings and appeals. In the event the board modifies the request of a hospital for a change in its rates so that the hospital obtains only a partial increase in its rate schedule, the hospital shall have the right to accept the benefits of the partial increase in rates and charge its purchasers accordingly without in any way adversely affecting or waiving its right to contest or appeal that portion of the decision and final order of the board which denied the remainder of the requested rate increase. Similarly, if an interested party contests or appeals the decision and final order of the board, the hospital may charge its purchasers in accordance with the board's decision and final order until the final order is subsequently modified.

4.7. Notice to the community. Contemporaneously with the filing of the application and proposed budget pursuant to section 4 of this rule, the hospital shall also cause to be published in a newspaper of general circulation in the county in which the hospital is located a legal advertisement setting forth the fact that the hospital is applying to the board for a change or amendment to its schedule of rates. The legal advertisement shall summarize the effect of the requested relief and shall further state that any person desiring to inspect the application and proposed budget may do so at the hospital during the hospital's regular business hours and also at the offices of the board. Also, the legal advertisement shall advise the public that any person or entity who claims to be an interested party in the proceedings for the changing or amending of the schedule of rates must file with the Authority a written notice setting forth the interested parties' names, address and the facts relied upon to establish his or her interest. The legal advertisement must inform the public that interested parties must file this notice within thirty (30) days of the hospital's filing of its application with the Authority or else the Authority will, except for good cause shown, deny the interested party's notice. The Authority will then send notices of all proceedings and copies of all orders to those parties deemed to be interested in the matter. Proof of publication of the legal advertisement by the hospital must be submitted to the Authority within ten (10) days of the filing of its application and pro-

posed budget.

4.8. Reconsideration. In the event that a hospital or interested party wishes the board to reconsider a prior order, it shall file its request in writing and shall detail the grounds for the reconsideration. Such a request must be filed within twenty (20) days of the receipt by the hospital of the disputed order. A request for reconsideration shall toll the running of the period in which an appeal must be taken. The board shall respond to the request for reconsideration in writing and shall state its reasons for granting or denying the request.

#### §65-3-5. Automatic rate of inflation increases.

5.1 Any hospital which wishes to increase its gross inpatient revenues per discharge for nonmedicare and nonmedicaid payors in an amount equal to or less than the rate of inflation for the hospital industry nationally shall do so in accordance with this rule.

5.2 At least five (5) days prior to instituting the increase, the hospital must notify the Authority of its intention to implement the increase. The notice shall include completion of the form attached to these rules for such increases.

5.3 The hospital must inform the Authority of its inpatient utilization during the fiscal year prior to the date of the notice and the anticipated inpatient utilization for the fiscal year affected by the increase. The hospital shall also inform the Authority of the amount of gross inpatient revenue it received for the fiscal year prior to the increase and the amount of gross inpatient revenue it expects to receive during the fiscal year affected by the increase.

5.4 Within thirty (30) days after implementing the increase in its gross inpatient revenues per discharge for its nonmedicare and nonmedicaid payors, the hospital shall file an amendment to its schedule of rates and a revised budget both reflecting the effect of the increase.

5.5 The hospital shall determine the applicable rate of inflation for the hospital industry by referring to the most recent "hospital and related services" item of the Consumer Price Index for all urban consumers as reported by the United States Bureau of Labor Statistics for the hospital's immediately completed fiscal year. The hospital may request the Authority to provide it with this figure prior to filing the notice required by section 5.2. of this rule. The rate of inflation so reported shall not be adjusted for increas-

ing costs of technology, increases in nonsupervisory wages, malpractice premiums, new services, or any other reason.

5.6. Within thirty (30) days of receiving the hospital's schedule of rates and revised budget as required by section 5.4, the Authority shall issue a decision approving or disapproving the increase put into effect by the hospital. The hospital is not prohibited from implementing the rate increase during this thirty (30) day period. The HCCRA's evaluation will be limited to the rate of increase for gross inpatient revenues per discharge for nonmedicare and nonmedicaid payors and will establish that the increase is equal to or less than the rate of inflation for the hospital industry nationally. The determination shall be made upon the facts presented by the hospital and the records on file with the Authority. The decision may be treated as a final order and an appeal or reconsideration may be requested by the hospital or an interested party pursuant to sections 4.5 and 4.8 of this rule.

5.7. Notwithstanding the provisions of section 5.6 of this rule, if the board subsequently determines that the increase put into effect by the hospital actually exceeded the national rate of inflation for the hospital industry, for whatever reason, the board may institute a review and investigation of the hospital's rates and budget and take such action as it deems necessary to establish a new rate schedule and also direct a refund to the hospital's patients or a temporary decrease in the hospital's rates if any of such should prove necessary. The decision resulting from any such review and investigation may be treated as a final order and an appeal or reconsideration may be requested by the hospital or an interested party pursuant to sections 4.5 and 4.8 of this rule.

5.8. This section also applies to any hospital which seeks to increase or decrease its outpatient revenue or its nonpatient revenues from nonmedicare or nonmedicaid sources. In addition, if the hospital experiences less inpatient utilization for the twelve (12) months following the increase than it had anticipated when the automatic rate of inflation increase was obtained, the hospital's average rate per discharge shall not later be increased to make up for the decline in gross inpatient revenue without permission of the board.

5.9. For hospitals which have obtained an automatic rate of inflation increase, if the hospital actually experiences gross inpatient revenues per discharge for nonmedicare and nonmedicaid payors in excess of the amount it was allowed, then the hospital is noti-

fied that it may be subject to all of the penalties provided for by the Act including refunds and temporary rate decreases as provided for by West Virginia Code, subsection (d) of section twenty-one article twenty-nine-b, chapter sixteen, and also the criminal provisions of West Virginia Code, section twenty-seven, article twenty-nine-b, chapter sixteen. Such liability will be determined by reference to those sections and not by these rules.

5.10. Hearings. In the event that either the Authority, the hospital, or an interested party requests a hearing on the increase, the hearing shall be conducted pursuant to section 4.3 of this rule.

