WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #2

Do Not Mark In this Box

FILED

Oct 28 2 35 PM '98

OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: WEST VIRGINIA HEALTH CARE AUTHORITY TITLE NUMBER: 65

RULE TYPE: LEGISLATIVE ; CITE AUTHORITY W. VA. CODE §16-29B-8(a)(1), 19, 19a & 20

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 26

TITLE OF RULE BEING PROPOSED: BENCHMARKING AND DISCOUNT CONTRACT RULE

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 NOVEMBER 30, 1998 AT 5:00 p.m.

ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS.

WEST VIRGINIA HEALTH CARE AUTHORITY
100 DEE DRIVE, SUITE 201
CHARLESTON, WEST VIRGINIA 25311-1692

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

Joan E. Ohl
Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

$6.80

BRIEF SUMMARY OF THE RULE

BENCHMARKING AND DISCOUNT CONTRACT PROPOSED RULE

SUMMARY: This proposed new legislative rule, Benchmarking and Discount Contract Rule, proposes an alternative rate setting system and a new method to review discount contracts. Senate Bill 458, which was passed by the legislature in 1997, directs the Health Care Authority (Authority) to develop this rule and to file it as an emergency rule.

The new rate setting method establishes a benchmarking system for acute care hospitals in West Virginia. This system streamlines the rate setting process requiring less time and documentation for hospitals filing rate applications, thus reducing costs for hospitals.

The discount contract section allows more liberal filing times for the approval of contracts. It also defines "cost" as required by W. Va. Code §16-29B-20.

The Authority will administer and enforce the rule. For further information contact: Marianne K. Stonestreet, General Counsel, Health Care Authority, 100 Dee Drive, Suite 201, Charleston, West Virginia 25311-1692, telephone number (304) 558-7000; fax (304) 558-7001.

STATEMENT OF CIRCUMSTANCES WHICH REQUIRE THE RULE TO BE FILED AS AN EMERGENCY

BENCHMARKING AND DISCOUNT CONTRACT PROPOSED RULE

The 1997 Legislature passed Enrolled Committee Substitute for Senate Bill 458 which directs the Health Care Authority (Authority) to develop an alternative rate setting system and to develop rules for the approval of discount contracts. W. Va. Code §§16-29B-8(a) and 20(a)(2) give the agency the authority to file these rules as emergency rules.

The purpose of this rule is to streamline the rate setting process which will reduce costs to hospitals. The implementation of this rule as an emergency rule will therefore ensure the immediate protection of the public health and welfare. Reducing health care costs will also prevent substantial harm to the public interest.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: BENCHMARKING AND DISCOUNT CONTRACT RULE

Type of Rule: X Legislative ____ Interpretive ____ Procedural

Agency: WEST VIRGINIA HEALTH CARE AUTHORITY

Address: 100 DEE DRIVE, SUITE 201

CHARLESTON, WEST VIRGINIA 25311-1692

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 & ALTERNATIONS	0	0	0	0	0
EQUIPMENT	0	0	0	0	0
OTHER	0	0	0	0	0

2. Explanation of above estimates:

THE RULE WILL HAVE NO FISCAL IMPACT ON THE AGENCY.

3. Objectives of these rules:

TO CREATE AN ALTERNATIVE RATE SETTING SYSTEM AND A NEW DISCOUNT CONTRACT REVIEW FOR ACUTE CARE HOSPITALS IN WEST VIRGINIA AS DIRECTED BY W.VA. CODE §16-29B-19, 19a and 20.

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.**

   COST SAVINGS TO ACUTE CARE HOSPITALS BY STREAMLINING RATE PROCESS

   C. **Economic Impact on Citizens/Public at Large.**

   HOSPITALS SHOULD PASS COST SAVINGS TO PATIENTS THEREFORE RESULTING IN LOWER HOSPITAL CHARGES FOR THE CITIZENS OF WEST VIRGINIA

Date: 10/28/98

Signature of Agency Head or Authorized Reprensentative

D. Parker Holdiy

65CSR26

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. -

1.4. Effective Date. -

§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 §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.

§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, regulation or final order of the Authority and setting forth with particularity the basis for such 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.

This rule establishes a benchmarking process for setting 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. 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.

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.

The Health Care Authority will calculate the benchmarks on an annual basis and inform all acute hospitals if they are eligible for the benchmark review. The initial calculations will utilize the uniform billing data for the fiscal year beginning October 1, 1996 and ending September 30, 1997. The calculations will be updated annually with new UB-92 data for fiscal years ending September 30 in subsequent years. 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.

