WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION

Form #2

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2002 JUN 26 P 3:07

OFFICE WEST VIRGINIA SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Health Care Authority TITLE NUMBER: 65

RULE TYPE: Legislative CITE AUTHORITY: W.Va. Code § 16-29B-8(a)(1), 19, 19a and 20.

AMENDMENT TO AN EXISTING RULE: YES X NO ___

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 26

TITLE OF RULE BEING AMENDED: Benchmarking and Disoount Contract Rule

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ___

TITLE OF RULE BEING PROPOSED: ___

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON July 26 AT 4:30 p.m. ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

Marianne Kapinos
100 Dee Drive
Charleston WV 25311

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Sonia K Chandler
Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

SCANNED

6.90

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: June 26, 2002

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: *(Agency Name, Address & Phone No.)* Health Care Authority

100 Dee Drive

Charleston, WV 25311 304-558-7000

LEGISLATIVE RULE TITLE: Benchmarking and Discount Contract Rule

1. Authorizing statute(s) citation W.Va. Code § 16-29B-8(a)(1), 19, 19a, 20

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

June 26, 2002

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

Newsletter, Webpage, Board Meeting

c. Date of Public Hearing(s) ***or*** Public Comment Period ended:

July 26, 2002

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

Attached n/a No comments received n/a

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

n/a

f. **Name, title, address and <u>phone/fax/e-mail numbers</u>** of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)

Marianne Kapinos, General Counsel

100 Dee Drive, Charleston, WV 25311

304-558-7000, fax 304-558-7001

mkapinos@hcawv.org

g. <u>IF DIFFERENT</u> **FROM ITEM 'f'**, please give **Name, title, address and phone number(s)** of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

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 or comment period:

n/a

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

n/a

d. Attach findings and determinations and reasons:

Attached n/a

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Benchmarking and Discount Contract Rule

Type of Rule: X Legislative ____ Interpretive ____ Procedural

Agency: Health Care Authority

Address: 100 Dee Drive

Charleston, WV 25311

1. Effect of Proposed rule:

	ANNUAL		FISCAL YEAR		
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
ESTIMATED TOTAL COST	0	0	0	0	0
PERSONAL SERVICES	0	0	0	0	0
CURRENT EXPENSE	0	0	0	0	0
REPAIRS & ALTERATIONS	0	0	0	0	0
EQUIPMENT	0	0	0	0	0
OTHER	0	0	0	0	0

2. Explanation of Above Estimates:

The proposed rule is an amendment to an existing rule and will have no additional fiscal impact on the agency.

3. Objectives of These Rules:

To streamline the rate review process.

Rule Title: Benchmarking and Discount Contract Rule

4. Explanation of Overall Economic Impact of Proposed Rule:

A. Economic Impact on State Government:

none

B. Economic Impact on Political Subdivisions; Specific Industries; Specific Groups of Citizens:

By streamlining the rate review process, the rule should reduce hospital costs.

C. Economic Impact on Citizens/Public at Large.

Minimal

Date: June 26, 2002

Signature of Agency Head or Authorized Representative:

TITLE 65
LEGISLATIVE RULE
HEALTH CARE AUTHORITY
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 26
BENCHMARKING AND DISCOUNT CONTRACT RULE

§65-26-1. General.

1.1. Scope. -- This rule establishes an alternative rate setting system and ~~a new~~ discount contract review for acute care hospitals in West Virginia.

1.2. Authority. -- W. Va. Code §§16-29B-8(a)(1), 19, 19a and 20.

1.3. Filing Date. -- ~~April 2, 1999~~.

1.4. Effective Date. -- ~~April 15, 1999~~.

§65-26-2. Introduction.

This legislative rule ~~implements certain provisions of Enrolled Committee Substitute for Senate Bill 458 which was passed by the Legislature on April 12, 1997, effective ninety days from passage. This bill amended W. Va. Code §§16-29B-19, 19a and 20 which direct the Health Care Authority to develop an alternative rate setting system and to develop rules for the approval of discount contracts.~~ amends the original benchmarking and discount contract rule which became effective April 15, 1999.

§65-26-3. Definitions.

3.1. Act - The West Virginia Health Care Authority Act, W. Va. Code §16-29B-1 et seq.

3.2. Affected party - Any interested party which is recognized by the Authority as an affected party.

3.3. Authority - Health Care Authority.

3.4. DRG - Diagnosis related group which is a relative measure of resources used to treat inpatients.

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

3.6. PEIA IME factor - Indirect medical education factor as developed for the Public Employees' Insurance Agency (PEIA) and Medicaid.