5.11. While the automatic rate of inflation increase will be calculated upon the actual average revenue per discharge for the hospital's past fiscal year, the board will continue to monitor the hospital's compliance with the board's prior orders. Should such monitoring reveal that the hospital exceeded its prior revenue limits, then the board will take corrective action against the hospital as a result of that excess and will also take corrective action against the rates being charged by the hospital after any automatic rate of inflation increase.

#### **§65-3-6. Temporary changes in a hospital's rates**

The legislative rules for the freeze on hospital rates and granting of temporary rate increases, West Virginia Code, article twenty-nine-b, chapter sixteen, Series II (1983), were drafted to implement Section 4 of the Act and to implement former Section 21(c) of the Act insofar as it pertained to Section 4 of the Act. Those rules do not have applicability to changes or amendments to a hospital's rate schedule.

6.1. Application for temporary rate change. In the event a hospital desires to obtain a temporary change in its schedule of rates, the hospital shall submit an application to the Authority which addresses the criteria set forth in Section 21(b) of the Act. The application must describe in detail the facts in support of the temporary rate change, the amount of increases in rates required to alleviate its situation, and shall summarize the overall effect of the rate increase. The claim shall be verified (that is, sworn to under oath) by either the chairman of the hospital's governing body or by the chief executive officer of the hospital.

6.2. Immediate effectiveness of application. Upon receipt by the board of the application for a temporary rate change, the rate change shall be effective, at the hospital's discretion, immediately and until such time

MAILING LIST FOR EMERGENCY RULE

6/27/89

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Public Employees Insurance Agency  
Building #5, Tenth Floor  
Charleston, West Virginia 25305

David K. Heydinger, M.D., Director  
West Virginia Department of Health  
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Charleston, West Virginia 25303

Emily A. Spiler, Commissioner  
Worker's Compensation Fund  
601 Morris Street  
Charleston, West Virginia 25301

Taunja Willis Miller, Commissioner  
Department of Human Services  
Building #6, Room B-617  
State Capitol Building  
Charleston, West Virginia 25305

The Honorable Larry A. Tucker  
President, West Virginia State Senate  
Drawer 310  
Summersville, West Virginia 26651

The Honorable Robert "Chuck" Chambers  
Speaker of the House  
West Virginia House of Delegates  
420 8th Street  
Huntington, West Virginia 25701

The Honorable Patricia H. White  
West Virginia House of Delegates  
Star Route, Box 9-A  
Poca, West Virginia 25159

The Honorable Robert K. Holliday  
Chairman of Senate Health & Human Resources  
West Virginia State Senate  
161 High Street  
Fayetteville, West Virginia 25840

The Honorable Earl Ray Tomblin  
Chairman of Senate Finance  
West Virginia State Senate  
Box 116  
Chapmanville, WV 25508

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Vice President  
Blue Cross-Blue Shield of West Virginia, Inc.  
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Charleston, West Virginia 25325

Mr. William Crouch  
Health Consultant  
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Nitro, West Virginia 25143

The Honorable Charles G. Brown, III  
Attorney General  
State Capitol Building #1, Room E-26  
Charleston, West Virginia 25305

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Arnett & Foster  
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Health Insurance Association of America  
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Charleston, West Virginia 25330

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Vice President of Legislative, Government & Public Affairs  
West Virginia Coal Association  
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Mr. Paul Arbogast, CPA  
Ernst & Whinney  
900 United Center  
Charleston, WV 25301

Mr. James Bowen  
Director, District #23  
United Steelworkers of America  
2084 National Road  
Wheeling, WV 26003



# WEIRTON MEDICAL CENTER

801 COLLERS WAY WEIRTON, WV 26063 606 734 1991

July 27, 1989

RECEIVED

AUG 1 1989

HEALTH CARE COST REVIEW AUTHORITY

Larry C. Fizer, Chairman  
State of West Virginia  
Health Care Cost Review Authority  
100 Dee Drive, Suite 201  
Charleston WV 25302

RE: Expedited Review for Rate Changes  
West Virginia Legislative Rule

Dear Mr. Fizer:

We have reviewed the referenced rules relating to the expedited review process for hospitals licensed for more than one hundred beds. The following are issues that Weirton Medical Center opposes regarding those rules:

1. It is our understanding that if a facility exceeds revenue limits of gross revenue, gross patient revenue, charges per discharge or gross outpatient revenue, it would be ineligible for the expedited review process. As the Authority is aware, several different factors, i.e., length of stay, acuity, etc. can affect these limits. It is our position that this additional criteria for the review process is unnecessary due to the inability of a facility to control these factors.

2. In addition, the rule states that a facility must provide charity care equal to or greater than the state average for the previous fiscal year. Weirton Medical Center is in agreement that a facility must provide an adequate amount of charity care. However, the measure of using the data which relates to the state average is unacceptable. There are two major tertiary facilities in addition to a disproportionate amount of rural facilities which distort the state average. Therefore, the measure is inadequate for a typical community facility.

Presently, hospitals have not differentiated between bad debt and charity care. In light of the impending ad valorem tax regulations, the state statistics will change significantly due to the reclassification of bad debts. Weirton Medical Center believes that this criteria should be eliminated from the rule due to the inequity of the measure.

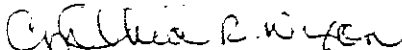
Larry Fizer  
HCCRA  
July 27, 1989  
Page Two

3. The rule states that a hospital is ineligible for an increase if a minimum of 365 days has not elapsed since its last rate increase. Weirton Medical Center is a hospital which has a fiscal year beginning in July and a rate increase which is implemented in March. For simplification purposes, the rule should state that a hospital is eligible for an expedited rate increase once during a fiscal period. If a hospital needs an additional increase, a different process could be utilized. We believe that this section should be modified to incorporate the above premise or should be eliminated entirely from the proposed rule.

In general we believe that if the hospital proposes to keep its rates within the DRI rate of inflation, then the process should be automatic and not subject to eligibility standards.

We appreciate the opportunity to comment on these rules. Should you have any questions regarding our position, please do not hesitate to contact me at 797-6140.