§65-26-6. Variables of the Benchmarking Process.

The major variables employed in the benchmarking process are adjusted inpatient cost per discharge and adjusted inpatient charge per discharge.

6.1. Inpatient charges.

The inpatient charge per discharge is the most 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:

6.1.a. Non-comparable costs - Direct medical education, CRNA's and physician costs which are included in rates;

6.1.b. Labor market - The Medicare hospital labor market index will be applied to the labor related portion of costs;

6.1.c. Case mix - DRG and major payer;

6.1.d. Indirect medical education - the PEIA IME factor is utilized; and

6.1.e. Compliance adjustments in the rates.

Hospitals will be divided into two peer groups initially: (1) over 100 beds and (2) 100 beds and under. Critical access hospitals are excluded from the benchmarking process until there are at least ten in the State. Once there are ten or more critical access hospitals, a third peer group of critical access hospitals will be used. Hospitals in the top 20% of each peer group above the average inpatient charge per discharge must undergo rate review pursuant to 65 CSR 5.

Outliers are not included in the calculation of the average charge per discharge for peer group determination. Outliers for hospitals with over 100 beds are defined as cases which have a charge, adjusted for the factors listed in subdivisions (a) through (e) in this subsection, exceeding $50,000 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 subdivisions (a) through (e) in this subsection, exceeding $25,000 or the mean charge for the DRG plus three standard deviations, whichever is greater. An example of the outlier calculation is contained in Table 65-26A.

Uncompensated care is not permitted to be used as an adjustment factor in determining the peer group status of a hospital in the benchmarking process.

Benchmarking will be done using all discharges. However the Authority will also do an analysis using only non-governmental cases in order to compare the results of the two analyses.

6.2. - Inpatient costs.

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

6.2.a. Non-comparable costs - Direct medical education, CRNA's and physician costs which are included in rates;

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

6.2.c. Case mix - DRG and major payer; and

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

The hospitals are divided into the peer groups to measure inpatient costs as described in subsection 6.1 of this rule. Hospitals in the top 20% of each peer group above the average cost per discharge must undergo rate review pursuant to 65 CSR 5.

Outliers and uncompensated care are also excluded from this calculation as described in subsection 6.1

§65-26-7. Standard Allowed Increase.

The standard allowed increase in the inpatient charge per discharge for hospitals near the benchmark average 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.

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. The scale for rate increases is contained in Table 65-26B.

§65-26-8. Outpatient Services.

Outpatient services cannot be included in the benchmarking analysis because of the lack of data to measure 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 inpatient charge per discharge because inpatient utilization is decreasing, largely due to declines in length of stay, but such productivity improvements are less available for outpatient services. Therefore these hospitals may increase their outpatient charge per visit by the DRI index.

§65-26-9. Adjustments.

Automatic adjustments for changes in volume and government contractual allowances are not permitted under this rule. Hospitals which require a higher rate change due to volume declines or increased government contractual allowances shall justify these increases to the Authority. These adjustments may be made without requiring the hospital to file a standard rate application if the hospital provides supporting documentation which is verifiable by audit that the volume change or change in government contractual allowances will occur and are reasonable.

§65-26-10. Compliance.

10.1. Compliance adjustments in the benchmarking process.

If a hospital overcharges relative to its approved 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.

10.2. Overcharging relative to approved rates.

If a hospital's average charge per discharge for nongovernmental inpatients or average outpatient services exceeds the allowed amount, it shall be subject to reductions in its requested rates for unjustified overages.

If a hospital overcharges by an amount less than or equal to 2% of total 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.

If the hospital overcharges by an amount more than 2% of its total acute inpatient or outpatient revenue, an interest on the unjustified overcharge shall also be applied in addition to recovering the overcharge. For example, if Hospital A is allowed to charge $4,300 per inpatient discharge and the projected actual is $4,800 therefore the hospital has an 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 $436.21 per discharge ($626,400 ÷1,436 = $436.21).

10.3. Justification for overcharging.

A hospital's average charge per 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 average value (the case mix).

Justification for the increased average inpatient charges can be determined in part or in whole 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 65-26C.