3.7. UB-92 - Uniform billing form for hospital services.

§65-26-4. Overview.

4.1. This rule establishes a benchmarking process for setting average nongovernmental rates for acute care hospitals in West Virginia. Benchmarking simplifies the rate setting process and makes it less burdensome for hospitals ~~which the Authority identifies as having control over their costs and charges.~~to file rate applications. All ~~H~~hospitals ~~with high costs and charges and those which do not qualify for the benchmarking process are required to undergo a detailed review pursuant to 65 CSR 5, "Hospital Cost Based Rate Review System." Hospitals with low costs and charges may~~ receive an automatic adjustment to their rates under the benchmarking system. Hospitals with lower costs and charges receive a higher rate of increase.

4.2. This rule also establishes the criteria and review process for the approval of discount

contracts for the payment of patient care services between a purchaser or third-party payer and a hospital.

§65-26-5. Calculation of Benchmarks.

5.1. The Health Care Authority shall calculate the benchmarks on an annual basis and inform all acute hospitals ~~if~~ they are eligible for the benchmark review. ~~The initial calculations shall utilize the uniform billing data for the year beginning October 1, 1996 and ending September 30, 1997.~~ The Authority shall update the calculations annually ~~with new UB-92 data for each subsequent year ending September 30th~~.

5.2. Hospitals which have not submitted accurate or complete information, including uniform billing and financial disclosure data, are not eligible for the benchmarking rate review process. However, if the failure to submit complete and accurate data is determined by the Authority to be due to problems associated with the Authority's data contractor, then data from an earlier period, appropriately price leveled, may be used for the hospital's benchmark. The calculation of the benchmarks shall utilize all discharges for all payors.

§65-26-6. Peer Groups and the Variables of the Benchmarking Process.

6.1. Peer Groups.

~~6.1.a.~~ The Authority shall divide the hospitals into two peer groups ~~initially~~: (1) over one hundred (100) beds and (2) one hundred (100) beds and under. ~~The Authority shall exclude critical access hospitals from the benchmarking process until there are at least ten (10) in this state. Once there are ten (10) or more critical access hospitals, the Authority shall create a third peer group of critical access hospitals.~~

~~6.1.b. Hospitals in the 20th percentile of each peer group above either the median inpatient charge per discharge or the median cost per discharge are not eligible for benchmarking and shall undergo standard rate review pursuant to 65 CSR §5-1 et seq., "Hospital Cost Based Rate Review System."~~

6.2. Variables. The two variables employed in analyzing the peer groups in the benchmarking process are the adjusted average inpatient cost per discharge and the adjusted average inpatient charge per discharge.

6.2.a. Inpatient charges. The average inpatient charge per discharge is ~~the most~~an important variable~~,~~ since the charges are the basis on which most of the private payers are paying for hospital services. These are adjusted for the following factors:

6.2.a.1. Non-comparable costs - Direct medical education, CRNA's (certified registered nurse anesthetists) and physician costs which are included in rates;

6.2.a.2. The labor market - The Medicare hospital labor market index shall be applied to the labor related portion of costs;

6.2.a.3. The case mix - DRG and major payer;

6.2.a.4. Indirect medical education - the PEIA IME factor is utilized; and

6.2.a.5. Compliance adjustments in the rates.

6.2.a.6. Outliers.

6.2.b. Inpatient costs. The other variable is average inpatient costs. The inpatient average cost per discharge is calculated by applying a ratio of costs to charges to the charge for the case. Adjustments shall be made for:

6.2.b.1. Non-comparable costs - Direct medical education, CRNA's (certified registered nurse anesthetists) and physician costs which are included in rates;

6.2.b.2. The labor market - The Medicare hospital labor market index shall be applied to the labor related portion of costs;

6.2.b.3. The case mix - DRG and major payer; and

6.2.b.4. Indirect medical education - the PEIA IME factor is utilized.

~~6.2.c. Outliers. Outliers are not included in the calculation of the average charge per discharge or the average cost per discharge.~~

§65-26-7. Allowed Adjustments.

7.1. Adjustments in a~~n eligible~~ hospital's average nongovernmental inpatient charge per discharge shall be determined based upon the hospital's ranking in its peer group ~~for the primary variable: inpatient charge per discharge~~. The hospital shall be ranked within its peer group based upon two variables: (1) inpatient charge per discharge and (2) inpatient cost per discharge. The Authority shall calculate the adjustments using the hospital's prior year's ~~approved~~projected actual nongovernmental charge per discharge.