Sincerely,



Cynthia R. Nixon  
Assistant Director/Finance

dfk

cc: Stephen F. Brenton, President WVHA  
bcc: Ronald D. Anspaugh, St. Joseph's Hospital  
Robert J. Turner, President WMC



# Doak, Cuppett & Poling

Certified Public Accountants

RECEIVED  
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HEALTH CARE COST REVIEW  
AUTHORITY

cc: Ed. Mansone

July 31, 1989

Mr. Larry C. Fizer, Chairman  
Health Care Cost Review Authority  
100 Dee Drive Suite 201  
Charleston, West Virginia 25311

RE: ~~EMERGENCY RULE FOR EXPEDITED REVIEW~~

Dear Mr. Fizer:

Recently, I received the emergency rule regarding the expedited review process applicable to hospitals that are licensed for more than 100 beds or that are located in a standard metropolitan statistical area. In regard to the emergency rule, the following comment is being made.

During the summer and fall of 1988, a task force composed of representatives from the Authority and the healthcare industry met to consider changes to the rate review process. Various concepts and ideas were presented; however, it was decided to wait until after the 1989 legislative session before finalizing any actions.

The legislature did require certain changes as identified in the Omnibus Health Care Act and the subsequent emergency rule which has been passed. In this legislation the point is being made that the effect on the public of a rate increase for a large hospital is greater than for a smaller facility. For this reason, a different set of criteria for an expedited rate application must be adopted.

It would be my suggestion that the different set of criteria only apply to the inflation factor used for the expedited application. Under this suggestion, the existing expedited application rules applicable to small facilities would also apply to large facilities. The only difference would be the inflation factor applicable to the small versus the large hospitals. The benefit to this concept is that there is only one set of rules and there is consistency with prior experience.

The next step in the process would be to have the task force begin meeting again. In these meetings, the complete concept of the rate review process could be considered. If an alternative is adopted, it will be simpler to implement if only one primary set of regulations is in place.

I appreciate your consideration of this response to the emergency rule. Please contact me if I can provide further explanations of this response.

Respectfully,

DOAK, CUPPETT & POLING

E. Mark Doak, CPA  
Partner

BEFORE THE WEST VIRGINIA  
HEALTH CARE COST REVIEW AUTHORITY

IN RE:

TITLE 65  
WEST VIRGINIA LEGISLATIVE RULE  
HEALTH CARE COST REVIEW AUTHORITY  
EXPEDITED REVIEW FOR RATE CHANGES

TRANSCRIPT OF PROCEEDINGS had and testimony adduced before the West Virginia Health Care Cost Review Authority, taken pursuant to agreement on the 1st day of August, 1989, commencing at 10:00 a.m., at the Authority's Hearing Room, Dee Drive, Charleston, West Virginia.

BEFORE: LARRY FIZER, Chairman  
WALTER DELL, Board Member  
DON KEESLING, Board Member

*Action Court Reporting*  
*V. Ann Woolfer*  
Post Office Box 4449  
Charleston, West Virginia 25364  
304-925-5588

ORIGINAL

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STAFF:            MARIANNE STONESTREET, General Counsel  
                  MARGIE HIGH, Rate Review Analyst  
                  PATTY RAMEY, Rate Review Analyst.  
                  RALPH SULLIVAN, Direct, Rate Review Program

1 MR. FIZER: The hearing will come to order at this  
2 point in time. We'll start off very briefly with the  
3 introductions of those who are sitting here this morning for  
4 those of you who do not know all of us here at the Health Care  
5 Cost Review Authority. I'm Larry Fizer, the Chairman of the  
6 Authority. To my left is Walter Dell, Board Member, and to  
7 my right is the other Board Member, Don Keesling. To the  
8 immediate left of Mr. Dell, then, is Marianne Stonestreet,  
9 the General Counsel for the Agency. To her left is Margie  
10 High, the Rate Review Analyst. To her left, also, is Patty  
11 Ramey, a Rate Review Analyst, and to her left is Ralph  
12 Sullivan, the Director of the Rate Review Program for the  
13 Health Care Cost Review Authority.

14 This morning's hearing is for the purpose to take the  
15 comments on the Legislative Rules developed to implement the  
16 expedited review for rate changes as a result of the statutory  
17 changes, and those rules are titled as 65 Series 14.

18 I, again, would hope that everyone has had the  
19 opportunity to sign the list indicating as to whether they  
20 do wish to speak this morning or not. With that, with the  
21 list that I have here, I am going to have to make one  
22 exception to the way that they're signed up here this morning,  
23 as a result of a potential conflict of schedule, and I'd like  
24 to take Mr. Whitler as the first speaker this morning on  
25 behalf of the West Virginia Hospital Association. Mr. Whitler?

1 MR. WHITLER: Mr. Chairman, I've also brought up  
2 comments of Jeff Simmons; he faxed them to me yesterday. I'll  
3 give them to you.

4 CHAIRMAN FIZER: You may proceed, Mr. Whitler.

5 MR. WHITLER: Mr. Chairman, Members of the Board, I  
6 am Bob Whitler, Vice President/Public Policy Development, for  
7 the West Virginia Hospital Association. I appreciate the  
8 opportunity to testify today on behalf of the Hospital  
9 Association and its 63 member hospitals concerning the  
10 legislative rule establishing a new expedited review process  
11 for hospitals licensed for more than one hundred (100) beds,  
12 or that are located in a metropolitan statistical area (MSA).

13 Senate Bill 576 authorizes the Health Care Cost Review  
14 Authority to establish the new expedited rate review for  
15 larger hospitals and those hospitals located in an urban area  
16 because we believe that there was a considerable amount of  
17 confusion during the last Legislative Session. The particular  
18 provision that we're addressing today in Senate Bill 576 changes  
19 the automatic inflation factor, which was the hospital component  
20 of the consumer price index, which during the Legislative  
21 Session was about 11 percent. The perception of the  
22 Legislature was that this was much too high. We believe that  
23 their perception was based on a misunderstanding of what that  
24 automatic inflation factor actually did. It allows hospitals  
25 to increase only gross revenues by that percentage.