If the overcharge is on outpatient services, the hospital shall be permitted to justify the overcharge if it can demonstrate that there has been a change in the mix of outpatient services being provided. The hospital must submit a budget estimate of certain high cost services. The estimate must show the expected utilization and the expected revenue from each of the high cost services the hospital selects to use. When the hospital submits its next application, it shall show the actual utilization and revenue from these same high cost services. The hospital should also consider and budget for any anticipated loss of high volume low cost 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.

10.4. Undercharging.

If the hospital undercharges, 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 65-26D.

10.5. Miscellaneous.

10.1.a. These compliance adjustments shall affect rates for only one year.

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

10.1.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 65-26E contains an example of this calculation.

10.1.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 65-26F contains an example of this calculation.

10.6. 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 shall be eligible to participate in the benchmarking process if they have overcharged.

10.7. Penalties held in abeyance from prior years.

10.7.a. Inpatient overage - apply 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 such penalties in abeyance or apply them over several years.

10.7.b. Outpatient overage - apply 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 such penalties in abeyance or apply them over several years.

10.7.c. Distinct part units - do not apply under the benchmarking system. Applicable to other rate applications.

10.7.d. Underspent wages - do not apply under benchmarking system or other rate application processes.

10.7.e. Non-governmental contractual allowances - Under benchmarking process and all other rate application processes, the nongovernmental contractuals shall be treated as follows:

10.7.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 such cases, the Authority may continue to hold the penalty in abeyance or apply it over several years.

10.7.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.

10.7.f. Self-insurance - do not apply under the benchmarking system or other rate application processes.

§65-26-11. Procedure for Requesting a Rate Increase Under the Benchmarking System.

11.1. 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.

11.2. Application.

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

11.2.a. Board approved budget

11.2.b. BMM1 - Utilization statistics - Inpatient discharges
11.2.c. BMM1-A - Utilization statistics - Inpatient days
11.2.d. BMM1-B - Utilization statistics - Outpatient visits
11.2.e. BMM2 - Gross Patient Revenues
11.2.f. BMM3 - Distribution of Operating Expenses
11.2.g. BMM4 - Statement of Revenue and Expense (Total)
11.2.h. BMM9 – Monitor and Variance Report for Nongovernmental Payors
11.2.i. BMMDC – Summary Information of Discount Contracts

§65-26-12. 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.

§65-26-13. Order.

The order shall be sent by certified mail, return receipt requested, to the hospital.

§65-26-14. Revised Budget and Schedule of Rates.

Within twenty days of receipt of the order, the hospital must 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.

§65-26-15. 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, outpatient per visit and each distinct part unit, 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 must 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 deemed by the Authority to be interested or affected parties in the matter. Proof of publication of the legal advertisement by the hospital shall be submitted to the Authority within ten (10) days of the filing of the application.

§65-26-16. 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. Such 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.

§65-26-17. 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.

§65-26-18. 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 bases as the Authority determines constitutes good cause. Provided that, the Authority will not grant a request for reconsideration based upon an insignificant or immaterial difference between the projected data in the hospital's application and its actual data. A request for reconsideration must be filed within thirty (30) days of the receipt of the final order by the requesting party. 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 by stipulation by the applicant and all affected parties.

§65-26-19. 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.

§65-26-20. 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.

§65-26-21. Denial of an Application.

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

21.1. fails to pass the mathematical edit;

21.2. is materially inconsistent, inaccurate, or contains unreliable data;

21.3. is materially inconsistent with other financial data required to be filed by the hospital with the Authority pursuant to 65 CSR 13, "The Financial Disclosure Rule";

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

21.5. contains material misrepresentations made by the hospital to the Authority; or

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

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

§65-26-22. Compliance Reports and Orders.

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.

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.

§65-26-23. 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.

§65-26-24. Discount Contracts.

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

Pursuant to W. Va. Code §19-29B-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 must 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.

25.1. Time frames for filing.

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

25.2. Discount contract forms.

To obtain approval of a discount contract, the hospital must file with the Authority a copy of the proposed contract and a discount contract form which contains the following:

25.2.a. The name of the hospital;

25.2.b. The name of the payer;

25.2.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 cost of the service, as reported in the most recent rate filing by the hospital with the Authority, minus depreciation and interest.

At the end of each fiscal year, the Authority will analyze whether hospitals are in compliance with the various requirements of this rule, including whether they have been paid an amount equal to or above their cost as defined in this subsection.

25.2.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 must be reported as contractual allowances.