7.2. The standard allowed increase in the average nongovernmental inpatient charge per discharge for hospitals ~~near the benchmark median is the DRI forecast hospital price index increase (DRI) adjusted by the estimate of hospital productivity improvement produced by the Medicare Payment Advisory Commission (MedPAC.). The productivity estimate shall be updated annually by the Authority when published by MedPAC. The DRI is regularly updated by the Authority according to hospital fiscal year ending dates.~~

~~7.3. If a hospital is particularly efficient, it may not have as much ability to respond with productivity improvements as a hospital which is relatively inefficient. This has been taken into consideration in establishing the sliding scale of increases~~shall range from 2% to a maximum of 7%. The scale for rate increases is contained in Table 65-26A of this rule.

§65-26-8. Outpatient Services.

Outpatient services cannot be included in the benchmarking analysis because of the lack of data to measure the hospitals' relative performance in providing outpatient services. However it is necessary to provide some automatic rate adjustment to the outpatient rates of hospitals which ~~are eligible for and~~ elect to participate in the benchmarking process. ~~This adjustment is different from that provided for average nongovernmental inpatient charge per discharge because inpatient utilization is decreasing, largely due to declines in length of stay, but these productivity improvements are less available for outpatient services.~~ Therefore, ~~these~~ hospitals may increase their average nongovernmental outpatient charge per visit by the ~~DRI index~~the same rate of increase granted for the nongovernmental charge per discharge. This adjustment shall be calculated using the hospital's prior year's ~~approved~~projected actual nongovernmental outpatient charge per visit.

§65-26-9. Compliance.

9.1. Compliance adjustments in the benchmarking process.

9.1.a. If a hospital overcharges relative to its approved nongovernmental rates in a prior year and the amount of the overcharge was removed from the rates for the benchmarking period, the approved rates of the hospital are lower than they would have been if the hospital had not previously overcharged. Thus, the hospital should not be allowed to benefit as a result of its previous overcharging. Therefore the impact of the compliance adjustments shall be eliminated from the charges used in the benchmarking process. For example, if a hospital overcharged by $100,000 in year 1, that amount is removed from rates as a compliance adjustment in year 2 and year 2 is the year used to calculate the benchmark. If no adjustment is made, then the hospital will appear lower on the benchmark because of the overcharge in year 1. Therefore the charges in year 2 shall be increased to add back the effect of the $100,000 compliance adjustment.

9.2. Overcharging relative to approved

rates.

~~9.2.a. If a hospital's average charge per discharge for nongovernmental inpatient or average charge per nongovernmental outpatient visit exceeds the average allowed amount, it is subject to reductions in its requested rates for unjustified overages.~~

~~9.2.b. If a hospital overcharges by an amount less than or equal to 2% of either its nongovernmental hospital gross acute inpatient or outpatient revenue, it shall repay the overcharge in a subsequent year. The amount of the overcharge shall be removed from its approved rates for that subsequent year.~~

~~9.2.c. If the hospital overcharges by an amount more than 2% of either its nongovernmental hospital gross acute inpatient or outpatient revenue, interest on the unjustified overcharge shall also be applied in addition to recovering the overcharge. An example of this calculation is contained in Table 65-26B of this rule.~~

9.3. Justification for overcharging.

9.3.a. Inpatient - A hospital's average charge per nongovernmental inpatient discharge is based on its costs of providing the services to its patients. This cost is based on the resources used to provide the services as measured by its own case mix index. This index is determined by calculating the total amount of diagnosis related groups (DRG's) weights and dividing them by the total discharges to derive the weighted average value (the case mix).

9.3.a.1. Justification for an overage in the approved nongovernmental inpatient charges can be determined by the percentage increase of the case mix index from one year to the next applied to the hospital's previous years' allowed rates. An example of the case mix calculation is contained in Table 65-26B~~C~~ of this rule.

9.3.a.2. Justification for an overage in the approved nongovernmental inpatient charges may also be determined by outliers. Outliers for hospitals with over 100 beds are defined as cases which have a charge, adjusted for the factors listed in subdivision 6.2.b., paragraphs (1) through (5) of this rule, exceeding $50~~44~~,000 ~~or the mean charge for the DRG plus three standard deviations, whichever is greater~~. Outliers for hospitals with 100 beds or less and the ~~critical access group~~ are defined as cases which have a charge, adjusted for the factors listed in subdivision 6.2.b., paragraphs (1) through (4) of this rule, exceeding $25~~6~~,000 ~~or the mean charge for the DRG plus three standard deviations, whichever is greater. An example of the outlier calculation is contained in Table 65-26D of this rule~~.