A.C.R.

1           Following deductions for charity care and bad debt,  
2 as well as Medicare and Medicaid shortfalls and contractual  
3 allowances, an 11 percent increase in gross revenues could  
4 and usually does result in only a four or five percent increase  
5 in net revenues. 60.2 percent of West Virginia hospitals gross  
6 patient revenues are government, and are not controlled by  
7 HCCRA and are, therefore, not affected by the HCCRA rate review  
8 process.

9           43.6 percent of our patients are Medicare, 9.2 percent  
10 are Medicaid, and 7.4 percent are charity and bad debt, or  
11 uncompensated health care.

12           The new inflation factor proposed by the Health Care  
13 Cost Review Authority in these rules, the DRI, is currently  
14 at 6.9 percent, or 40 percent below the most recently published  
15 CPI inflation factor of 11.3 percent. Again, the inflation  
16 factor as proposed by HCCRA is based on gross revenues, so  
17 that, in reality, after you deduct Medicaid, Medicare, bad  
18 debt, and charity, the increase allowed in terms of net  
19 revenues will only be about half of that. So if we're looking  
20 at a seven-point inflation factor, we're looking at probably  
21 an automatic inflation factor increase of 3.5 percent.

22           The West Virginia Hospital Association strongly  
23 recommends that in the very near future a new rate review  
24 system be developed which will include an automatic inflation  
25 factor based on net revenue as opposed to gross revenue.

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1           The Health Care Cost Review Authority proposes not  
2 only to reduce the automatic inflation factor allowed hospitals  
3 by 40 percent, which is a substantial reduction, but it also  
4 proposes to place additional screens on individual hospital  
5 access to that lowered inflation index. The West Virginia  
6 Hospital Association opposes the additional screens called  
7 for in the proposed rules in order to take advantage of the  
8 expedited review process, including the provision of charity  
9 care equal to or greater than the state average for the  
10 previous fiscal year, and the requirement that hospital not  
11 exceed any revenue limits. I'd like to discuss each of those  
12 in some detail below.

13           As you know, hospitals are presently using different  
14 methods of classifying charity care and bad debt, and in fact,  
15 they are now in the process of revising charity care policies  
16 and reporting procedures in order to comply with the State  
17 Tax Department's new ad valorem tax rules. To impose such  
18 a screen when hospitals do not have common reporting criteria  
19 would create confusion and unnecessarily complicate what should  
20 be a very simple expedited review process. If the reported  
21 level of charity care is used as a screen, as proposed in the  
22 rules, our data indicates that only nine hospitals would still  
23 be eligible for the expedited review process. This is nine  
24 out of 33 potential hospitals.

25           In addition, to utilize a charity care screen to access

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1 an inadequate automatic inflation adjustment factor is hardly  
2 a reward for providing charity care. Instead, perhaps, a  
3 hospital should be allowed an extra increase above the index  
4 as an incentive to provide such care.

5 Next, the authority proposes to review revenue limits  
6 in the following categories: gross revenue, gross patient  
7 revenue, gross inpatient revenue, charges per discharge, and  
8 gross outpatient revenue. Except for gross outpatient revenue,  
9 if any hospital has exceeded these limits, it would be ineligible  
10 for the expedited review process. Because of the nature of  
11 the revenue caps, many hospitals, even those hospitals that  
12 have net operating losses, exceed at least one of the caps.  
13 Therefore, this screen will effectively eliminate from the  
14 expedited review process those hospitals that may pass the  
15 charity care screen. A review of the data by the Hospital  
16 Association indicates that, again if we look at charity care,  
17 only nine hospitals would qualify out of 33. If, on top of  
18 charity care, the charity care screen, we place another screen  
19 based on gross patient revenue and gross inpatient revenue,  
20 that would knock out the remaining -- probably seven of the  
21 remaining hospitals, so that in effect only one or two of the  
22 total of 33 hospitals would be eligible for the expedited  
23 review process.

24 Essentially, then, the HCCRA has created a non-process  
25 which we would argue fails to recognize the legislative intent

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1 which was to reduce the automatic inflation factor for larger  
2 hospitals, but to also keep in place an automatic rate  
3 increase mechanism to reduce unnecessary paperwork and to  
4 recognize management efficiencies.

5 This is what we believe is the key issue in today's  
6 hearing, and we're proposing this. "Is the hospital proposing  
7 to keep rate increases due to inflation at or below the DRI?"  
8 If yes, then the rate increase should be automatic.

9 As you know, Mr. Chairman, the Connecticut Legislature  
10 recently repealed their state's DRG system and replaced it  
11 with a cost containment mechanism based on revenue caps.  
12 During a transition year that will begin October 1, 1989,  
13 hospitals will be able to avoid detailed budget review by the  
14 State's Commission on Hospitals and Health Care Providers  
15 where increases in net revenue, as opposed to gross revenue,  
16 increases in net revenue do not exceed eight percent, and  
17 with the DRI we're talking about a cap of around 6.9 percent  
18 on gross revenue. In terms of gross revenue, they would allow  
19 inflation up to 13 percent. This is an interim arrangement.  
20 In the year beginning October 1, 1990, a new threshold will  
21 be created that permits hospital net revenue to increase at  
22 the rate of inflation, as measured by the DRI, plus two  
23 percentage points. So essentially what West Virginia is  
24 doing is taking the DRI, is taking gross revenue, allowing  
25 gross revenue to increase by the DRI, whereas Connecticut,

1 which is a fairly highly regulated state, is allowing a  
2 hospital's net revenue to increase by the DRI, plus they're  
3 giving an additional two percentage points.

4 The West Virginia Hospital Association urges the Health  
5 Care Cost Review Authority to drop its reliance on the  
6 relatively meaningless gross revenue caps and move, like  
7 Connecticut, towards caps on net revenue. I know this is a  
8 position that the HCCRA Board also agrees with.