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

25.2.f. A statement that the discount is based upon criteria which constitute a quantifiable economic benefit to the hospital. The hospital must justify that the contract provides an economic benefit by demonstrating:

25.2.f.1. That the payments under the contract are above cost as defined in subdivision 25.2.c. and therefore provide some contribution to overhead;

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

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

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

25.2.f.5. That reduced costs without cost shifting will force the hospital to become more efficient; or,

25.2.f.6. That approval of the contract will assist the hospital in avoiding bad debt and charity care.

25.2.g. Such other information as the Authority may require; and,

25.2.h. The form(s) 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(s) is accurate and true to the best of his or her knowledge.

25.3. Effective date.

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

25.4. 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.

§65-26-25. Health Care Facility Financial Disclosure Act.

Before any application for a rate increase or discount contract shall be accepted for review, the hospital must be 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. Failure

to be in compliance with these requirements shall cause the Authority to refuse to accept the application or contract and to reject it.

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

Failure by a hospital or an interested or affected party to comply with any of the requirements of this rule shall subject the hospital or the interested or affected party 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 deemed to have waived the time periods set forth in the Act and this rule or the Authority may impose another appropriate sanction.

§65-25-27. 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.

§65-25-28. Time Periods.

28.1. 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.

28.2. 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.

§65-25-29. 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 will be added if the Authority is requested to make the copies.

TABLE 65-26A

OUTLIER EXAMPLE

If in the 100 beds or less peer group, 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 26B

RATE INCREASE SCALE FOR HOSPITALS UNDER THE BENCHMARKING SYSTEM

POSITION RELATIVE TO BENCHMARK AVERAGE	ALLOWABLE INCREASE
More than 15% below	DRI increase + 2%
7.5% to 15% below	DRI increase + 1%
7.5% below to 7% above (standard)	DRI increase – productivity
7.5% above to top 20% of each peer group	DRI increase – productivity – 1%
Top 20% of each peer group	Not eligible for benchmarking

TABLE 65-26C

CASE MIX JUSTIFICATION CALCULATION

Hospital A has an allowed average inpatient charge per discharge of $5,000 with a case mix index of .9527 for 19x-2. In the budget year's request the hospital provides the Authority with information for 19x-1 which is partially actual information and partially projected information (projected actual) and information for 19x+ which is all budgeted information (budget). [The projected actual charge for 19x-1 is $5,350 or $350 more than the $5,000 allowed for 19x-2] Hospital A reports the following for 19x-1: $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 - $181 = $169) to be applied to the budget year requested average charge per inpatient discharge.

TABLE 65-26D

UNDERCHARGING EXAMPLE

Hospital A is allowed to charge $4,300 per inpatient discharge and the projected actual 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 4.4% = $783,000 as undercharge plus interest to be added to rates. Assume a decrease in discharges to 1,436. Therefore, the addition to the per discharge would equal $545.26 for undercharge plus interest. Further assume Hospital A qualified for DRI plus 2%, the new rate would be calculated as follows:

Projected actual of $3,800 + DRI (2.4) + 2% = $3,800 + $167.20 = $3,967.20 + $545.26 for undercharge plus interest = $4,512.46 as the allowed rate. This equals an 18.7% increase over projected actual of $3,800 or 4.9% increase over the previously allowed rate of $4,300 per discharge.

TABLE 65-26E

LATE IMPLEMENTATION OF RATES EXAMPLE

Assume the hospital has inpatient charges of $5,000 per discharge and $300 per outpatient visit with 600 discharges and 15,000 outpatient visits. It meets the benchmark 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 (plus the 20 days to implement the changes). The new rates on an annual basis would be $5,025 per inpatient discharge and $308 per outpatient visit. Therefore the annualized revenue would be:

Inpatient: $5,025 x 600	=	$3,015.000
Outpatient: $308 x 15,000	=	4,620,000
Total		$7,635,000

Since the hospital only has eight months to make up this revenue, the revenue would be computed as follows:

Inpatient: ($5,025 ÷ .6667) x (600 x .6667)				
$7,537.12	x	400	=	$3,014,848
Outpatient: ($308 ÷ .6667) x (15,000 x .6667)				
$461.98	x	10,000	=	4,619,800
				$7,634,648

At the end of its fiscal year, the hospital would have to reduce the charges in the charge master to equal the approved rates of $5,025 per inpatient discharge and $308 per outpatient visit.

TABLE 65-26F

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.