9.3.b. Outpatient - If the overcharge is on nongovernmental outpatient services, the hospital may justify the overcharge if it can demonstrate that there has been a change in the mix of outpatient services being provided.

9.3.b.1. A hospital submitting an application under this rule shall submit a budget estimate of high cost nongovernmental outpatient services. The estimate shall show the expected utilization and the expected revenue from each of the high cost services the hospital elects to use. When the hospital submits its application for the subsequent year, it shall show the projected actual utilization and revenue from these same high cost services. If the hospital fails to provide the budget estimates, the hospital may not use the increase in services as justification for an overage the next year.

9.3.b.2. The hospital shall also consider and budget for any anticipated loss of high volume or low cost nongovernmental outpatient services that it may no longer be providing as the loss of these services could result in a significant increase in the average per visit charge. If the hospital fails to provide the budget estimates, the hospital may not use the loss of these services as justification for an overage the next year.

~~9.4. Undercharging.~~

~~If the hospital undercharges by more than 2% of its nongovernmental hospital gross acute inpatient revenue, the undercharge, plus interest on the undercharge only, shall be added to the approved rates for a subsequent year. An example of this calculation is contained in Table 65-26E of this rule.~~

~~9.5. Miscellaneous.~~

~~9.5.a. The compliance adjustments in this section shall affect rates for only one year.~~

~~9.5.b. The interest rate to be charged shall be the prime rate reported in the Wall Street Journal effective the first day of the hospital's fiscal year in which the overcharge or undercharge occurred.~~

~~9.5.c. If a hospital receives its rates later than the beginning of its fiscal year, the allowed average charge for services to nongovernmental patients shall be marked up so the gross patient revenue is recouped over the remaining portion of the year. Table 65-26F of this rule contains an example of this calculation.~~

~~9.5.d. If a hospital receives its rates later than the beginning of its fiscal year and there is a compliance adjustment due to the requested rate, the compliance adjustment shall be marked up so the entire compliance adjustment (i.e. penalty, overage, overage plus interest) shall be repaid over the remaining portion of the year. Table 65-26G of this rule contains an example of this calculation.~~

~~9.6. Eligibility of hospitals which overcharge.~~

~~If a hospital has a substantial overcharge, it will appear higher in the peer group than it otherwise would. This should discourage hospitals from overcharging relative to approved rates. Therefore, hospitals are eligible to participate in the benchmarking process if they have overcharged.~~

9.~~7~~4. Penalties held in abeyance from prior years.

9.~~7~~4.a. Inpatient overage - These penalties shall be applied in total. In some situations the penalties held in abeyance may be so large it would do financial harm to the hospital if the entire amount was applied in one year. In those cases the Authority may continue to hold such penalties in abeyance or apply them over several years.

9.~~7~~4.b. Outpatient overage - These penalties shall be applied in total. In some situations the penalties held in abeyance may be so large it would do financial harm to the hospital if the entire amount was applied in one year. In such cases the Authority may continue to hold those penalties in abeyance or apply them over several years.

~~9.7.c. Distinct part units - These penalties are not applicable under the benchmarking system.~~

~~9.7.d. Underspent wages - These penalties are not applicable under the benchmarking system.~~

9.~~7~~4.e~~c~~. Nongovernmental contractual allowances - ~~Under the benchmarking process, the nongovernmental contractuals shall be treated as follows:~~These penalties shall be applied in total. In some situations the penalties held in abeyance may be so large it would do financial harm to the hospital if the entire amount was applied in one year. In those cases the Authority may continue to hold such penalties in abeyance or apply them over several years.

~~9.7.e.1. If the contract was implemented prior to its approval by the Authority and the penalty is a result of that implementation without approval, 20% of the penalty shall be applied. In some situations the penalty may be so large it would do financial harm to the hospital if the entire amount of the penalty was applied in one year. In those cases, the Authority may continue to hold the penalty~~

~~in abeyance or apply it over several years.~~

~~9.7.e.2. If the contract was approved by the Authority, but the discount percent is larger than budgeted or the discount amount is greater than budgeted, no penalty is applied provided the contract meets the requirements of W. Va. Code §16-29B-20. In the event the approved discount contract doesn't meet the requirements of W. Va. Code §16-29B-20, the Authority shall disallow the contract in its entirety.~~

~~9.7.f. Self insurance These penalties are not applicable under the benchmarking system.~~

§65-26-10. Procedure for Requesting a Rate Increase Under the Benchmarking System.