9 Finally, the West Virginia Hospital Association would  
10 like to point out that those hospitals exempted from rate review  
11 under Section 3.4.2, includes psychiatric hospitals and long-  
12 term care institutions, medical rehabilitation facilities are  
13 not included. In talking to Mr. Sullivan, and knowing the  
14 past decisions of the Board, we believe this is simply a  
15 staff oversight. We like to see medical rehabilitation  
16 facilities included as an exempt hospital.

17 That's the -- the letter I brought down from Jeff  
18 Simmons also indicates that.

19 Mr. Chairman and Members of the Board, we appreciate  
20 very much the opportunity to express our views and would like  
21 to offer our assistance to you as you move towards a more  
22 reasoned rate-setting methodology based on net revenue.

23 I would be glad to answer any questions you may have.

24 CHAIRMAN FIZER: Thank you. The format of the hearing  
25 here today is to take comments from those here.

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1 MR. WHITLER: No questions, okay. Thank you very much.

2 CHAIRMAN FIZER: Thank you very much, Mr. Whitler.  
3 Mr. Sheppard?

4 MR. SHEPPARD: For the record, I'm William L. Sheppard,  
5 CEO of Princeton Community Hospital. Mr. Chairman, Members  
6 of the Board, I do appreciate the opportunity of being able  
7 to comment on the proposed rates.

8 I think the Legislative intent, and I think Senate  
9 Bill 576, and I think a lot of us were personally involved,  
10 I think, in some of the last-minute negotiations of that bill,  
11 I think the intent was there to still provide a mechanism for  
12 expedited review in the rate-setting process. The regs as  
13 set forth, I think, basically eliminates that, at least for  
14 the hospitals in the 100 bed or larger category, for three  
15 reasons. First of all, your application must be submitted  
16 prior to your fiscal year. In my case, my fiscal year has  
17 already started July 1, and that eliminates me at least for  
18 this year in applying. My second objection, as well as the  
19 Hospital Association, is with the Date Resources Index. Not  
20 only is that index much lower than the consumer market basket  
21 for hospitals, but the index itself, particularly in the wage  
22 area, in the wage area that index was made up of ten components;  
23 only one of those components is hospital-related. As you know,  
24 hospitals are very labor-intensive. Although you might come  
25 back and say, "Well, that's a pass-through, at least for your

1 hourly people," but it's not a pass-through when you get onto  
2 the caps, and I think that's where the problem lies, and  
3 perhaps maybe a suggestion even that the present caps on gross  
4 is to pass that through on the caps, on the gross as well,  
5 at least on your labor increases for the hourly people. I  
6 think that's only half of our objections to the Date Resources  
7 Index. The other half is the equipment and the intensive side  
8 of technology. You go buy a drill, a normal hand drill at  
9 Sears and pay \$30 for it; we have to buy one that we can  
10 sterilize, and it cost us \$900, 30 times more, and it does  
11 the same function. And that's the problem when we talk about  
12 technology-intensive in our industry. So I, too, object to  
13 the Date Resources because of that.

14 The third area, I think, that exempts almost all of  
15 us, and that's the -- if you've ever exceeded the cap. Give  
16 an example in my case of why the caps I think on gross are  
17 just totally not accurate, and provides the entirely wrong  
18 incentive. Three years ago we recruited a neurosurgeon. Prior  
19 to that, our cases were being airlifted to Roanoke, out of  
20 our state. Now that service is available in Princeton. Even  
21 low backs, we were sending our back cases, laminectomies, down  
22 to Duke. That neurosurgeon is doing those now. He increased  
23 by gross that year by almost \$2,000,000, and I exceeded our  
24 cap. True, that was approved by this Board, but the caps on  
25 gross is misnomer, it's totally a misnomer. I asked this

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1 morning if you all -- a computer, what the average charges,  
2 or the minimum average, what the mean was, what the highest  
3 charges were for any services, say, a CAT scan or CBC, and  
4 that's not available, although the rates for all of our  
5 hospitals are submitted here on an annual basis.

6 You do have, from the UB82, I understand, on inpatient  
7 only, the availability of charges per procedure. What's far  
8 important for the people of this state to know, I think, is  
9 what does an appendectomy cost in my hospital versus  
10 Charleston versus Parkersburg or wherever they may go for  
11 that appendectomy. What does a laminectomy cost now in  
12 Princeton versus what you paid when they went to Due? What's  
13 more important than a cap on gross or a cap on the daily  
14 charges; they are totally inaccurate in any assumption or any  
15 analysis of my services.

16 Finally, you're charged in the initial enabling  
17 legislation of assuring the financial viability of the  
18 hospitals in this state. That's the second paragraph, I  
19 believe, if you read that legislation. Several of the  
20 hospitals closed last year, and I think there's going to be  
21 more closing before it's over. I think we need to develop  
22 a better system of analyzing the charges, and get off the gross  
23 on caps and the gross on daily charges.

24 Thank you again for the opportunity. I will leave  
25 my comments.

A.C.R.

1 CHAIRMAN FIZER: Thank you, Mr. Sheppard.

2 Mr. Ward?

3 MR. WARD: Thank you. My name is Monte Ward, and I'm  
4 Chief Financial Officer at Cabell-Huntington Hospital in  
5 Huntington, West Virginia. I have just a few brief comments.  
6 First of all, I want to thank all of you for allowing us the  
7 opportunity for comment.

8 I believe the regulations for expedited applications  
9 would serve as an incentive for hospitals to keep rate  
10 increases at a reasonable level. Therefore, the criteria for  
11 an expedited application should be based solely on the  
12 proposed increase in a hospital's scheduled charges. If the  
13 proposed increase is within the DRI plus a percent for  
14 technology, or the published DR rate plus a percent for  
15 technology, then the increase in the charge schedule should  
16 be automatically approved.

17 We believe that other issues, such as utilization  
18 review, should be monitored in other mechanisms. Utilization  
19 review should be reviewed by review organizations, and not  
20 through the rate-setting process.

21 Additionally, even though Cabell-Huntington Hospital  
22 has and very likely will continue to provide well beyond the  
23 amount of charity care needed to meet the proposed criteria,  
24 we still believe that that should be handled as a separate  
25 issue. We believe that care for the indigent is a very

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1 important issue, and should be addressed completely separately.

