WEST VIRGINIA
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ADMINISTRATIVE LAW DIVISION

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Form #6

NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE RULE AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE

AGENCY West Virginia Health Care Authority NUMBER: 65

AMENDMENT TO AN EXISTING RULE: YES X NO ___

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 26

TITLE OF RULE BEING AMENDED: Benchmarking and Discount Contracts

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ___

TITLE OF RULE BEING PROPOSED: ___

THE ABOVE RULE HAS BEEN AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AUTHORIZATION IS CITED IN (house or senate bill number) HB 2625

SECTION 64-5-1, PASSED ON March 5, 2003

THIS RULE IS FILED WITH THE SECRETARY OF STATE. THIS RULE BECOMES EFFECTIVE ON THE FOLLOWING DATE: June 1, 2003

Authorized Signature

$4.40

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 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. --

1.4. Effective Date. --

§65-26-2. Definitions.

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

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

2.3. Authority - Health Care Authority.

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

2.5. Interested party – Any individual, group or organization which files a written request with the Authority on or before the prehearing conference date 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.

2.6. IME factor - Indirect medical education factor as developed by the Authority.

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

2.8. Outliers – Charges which exceed $44,000 for a hospital with more than 100 licensed beds and charges which exceed $26,000 for hospitals with 100 beds or less.

§65-26-3. Overview.

3.1. 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 to file rate applications. Hospitals receive an automatic adjustment to their rates under the benchmarking system. Hospitals with lower costs and charges receive a higher rate of increase under the benchmarking model.

3.2. 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.

§65-26-4. Calculation of Benchmark Rankings.

4.1. The Authority shall calculate the benchmark rankings on an annual basis and inform all acute hospitals of their rankings and the increase for which they are eligible using the benchmark review. The Authority shall update the calculations annually with new data for each subsequent year ending September 30th.

4.2. 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 use all discharges for all payors.

§65-26-5. Peer Groups and the Variables of the Benchmark Ranking Process.

5.1. Peer Groups. The Authority shall divide the hospitals into two peer groups: (1) over one hundred (100) licensed beds and (2) one hundred (100) licensed beds and under.

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

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

5.2.a.1. Non-comparable costs – These include direct medical education, CRNA's (certified registered nurse anesthetists) and physician costs which are included in rates;

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

5.2.a.3. The case mix – This includes DRG and major payer;

5.2.a.4. Indirect medical education - the Authority IME factor is used;

5.2.a.5. Compliance adjustments in the rates – If penalties were levied against a hospital's approved non-governmental revenue limits in the prior year and the amount of the levied penalties was removed from the revenue limits for the benchmarking period, the approved revenue limits of the hospital are lower than they would have been if the hospital had not had penalties levied. Accordingly, the hospital should not be allowed to benefit in the benchmark rankings as a result of its levied penalties. Therefore, the impact of the levied penalties shall be eliminated from the charges used in the benchmarking model. For example: If a hospital had penalties of $100,000 in year 1 and the amount is removed from its rates in year 2 and year 2 is the year used to calculate the benchmark, then the charges in year 2 shall be increased to add back the effect of the $100,000 levied penalties; and

5.2.a.6. Outliers – Outlier revenues are removed from the calculation of the average charge per discharge in the benchmark ranking process.

5.2.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 are made for:

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

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

5.2.b.3. The case mix – This includes DRG and major payer;

5.2.b.4. Indirect medical education - the Authority IME factor is used;

5.2.b.5. Compliance adjustments – If penalties were levied against a hospital's approved non-governmental revenue limits that are considered as cost, i.e. underspending of wages penalty, these costs are converted to revenue by utilizing a charge to cost factor and the impact of the levied cost penalty is added to

the revenue limits; and

5.2.b.6. Outliers – Outlier cost is excluded from the calculation of the average cost per discharge in the benchmark ranking process.

§65-26-6. Allowed Adjustments.

6.1. Adjustments in a hospital's average nongovernmental inpatient charge per discharge shall be determined based upon the hospital's ranking in its peer group . 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 projected actual nongovernmental charge per discharge.

6.2. The standard allowed increase in the average nongovernmental inpatient charge per discharge for hospitals shall range from 2% to a maximum of 7%. The scale for rate increases is contained in Table 65-26A of this rule.

§65-26-7. Outpatient Services.

Outpatient services are not included in the benchmarking analysis because of the lack of data to measure the hospitals' relative performance in providing outpatient services. When this data becomes available, outpatient services may be included in the benchmarking analysis. However it is necessary to provide some automatic rate adjustment to the outpatient rates of hospitals which elect to participate in the benchmarking process. Therefore, hospitals are eligible for the same rate of increase for both the average nongovernmental charge per discharge and the non-governmental outpatient charge per visit. . This adjustment shall be calculated using the hospital's projected actual nongovernmental outpatient charge per visit.

§65-26-8. Procedure for Requesting a Rate Increase Under the Benchmarking System.