10.1. Time frame.

A hospital shall file its application for a benchmark increase on forms prescribed by the Authority a minimum of sixty (60) days prior to the beginning of its fiscal year. ~~This time period is waived for hospitals with a fiscal year beginning January 1, 1999.~~

10.2. Application.

The application for benchmarking shall contain, at a minimum, the following:

10.2.a. A budget approved by the hospital's board;

10.2.b. Forms provided by the Authority; ~~and,~~

10.2.c. A copy of the legal advertisement required pursuant to section 14 of this rule.~~;~~

10.2.d. The benchmarking checklist; and,

10.2.e. A copy of the hospital's current license.

§65-26-11. Review by the Authority.

Upon receipt of the hospital's application, the Authority's staff shall review and analyze the application and submit to the Authority's board proposed revenue limits for the hospital. Thereafter, the Authority shall issue an order setting the hospital's approved revenue limits no later than five (5) days prior to the beginning of the hospital's fiscal year except when a hearing is requested on the hospital's rate application pursuant to section 15 of this rule.

§65-26-12. Order.

The Authority shall send the order to the hospital by certified mail, return receipt requested.

§65-26-13. Revised Budget and Schedule of Rates.

Within twenty days of ~~receipt~~the effective date of the order, the hospital shall file with the Authority a revised budget, if applicable, and schedule of rates, each of which shall be drafted in accordance with the revenue limits set by the order of the Authority. The schedule of rates shall indicate the date of implementation of the rates. Thereafter, the Authority shall issue a notice acknowledging receipt of the hospital's budget and schedule of rates. None of the revenue limits established by the order may be implemented by the hospital prior to the beginning of the hospital's fiscal year. The Authority may rescind the order and require the hospital to repay purchasers and third party payers if the hospital implements the approved rates prior to the beginning of its fiscal year or prior to the date of the order.

§65-26-14. Notice to the Community.

Contemporaneously with the filing of an application under the benchmarking system pursuant to this rule, the hospital shall publish in a newspaper of general circulation in the county in which the hospital is located a legal advertisement setting forth the fact that the hospital is applying to the Authority for a

change or amendment to its schedule of rates. The legal advertisement shall state the requested amount of the rate increase or decrease based upon the hospital's projected actual ~~and current approved~~ revenue limits per nongovernmental discharge and per nongovernmental outpatient visit, summarize the effect of the requested relief, and further state that any person desiring to inspect the application may do so at the hospital during the hospital's regular business hours and also at the offices of the Authority. Also the legal advertisement 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 shall file with the Authority a written notice setting forth the party's name, address and the facts relied upon to establish his or her interest. The legal advertisement shall inform the public that interested parties shall file this notice within thirty (30) days of the hospital's filing of its application with the Authority or else the Authority shall, except for good cause shown, reject the interested party's notice. The Authority shall then send notices of all proceedings and copies of all orders to those parties determined by the Authority to be interested or affected parties in the matter. The hospital shall submit proof of publication of the legal advertisement to the Authority within ten (10) days of the filing of the application.

§65-26-15. Request for Hearing.

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

§65-26-16. Hearings.

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

§65-26-17. Reconsideration.

If a hospital or affected party wants the Authority to reconsider a final order, it shall file its request in writing and shall detail the reasons for the request for reconsideration. The Authority shall consider the following as reasons to grant a request for reconsideration: a) a presentation of significant, relevant information not previously considered by the Authority, and a demonstration that with reasonable diligence the information could not have been presented before the Authority issued its final order; b) a demonstration that there have been significant changes in factors or circumstances relied upon by the Authority in issuing its final order; c) a demonstration that the Authority has materially failed to follow its adopted procedures in issuing its final order; or d) such other basis as the Authority determines constitutes good cause. An affected party shall file a request for reconsideration within thirty (30) days of the receipt of the final order by the requesting party. An affected party may ask for reconsideration without a public hearing. The Authority shall respond to the request for reconsideration in writing and shall state its reasons for granting or denying the request. The Authority is not required to hold a public hearing in every reconsideration proceeding. Instead, if the Authority determines that the issues do not involve a factual dispute or otherwise do not require the taking of further evidence upon the record, the Authority may issue its reconsideration decision without conducting a public hearing. In the event the Authority grants a reconsideration request but determines that a public hearing is not required, the Authority may

enter additional evidence into the record.

§65-26-18. Appeals.

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

§65-26-19. Rates During Reconsideration Proceedings and Appeals.

The hospital, at its discretion, may elect not to implement a partial increase in its rates as approved by the Authority. If this option is elected, the hospital may not recover these unimplemented rates at a later date.