2 Just to repeat, we believe that these regulations  
3 should serve as an incentive for hospitals to keep rate  
4 increases at a reasonable level. And if a proposed increase  
5 is within a reasonable level, it should be approved without  
6 being subject to other criteria.

7 Thank you.

8 CHAIRMAN FIZER: Thank you, Mr. Ward.

9 Ron?

10 MR. ANSPAUGH: Mr. Chairman, Members of the Board and  
11 Members of the Staff, this morning I speak on behalf of the  
12 West Virginia Chapter of the Health Care Financial Management  
13 Association. I'm employed at St. Joseph's Hospital in  
14 Parkersburg. The West Virginia Chapter of HFMA is an  
15 organization, there's about 26,000 members nationally that  
16 we are members; members are CFO's, and consultants, members  
17 of various third-party payers, various types of providers,  
18 chief financial officers, and senior financial people. In  
19 the State of West Virginia we represent about 200 individuals,  
20 over 200 individuals that work at various providers and various  
21 financial employers.

22 Our comments, as you see before you, I just want to  
23 go through them quickly. We comment on the change from the  
24 Consumer Price Index to the Data Resources Index, the CPI to  
25 the DRI. The DRI inflation factor proposed by the Health Care

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1 Cost Review Authority is currently at 6.9 percent, or  
2 approximately 40 percent below the most recently published  
3 CPI rate of 11.3. The proposed DRI rate when applied to gross  
4 revenue could only yield an increase in that revenue on the  
5 average of about one-half of that amount, as we saw earlier  
6 this morning. The West Virginia Chapter of HFMA believes that  
7 the use of the DRI by itself without the addition of one or  
8 two percent for the increasing cost of technology is unduly  
9 penalizing providers of the State of West Virginia. These  
10 same facilities are the ones bringing new technology and  
11 service to the State to provide better and up-to-date care  
12 for the people of West Virginia.

13 Recent data provided by the State of West Virginia  
14 clearly shows that more than 20 percent of the PEIA patients  
15 dollars go to out-of-state providers. Obviously, some of those  
16 providers probably could have been treated in West Virginia  
17 if the service was provided in West Virginia, as we saw,  
18 again, by some of the examples earlier this morning.

19 The problem is that the surrounding states health care  
20 costs, we found through national literature, are higher, in  
21 some cases much higher, than many West Virginia providers.  
22 So those dollars are going out and not getting the same value  
23 they would get if the technology was available in our own  
24 state.

25 For similar reasons, Connecticut has recently repealed

1 their DRG system for hospitals, and will be implementing on  
2 October 1, 1990, a new system that permits hospitals net  
3 revenue to increase by the DRI plus two percentage points.  
4 They are allowing for the technology advances that we've been  
5 talking about.

6 The West Virginia Chapter of HFMA strongly urges the  
7 Health Care Cost Review Authority to add a one or two percent  
8 adjustment for technology to the DRI inflation factor.

9 Secondly, eligibility standards, the proposed screens  
10 to eliminate the use of expedited review, our comments are  
11 as follows: The West Virginia Chapter of HFMA believes that  
12 the intent of the 1989 Legislature was to modify the prior  
13 expedited review process only to the point of reducing the  
14 eligibility standard to what was in their mind a more  
15 reasonable level, i.e., seven percent versus eleven percent;  
16 a process that provides cost containment rules for health  
17 care providers, while not overly increasing the level of review  
18 and burdening the bureaucratic process in a time of limited  
19 State funds and limited State manpower.

20 Developing stringent eligibility standards in addition  
21 to reducing the inflation factor will serve only to increase  
22 health care costs by forcing providers to complete the  
23 expensive and time-consuming rate request application, when,  
24 in fact, that provider may be doing an excellent job and  
25 otherwise maintaining health care costs.

1           In addition, reliance upon a charity care screen to  
2 qualify hospitals for the expedited review process may appear  
3 to favor some providers as a result of exceeding a State  
4 average, when, in fact, the provider may be providing a  
5 substantial amount of charitable health care service to its  
6 community, yet remaining below the State average. The reasons  
7 for such could range from the economic condition to that  
8 particular community to the method a provider chooses to record  
9 charitable service. Accurate charity care guidelines can  
10 not be developed until such time that all providers and State  
11 agencies develop a universal method of classifying charity  
12 care, uncompensated care, and bad debt, a process that's  
13 currently underway with the State Tax Department, the West  
14 Virginia Hospital Association, the West Virginia Chapter of  
15 HFMA, and hopefully including the HCCRA Staff.

16           An imposed screen on revenue limits could arbitrarily  
17 disqualify a hospital provider from expedited review even if  
18 the hospital could reasonably justify the increase or even  
19 if they were operating at a net loss. Because of the nature  
20 and variety of the revenue caps, as well as circumstances,  
21 such as an increase in patient acuity, a change in a physician  
22 referral or admission pattern, new high-cost products, or even  
23 the addition of a new physician, such as a specialist to a  
24 community's hospital staff, a hospital can exceed a cap for  
25 a very just circumstance.

1           Finally, the HCCRA proposed screen that a minimum of  
2 365 days must have elapsed prior to the hospital placing into  
3 effect its last approved rate increase, our hospitals could  
4 be unduly penalized for delays in the bureaucratic process.  
5 Particularly, a full review will become reality as a result  
6 of the proposed rules. A hospital submitting a completed rate  
7 request two or three months prior to its fiscal year may not  
8 receive final approval until three or four months into its  
9 fiscal year; I think that would be very realistic.  
10 Consideration should be given to permit expedited review  
11 requests based on a provider's fiscal year.

12           In summary, recent data prepared by the West Virginia  
13 Hospital Association clearly indicates that only one or two  
14 hospitals would qualify for the expedited review process as  
15 a result of the proposed rules, and the change from the CPI to  
16 the DRI for hospital providers larger than 100 beds or those  
17 located within a metropolitan statistical area.