8.1. 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.

8.2. Application - The application for benchmarking shall contain, at a minimum, the following:

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

8.2.b. Forms provided by the Authority;

8.2.c. A copy of the legal advertisement required pursuant to section 10 of this rule;

8.2.d. The benchmarking checklist; and,

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

§65-26-9. 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.

§65-26-10. 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 revenue limits per nongovernmental discharge and per nongovernmental outpatient visit 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.

§65-26-11. 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.

§65-26-12. 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. The Authority shall designate affected parties at the prehearing conference unless good cause is shown by the party for the Authority to designate affected party status at the hearing.

§65-26-13. Compliance.

13.1. Overcharging relative to approved inpatient rates. If a hospital's average charge per discharge for nongovernmental inpatient exceeds the average allowed amount, it is subject to reductions in its requested rates for unjustified overages. The hospital may justify the overcharge if it can demonstrate that there has been an increase in its Case Mix Index (CMI) or an increase in outliers.

13.1.a. Case Mix - 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). 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 65-26 of this rule.

13.1.b. Outliers – 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 exceeding $44,000. Outliers for hospitals with 100 beds or less are defined as cases which have a charge exceeding $26,000.

13.2. Overcharging relative to approved outpatient rates – If a hospital's average charge per nongovernmental outpatient visit exceeds the average allowed amount, it is subject to reductions in its requested rates for unjustified overages. The hospital may justify the overage if it can demonstrate that there has been a change in the mix of outpatient services being provided.

13.2.a. 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.

13.2.b. The hospital shall also consider and budget for an 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.

13.3. Other reductions and penalties – The Authority may also reduce a hospital's requested rates for inpatient and outpatient services if the hospital is not in compliance with budgeted amounts for other items subject to review under the standard rate review process.

13.4. Penalties/reductions held in abeyance from prior years - The Authority may use penalties and reductions held in abeyance from prior years to reduce requested rates. If the application of the penalties and reductions by the Authority will cause undue financial hardship to the hospital, the entire amount may not be applied in one year. In such cases, the Authority may continue to hold these penalties and reductions in abeyance or apply them over several years.

§65-26-14. Denial of an Application.

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

14.1.a. fails to pass the mathematical edit;

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

14.1.c. is materially inconsistent with other financial data required to be filed by the hospital with the Authority pursuant to the Authority's legislative rule, "The Financial Disclosure Rule," 65 CSR §13;

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

14.1.e. contains material misrepresentations made by the hospital to the Authority;

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

14.1.g. The Authority may also deny an application for good cause as determined by the Authority.

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

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

14.2.b. is not in compliance with the related organization filing requirements;

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

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

14.2.e. has not paid the assessment required by W.Va. § 16-29B-8.

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

§65-26-15. Order.

16.1. Time Frame – 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 pursuant to Section 12 of this rule.

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

§65-26-16. Revised Budget and Schedule of Rates.

Within twenty days of 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 effective date of the order.

§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 by the Authority and the state agency designated by the governor 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. Compliance Reports and Orders.

20.1. Every hospital shall 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 shall 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.

20.2. 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.

§65-26-21. Reasonableness and Uniformity of Rates.

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

§65-26-22. Discount Contracts.

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

22.2. 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.

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

22.4. 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:

22.4.a. The name of the hospital;

22.4.b. The name of the payer;

22.4.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;

22.4.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;

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

22.4.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:

22.4.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;

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

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

22.4.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;

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

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

22.4.g. Any other information required by the Authority; and,

22.4.h. The chief executive officer of the hospital shall sign a form that contains 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.

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

22.6. 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.

22.7. Compliance.

22.7.a. During the review of the rate application, and throughout the 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.

22.7.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.

22.7.c. If the Authority previously approved the contract, 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.

§65-26-23. 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 Authority's legislative rule, "Health Care Facility Financial Disclosure Rule", 65 CSR §13-1. The Authority shall refuse to accept the application or contract and reject it if the hospital is not in compliance with these requirements.

§65-26-24. 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.

§65-26-25. 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.

§65-26-26. Time Periods.

26.1. 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.

26.2. 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.

§65-26-27. 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 not to exceed fifty cents per page. A handling charge, not to exceed ten dollars, 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 15.00% below	7.00%
15.00% - 9.00% below	6.00%
8.99% - 0% below	5.00%
.01% - 8.99% above	4.00%
9.00% - 15.00% above	3.00%
More than 15.00% above	2.00%

TABLE 65-26B

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 2002. In the budget year's request the hospital provides the Authority with information for 2002 which is partially actual information and partially projected information (projected actual) and information for 2003 which is all budgeted information (budget). The projected actual average charge per nongovernmental discharge for 2002 is $5,350 or $350 more than the $5,000 average charge per nongovernmental discharge allowed for 2002 Hospital A reports the following for 2002: a $5,350 projected actual average nongovernmental inpatient charge per discharge 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.