§65-26-20. Denial of an Application.

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

20.1.a. fails to pass the mathematical edit;

20.1.b. is materially inconsistent, inaccurate, or contains unreliable data;

20.1.c. is materially inconsistent with other financial data required to be filed by the hospital with the Authority pursuant to 65 CSR §13-1 et seq., "The Financial Disclosure Rule";

20.1.d. is not submitted at least sixty (60) days prior to the beginning of the hospital's fiscal year;

20.1.e. ~~——~~contains material misrepresentations made by the hospital to the Authority; ~~or~~

20.1.f. is filed prior to the final approval of the hospital's current rates; or

20.1.fg. may otherwise be denied for good cause as determined by the Authority.

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

20.2.a. is not in compliance with all financial disclosure requirements;

20.2.b. is not in compliance with th4e related organization filing requirements under financial disclosure law;

20.2.c. is not in compliance with all rate review requirements;

20.2.d. is not in compliance with all certificate of need requirements; or

20.2.e. is not in compliance with any other Authority requirements.

20.~~2~~3. If the Authority denies an application, it may, in its discretion, require the hospital to submit a new application within a specified time period.

§65-26-21. Compliance Reports and Orders.

21.1. Every hospital is required to file with the Authority a compliance report within thirty (30) days after the end of each quarter of the hospital's fiscal year. The information requested for the compliance report will be provided by the hospital on forms to be provided by the Authority. If the hospital fails to file the compliance report within thirty days after the end of each quarter, the Authority may deny a request for a rate increase.

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

§65-26-22. Reasonableness and Uniformity of Rates.

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

§65-26-23. Discount Contracts.

23.1. This section applies to all hospitals, regardless of their eligibility for benchmarking.

23.2. Pursuant to W. Va. Code §16-29B-20(a)(2), a contract which establishes a discount to a purchaser or third party payer cannot take effect until it is approved by the Authority. To obtain approval by the Authority, the hospital shall demonstrate that: (a) the discount does not constitute an amount below the cost to the hospital; (b) the cost of any discount contained in the contract will not be shifted to any other purchaser or third party payer; (c) the discount will not result in a decrease in the hospital's average number of Medicare, Medicaid or uncompensated care patients served during the previous three fiscal years; and, (d) the discount is based upon criteria which constitutes a quantifiable economic benefit to the hospital.

23.3. Time frames for filing. The hospital may file a discount contract with the Authority for approval at any time during its fiscal year.

23.4. Discount contract forms.

To obtain approval of a discount contract, the hospital shall file with the Authority a copy of the proposed contract and a discount contract form to be provided by the Authority which contains the following:

23.4.a. The name of the hospital;

23.4.b. The name of the payer;

23.4.c. A statement that the discount shall not decrease the charges for the services below the actual cost to the hospital. For purposes of reviewing discount contracts under this rule, "cost" is defined as the total operating expenses, as reported in the most recent rate filing by the hospital with the Authority;

23.4.d. A statement that the cost of any discount contained in the contract will not be shifted to any other purchaser or third-party payer. All discounts resulting from the discount contract shall be reported as contractual allowances;

23.4.e. A statement that the discount shall not result in a decrease in the hospital's proportion of Medicare, Medicaid or uncompensated care patients;

23.4.f. A statement that the discount is based upon criteria which constitute a quantifiable economic benefit to the hospital. The hospital shall justify that the contract provides an economic benefit by demonstrating at least one of the following:

23.4.f.1. The payments under the contract are above cost as defined in subdivision 23.4.c. of this section and therefore provide some contribution to overhead;

23.4.f.2. Effective management of cases will result in lower costs and the reductions in utilization will provide some benefit for other patients;

23.4.f.3. The increase in volume will result in a larger base of patients over which to spread fixed costs;

23.4.f.4. In the absence of the contract, the hospital will lose volume and will have to increase its charges to fully recover its fixed costs;

23.4.f.5. Reduced costs without cost shifting will force the hospital to become more efficient; or,

23.4.f.6. Approval of the contract will assist the hospital in avoiding bad debt and charity care;

23.4.g. Any other information required

by the Authority; and,

23.4.h. The form shall be signed by the chief executive officer of the hospital and contain a notarized statement that affirmatively states that the information contained in the form is accurate and true to the best of his or her knowledge.

23.5. Effective date.

The effective date of the approval of the contract is the date the order is signed by the board of the Authority.

23.6. Denial of contract.

In the event the Authority determines that the discount contract does not meet the criteria specified in this rule, the Authority shall issue a final order denying approval of the discount contract.