18           The West Virginia Chapter of HFMA believes that the  
19 expedited review process allows those providers maintaining  
20 health care costs at a reasonable level now established at  
21 the lower DRI level to continue to provide low cost health  
22 care to the community while not burdening them with costly  
23 and time-consuming reporting and paper processing. In  
24 addition, it provides HCCRA with the mechanism to concentrate  
25 on those providers appearing to require the agency's attention

1 at a reasonable staff level and cost to the State, and  
2 in particular to the taxpayer at a time when resources are  
3 limited. Therefore, the West Virginia Chapter of HFMA  
4 strongly urges compliance with the expedited review process  
5 as intended by the Legislature, and elimination of the  
6 proposed screens.

7 Also, a suggestion was made to consider a new rate  
8 review methodology that is based on that revenue and provides  
9 a technology increase of at least two percentage points. As  
10 stated earlier, the latter would allow West Virginians the  
11 access to health care technology now being provided in other  
12 states at a higher cost to West Virginia.

13 The West Virginia Chapter of HFMA in conjunction with  
14 the West Virginia Hospital Association is available to assist  
15 the HCCRA Staff wherever possible in implementing a workable  
16 health care methodology and review process.

17 Thank you very much.

18 CHAIRMAN FIZER: Thank you. Mr. Backus?

19 MR. BACKUS: James L. Backus, CFO for St. Joseph's  
20 Hospital in Parkersburg, West Virginia. I want to thank you  
21 for the opportunity to bring our comments to the Board today.

22 The screens that you have established effectively  
23 eliminate the expedited review process for the State's larger  
24 hospitals for those in the statistical areas. The first  
25 screen requires that 365 have elapsed since the hospital has

1 placed into effect its last rate increase. While the  
2 regulations state that HCCRA has 45 days to issue an order  
3 after receipt of a hospital's application, there are loopholes  
4 that would allow HCCRA to go beyond this timeframe. In  
5 addition to that, the hospitals are also excluded from  
6 expedited review if they exceed their limits for any of the  
7 following: gross revenue, gross patient revenue, gross  
8 inpatient revenue, and charges per discharge.

9 I would like to cite an example of a problem that we  
10 have that ties into these two areas. For the 1988 rate  
11 review, we had exceeded our caps, and we made an application  
12 in late November; we have a calendar year as our fiscal year.  
13 We did not receive approval of our rate until the middle of  
14 March, due to the overage on the caps. One of the major  
15 points of contention was the fact that we had an intensity  
16 increase, and we showed that our case mix index increased.  
17 However, it was felt by the Board that it would not be possible  
18 for our case mix index to increase while our length of stay  
19 decreased, and that seemed to be the major point of contention.

20 I can show you how that can happen very easily. We  
21 happen to be one of a few number of hospitals in the State  
22 who have a distinct mental health unit in the hospital.  
23 Mental health patients have a long length of stay but a  
24 relatively low DRT acuity. Our decrease in activity at that  
25 point in time was in the mental health area. Consequently,

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1 what happened was we reduced our numbers of patients who had  
2 low acuity but long length of stay. So the overall effect on  
3 this was then to reduce our length of stay and increase our  
4 acuity because of the heavier weight of the medical and  
5 surgical patients in that.

6 Consequently, by not receiving our rate until in March,  
7 we effectively reduced the rate by about 25 percent for that  
8 year because the first quarter we were unable to implement  
9 it.

10 The second screen requires that each hospital has  
11 provided charity care equal to or greater than the State  
12 average. Again, this screen would effectively eliminate  
13 hospitals from the expedited review process. The problem with  
14 using an average is that one or two hospitals with a large  
15 charity provision could skew the average up, making it  
16 difficult for the majority of the hospitals to reach. The  
17 provision of charity care should not be used as a way to  
18 screen out hospitals. Hospitals with a higher than average  
19 provision of charity care should be allowed to use a higher  
20 rate of inflation than those hospitals that are at or below  
21 the average.

22 The inclusion of each screen would effectively  
23 eliminate the expedited review process, which we feel was not  
24 the intent of the Legislature. We feel the intent was to  
25 still allow for an expedited review process, but with a

1 lower inflation rate index. This is accomplished by using  
2 the data resource index, rather than the medical consumer  
3 price index.

4 CHAIRMAN FIZER: Thank you, Mr. Backus.

5 Mr. Iseman?

6 MR. ISEMAN: I'm William Iseman, Vice President of  
7 Finance at Thomas Memorial Hospital, and I, too, would like  
8 to thank the Board for giving me this opportunity to testify  
9 today on the expedited review process for rate changes in  
10 the State.

11 First of all, I'd like to say that Thomas Memorial  
12 Hospital does agree with some of the comments that have been  
13 made by both the West Virginia Hospital Association and the  
14 West Virginia Health Care Financial Management Association.  
15 I'd like to make a few brief comments, however, about the  
16 regulations.

17 The Health Care Cost Review Authority proposes to  
18 reduce the automatic inflation factor roughly 40 percent by  
19 switching from the CPI inflation factor to the DRI inflation  
20 factor. The Authority should evaluate a new rate review  
21 system which considers a hospital's true financial needs and  
22 awards hospitals a fair rate of return to finance future  
23 capital expenditures and increases the working capital. This  
24 is very necessary for hospitals if they are going to be  
25 financially viable in the future.

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1           The second point I'd like to make is that charity for  
2 most hospitals is very difficult to manage. Hospitals without  
3 emergency rooms tend to have less charity care, only because  
4 they see less indigent patients. The provision in the rules  
5 to allow only those hospitals which provide charity care  
6 above the average for the State an access to expedited review  
7 essentially penalizes many efficient and well-meaning  
8 hospitals in the State.

9           If the Authority wishes to include charity care as  
10 an indicator for qualification in the expedited review process,  
11 then I suggest to the Authority to use charity as a percentage  
12 of gross patient service revenue as the indicator. At least  
13 the way the regulations are written at this point, it seems  
14 that you're using total dollars instead of a percentage of  
15 gross patient revenue. The percentage would then be compared,  
16 possibly, to the average percentage of charity care provided  
17 by hospitals in the State.