23.7. Compliance

23.7.a. At the end of each fiscal year, the Authority shall analyze whether hospitals are in compliance with the various requirements of this section, including whether they have been paid an amount equal to or above their cost as defined in subdivision 23.4.c. of this section.

23.7.b. If a discount contract was implemented prior to its approval by the Authority, the Authority shall apply 20% of the discount as a penalty. In some situations the penalty may be so large it would do financial harm to the hospital if the entire amount was applied in one year. In those cases, the Authority may hold the penalty in abeyance or apply it over several years.

23.7.c. If the contract was approved by the Authority, but the discount percent is larger than budgeted or the discount amount is greater than budgeted, no penalty is applied provided the contract meets the requirements of W.Va. Code §16-29B-20. In the event the approved discount contract doesn't meet the requirements of W.Va. Code §16-29B-20, the entire contract shall be disallowed ~~in its entirety~~.

§65-26-24. Health Care Facility Financial Disclosure Act.

The Authority shall not accept any application for a rate increase or discount contract for review, unless the hospital is in compliance with the Health Care Facility Financial Disclosure Act, W. Va. Code §16-5F-1 et seq., and the "Health Care Facility Financial Disclosure Rule", 65 CSR §13-1 et seq. The Authority shall refuse to accept the application or contract and reject it if the hospital is not in compliance with these requirements.

§65-26-25. Failure to Comply with Rules.

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

§65-26-26. Additional Information.

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

§65-26-27. Time Periods.

27.1. In each instance in this rule where a time period is stated, the period is intended to be a maximum period. In the event a given task is completed sooner than the stated period by the Authority, a hospital or an interested or affected party, then the next time period, if any, shall

commence upon the actual completion date.

27.2. Calculation of time periods.

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

§65-26-28. Decisions and Records Available.

Decisions and records of the Authority may be inspected in accordance with W. Va. Code §29B-1-3, and may be copied at a charge of twenty-five cents per page. A ~~five-dollar~~ handling charge, as determined by the Authority, will be added if the Authority is requested to make the copies.

TABLE 65-26A

RATE INCREASE SCALE FOR HOSPITALS UNDER THE BENCHMARKING SYSTEM

POSITION RELATIVE TO BENCHMARK MEDIAN	ALLOWABLE INCREASE
More than 15% below	~~DRI increase + 2~~7%
~~7.5% to~~ 15% - 9% below	~~DRI increase + 1~~6%
~~7.5~~8.99% - 0% below ~~to 7.5% above (standard)~~	~~DRI increase – productivity~~5%
~~7.5~~.01% - 8.99% above ~~to the top 20th percentile of each peer group~~	~~(DRI increase – productivity) – 1~~4%
~~Top 20th percentile of each peer group~~9% - 15% above	~~Not eligible for benchmarking~~ 3%
More than 15% above	2%

~~TABLE 65-26B~~

~~CALCULATION OF PENALTY FOR OVERCHARGING IN EXCESS OF 2%~~

~~Hospital A is allowed to charge an average of $4,300 per nongovernmental inpatient discharge and the projected actual average charge per nongovernmental discharge is $4,800, therefore the hospital has an average overage of $500 per nongovernmental discharge. Assume~~

~~the hospital could justify $100 of the overage, therefore, $400 is unjustified. Assume 1500 discharges - $400 x 1500 = $600,000 to which interest is to be applied. $600,000 plus interest of 4.4% = $626,400 as interest and penalty to be repaid. Assume a decrease in budgeted discharges to 1,436. The penalty would equal an average of $436.21 per discharge ($626,400 ÷ 1,436 = $436.21).~~

TABLE 65-26~~C~~B

CASE MIX JUSTIFICATION CALCULATION

Hospital A has an allowed average nongovernmental inpatient charge per discharge of $5,000 with a case mix index of .9527 for ~~19x-2~~2002. In the budget year's request the hospital provides the Authority with information for ~~19x-1~~2002 which is partially actual information and partially projected information (projected actual) and information for ~~19x+~~2003 which is all budgeted information (budget). [The projected actual average charge per nongovernmental discharge for ~~19x-1~~2002 is $5,350 or $350 more than the $5,000 average charge per nongovernmental discharge allowed for ~~19x-1~~2002] Hospital A reports the following for ~~19x-1~~2002: $5,350 with a case mix of .9872. This results in a case mix index increase of 3.62%. Hospital A has justified $181 of the overage leaving a penalty reduction of $169 ($350 - [5000 X 3.62% = $181] = $169) to be applied to the budget year requested average charge per nongovernmental inpatient discharge.

~~TABLE 65-26D~~

~~OUTLIER EXAMPLE~~

~~If in the peer group of 100 beds or less, DRG 1 has an average adjusted charge of $5,000 and the standard deviation in that adjusted charge is $4,000, the outlier threshold for DRG 1 is the greater of (a) $25,000 or (b) $5,000 + (3 x $4,000) = $17,000. Therefore the outlier threshold is (a) $25,000 since it is greater than $17,000.~~

~~TABLE 65-26E~~

~~UNDERCHARGING EXAMPLE~~

~~Hospital A is allowed to charge an average of $4,300 per nongovernmental inpatient discharge and the projected actual average charge per nongovernmental discharge is $3,800, therefore, the hospital has an undercharge of $500. Assume 1,500 discharges, therefore, $500 x 1,500 = $750,000 to which interest is to be applied. $750,000 plus interest of 6% = $795,000 as undercharge plus interest to be added to rates. Assume a decrease in discharges to 1,436. Therefore, the addition to the average charge per nongovernmental discharge would equal $553.62 for undercharge plus interest. Further, assume Hospital A qualified for DRI plus 2%, the new rate would be calculated as follows:~~

~~Projected actual average charge per nongovernmental discharge of $3,800 + DRI (2.4) + 2% = $3,800 + $167.20 = $3,967.20 + $553.62 for undercharge plus interest = $4,520.82 as the allowed average charge per nongovernmental discharge. This equals an 18.96% increase over projected actual average charge per nongovernmental discharge of $3,800 or 5.1% increase over the previously allowed average charge per nongovernmental discharge of $4,300.~~

TABLE 65-26F

LATE IMPLEMENTATION OF RATES EXAMPLE

Assume the hospital has average inpatient charges of $5,000 per nongovernmental discharge and $300 per nongovernmental outpatient visit with 600 nongovernmental discharges and 15,000 nongovernmental outpatient visits. It meets the benchmark requirements and is eligible for the standard adjustment of DRI minus productivity which is .5% (2.7% - 2.2%) for inpatients and DRI (2.7%) for outpatient and it has eight (8) months remaining in its fiscal year at the date the order is issued (minus the 20 days to implement the changes). The new rates on an annual basis would be $5,025 per nongovernmental inpatient discharge and $308 per nongovernmental outpatient visit. The annualized revenue would be:

Inpatient: ($5,000 x 1.005)	=	$5,025 x 600 =	$3,015,000
Outpatient: ($300 x 1.027)	=	$308 x 15,000 =	4,620,000
Total			$7,635,000

Since the hospital has been using the old rate for part of the year and will be using the new rate for a part of the year, the calculation of the rate and revenue for the remainder of the year would be:

	Days	Percent
Days in year:	365	100.00%
Days for four months and 20 days:	140	38.36%
Days remaining in year:	225	61.64%

Inpatient:

Budgeted discharges first part of year (600 x 38.36%)	=	230
Budgeted discharges last part of year (600 x 61.64%)	=	370
Total inpatient revenue allowed for year		$3,015,000
Inpatient revenue first part of year ($5,000 x 230)	=	1,150,000
Balance of revenue to be earned		$1,865,000
Discharges remaining part of year		÷370
Charge per discharge for remainder of year		$5,040.54

Outpatient:

Budgeted visits first part of year (15,000 x 38.36%)	=	5,754
Budgeted visits last part of year (15,000 x 61.64%)	=	9,246
Total outpatient revenue allowed for year		$4,620,000
Outpatient revenue first part of year ($300 x 5,754)	=	1,726,200
Balance of revenue to be earned		$2,893,800
Outpatient visits remaining part of year		÷9,246

~~Charge per outpatient visit for remainder of year~~ ~~$312.98~~

~~TABLE 65-26G~~

~~LATE IMPLEMENTATION OF RATES WITH A COMPLIANCE ADJUSTMENT EXAMPLE~~

~~Hospital A was allowed an average charge per nongovernmental discharge of $5,000. Projected actual is $5,350, resulting in an overcharge of $350. Assume the hospital provided acceptable justification for $181, leaving $169 unjustified per nongovernmental discharge or $101,400 (assuming 600 discharges). Assuming the hospital has 8 months left in its FY in which to repay the $101,400 overage. A penalty of $253.50 would be reduced from the per discharge request calculated as follows:~~

~~$169 (unjustified overage) x 600 budgeted discharges = $101,400 to be repaid. 600 discharges x .6667 = 400 discharges remaining in year to repay overage. $101,400 ÷ 400 = $253.50.~~