18           My last comment, hospitals in a competitive situation  
19 in the State might well be penalized for providing services  
20 to an increasing number of patients, when a hospital is  
21 determined to be ineligible because it exceeded its gross  
22 revenue, gross inpatient revenue, and gross patient service  
23 revenue limits. The only indicator that possibly should be  
24 used is the inpatient revenue for discharge indicator. Many  
25 hospitals in the State are in competitive situations much like

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1 we have here in Charleston, where you have Charleston Area  
2 Medical Center, St. Francis, and Thomas Memorial Hospital  
3 competing for patients. And in any particular fiscal year,  
4 we at Thomas Memorial Hospital might be able to increase our  
5 overall number of admissions beyond that budgeted for the  
6 fiscal year. And if we use the limits that are identified  
7 in the regulations, then that hospital, Thomas Memorial in  
8 this case, would be penalized and not have access to the  
9 expedited review process.

10 Again, I'd like to thank the Board for giving me this  
11 opportunity, and I appreciate it.

12 CHAIRMAN FIZER: Thank you, Mr. Iseman.

13 Mr. Iseman is the last one on the list that is  
14 indicated he wishes to speak this morning, but I would inquire  
15 again if there is additional persons that wish to speak at  
16 this time on the rules.

17 MR. WRIGHT: Yes.

18 CHAIRMAN FIZER: Mr. Wright?

19 MR. WRIGHT: I'm Gayle Wright, and I'm the Vice  
20 President of Finance at Camden-Clark Hospital. There are  
21 three areas that I would like to comment on this morning.  
22 One is the technicality in the fact that Section 4.1 requires  
23 the rate application be submitted at least 45 days prior to  
24 the beginning of the fiscal year. Section 4.2 disqualifies  
25 an applicant from expedited review unless a minimum of 365

1 days has elapsed since the hospital has placed into effect  
2 its last rate increase. Technically speaking, when you're  
3 looking at the application 45 days before the effective date,  
4 if the hospital has placed a rate increase in its current  
5 fiscal year, then it will be less than the 365-day requirement.

6 In addition to that, the 365-day rule effectively  
7 prohibits a hospital from implementing a rate increase on the  
8 first day of its fiscal year, unless the hospital has been  
9 able to place into effect on the first day of its fiscal year  
10 its rate increase every year, and can continue to do so.  
11 Very few hospitals, I feel, have been able to place their  
12 rates into effect on the first day of the fiscal year if  
13 for some reason, during the review process, additional  
14 information is requested. I would recommend that a more  
15 appropriate screen would be that the effective date of any  
16 proposed increase must be the first day of the hospital's  
17 fiscal year; and that any prior year's increase not effective  
18 on the first day of a fiscal year must not have been annualized  
19 for the delay in implementation.

20 My additional comment on the 45 days for the approval,  
21 45 days, in Section 4.5, the Board has set to approve an  
22 expedited rate increase shall not begin until the Authority  
23 receives from the hospital all the information pursuant to  
24 this rule for a complete application. This means that if a  
25 hospital properly completes all the R forms, attaches a copy

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1 of its license, includes a copy of its budget approved by the  
2 Board, and includes other specified documents, if the HCCRA  
3 Board requested additional information, which it's authorized  
4 to do, and sometimes is necessary to do, the 45 days does not  
5 start until the additional information is received. This  
6 removes any assurance that a hospital submitting its budget  
7 45 days or 60 days before the start of its fiscal year would  
8 be able to implement its new rates at the start of its fiscal  
9 year.

10 My third area would be gross revenues used as a screen.  
11 Gross revenues, as defined by the regulations, includes not  
12 only patient revenue, but contributions restricted and  
13 unrestricted. If a hospital received a large contribution  
14 for, say, a major building project or something of that order,  
15 it would eliminate that hospital from an expedited review  
16 because it clearly exceeds its gross revenue caps. I feel  
17 the use of net patient revenue would be a more appropriate  
18 screen to use. This would also allow hospitals whose  
19 economic conditions in the community had a downturn and  
20 charity care went up, the hospital could adjust for the  
21 increase in the charity care. Conversely, if the economy in  
22 the community did increase, and the bad debts and the charity  
23 care became less, it would remove the economic benefits, and  
24 the hospital would receive reduced bad debts.

25 Thank you.

A.C.R.

1           CHAIRMAN FIZER: Thank you.

2           Is there others that wish to speak this morning?

3                               (No response)

4           CHAIRMAN FIZER: There being no others, I would just  
5 note for the record this morning that we have received some  
6 additional written comments from the various entities of  
7 Blue Cross and Blue Shield of West Virginia, the United  
8 Steel Workers District 23 of West Virginia. We have also  
9 received comments from the Worker's Compensation Fund, and  
10 also from the firm of Steptoe & Johnson; they were submitted  
11 on behalf of the firm of Steptoe & Johnson. Those are all  
12 that I'm aware that I have.

13           Again, that will bring to a close the comment period  
14 on the regulations, and I thank all of you very, very much  
15 for your comments this morning.

16                               (WHEREUPON, the hearing was  
17 closed.)

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August 14, 1989

Legislative Rule-Making Review Committee  
State Capitol Building  
Charleston, West Virginia 25305

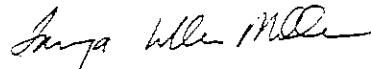
The Honorable Ken Hechler  
Secretary of State  
State Capitol Building  
Charleston, West Virginia 25305

Gentlemen:

Re: Proposed Legislative Rule:  
Expedited Review For Rate Changes

I have reviewed the proposed legislative rule for expedited review for rate changes drafted and approved by the Health Care Cost Review Authority. The Omnibus Health Care Act enacted by the Legislature and in effect from passage (April 8, 1989) requires the development of this expedited review process and also the adoption of regulations implementing said process. Consequently, I hereby approved the filing of this rule with the Legislative Rule-Making Review Committee and the Office of the Secretary of State.

Sincerely,



TAUNJA WILLIS MILLER  
Secretary  
Department of Health and  
Human Resources

TWM/MKS/jmh