# WEST VIRGINIA

# SECRETARY OF STATE

**KEN HECHLER**

# ADMINISTRATIVE LAW DIVISION

Form #3

**Do Not Mark In this Box**



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

AGENCY: WEST VIRGINIA HEALTH CARE AUTHORITY TITLE NUMBER: 65

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

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

Joan E. Ohl

Authorized Signature

$12.00

## 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: December 18, 1998

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM (*Agency Name, Address & Phone No.*) WEST VIRGINIA HEALTH CARE AUTHORITY
100 DEE DRIVE, SUITE 201
CHARLESTON, WV 25311 TELEPHONE: (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:

OCTOBER 28, 1998

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

AGENCY NEWSLETTER, DISTRIBUTION TO WEST VIRGINIA HOSPITAL ASSOCIATION, MOUNTAIN STATE BLUE CROSS BLUE SHIELD AND GREATER KANAWHA VALLEY EMPLOYERS' HEALTH CARE COALITION

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

NOVEMBER 30, 1998

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

Attached X No comments received _____

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

December 18, 1998

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 K. STONESTREET, GENERAL COUNSEL

WEST VIRGINIA HEALTH CARE AUTHORITY

100 DEE DRIVE, SUITE 201 E-MAIL ADDRESS: MSTONESTREET@HCAWV.ORG

CHARLESTON, WV 25311 PHONE: (304)558-7000, FAX: (304)558-7001

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:

_____

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

_____

d. Attach findings and determinations and reasons:

Attached _____

## 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. Jackson Hall

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 §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.

## §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 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. 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 year beginning October 1, 1996 and ending September 30, 1997. The calculations will be updated annually with new UB-92 data for each subsequent year ending September 30th.

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.

Hospitals shall be divided into two peer groups initially: (1) over one hundred (100) beds and (2) one hundred (100) beds and under. Critical access hospitals shall be excluded from the benchmarking process until there are at least ten (10). Once there are ten (10) or more critical access

hospitals, a third peer group of critical access hospitals shall be used.

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 must undergo standard rate review pursuant to 65 CSR 5, "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 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. Labor market - The Medicare hospital labor market index will be applied to the labor related portion of costs;

6.2.a.3. 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.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 will 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. Labor market - The Medicare hospital labor market index will be applied to the labor related portion of costs;

6.2.b.3. 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.**

Adjustments in an 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 adjustments shall be calculated using the hospital's prior year's approved nongovernmental charge per discharge.

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.

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 65-26A.

**§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 average nongovernmental 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 average nongovernmental outpatient charge per visit by the DRI index. This adjustment shall be calculated using the hospital's prior year's approved nongovernmental outpatient charge per visit.

**§65-26-9. Compliance.**

9.1. Compliance adjustments in the benchmarking process.

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.

If a hospital's average charge per discharge for nongovernmental inpatient or average charge per nongovernmental outpatient visit exceeds the average 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 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.

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.

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).

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 65-26C.

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 section 6.2.b., paragraphs (1) through (5) of this rule, 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 section 6.2.b., paragraphs (1) through (5) of this rule, 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 65-26D.

9.3.b. Outpatient - If the overcharge is on nongovernmental 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.

A hospital submitting an application under this rule must submit a budget estimate of high cost nongovernmental outpatient services. The estimate must 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.

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.

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.

9.5. Miscellaneous.

9.5.a. These compliance adjustments 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 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 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 shall be eligible to participate in the benchmarking process if they have overcharged.

9.7. Penalties held in abeyance from prior years.

9.7.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.

9.7.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.

9.7.c. Distinct part units - do not apply under the benchmarking system.

9.7.d. Underspent wages - do not apply under the benchmarking system.

9.7.e. Nongovernmental contractual allowances - Under the benchmarking process, the nongovernmental contractuals shall be treated as follows:

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 such 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 contract will be disallowed in its entirety.

9.7.f. Self-insurance - do not apply 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. Board approved budget;

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.

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

**§65-26-13. 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 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 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.

**§65-26-15. 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. 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.

**§65-26-16. 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 bases as the Authority determines constitutes good cause. A request for reconsideration must be filed within thirty (30) days of the receipt of the final order by the requesting party. The requesting 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.**

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

20.1. fails to pass the mathematical edit;

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

20.3. 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";

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

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

20.6. 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.

**§65-26-21. 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.

**§65-26-22. 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.**

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.

23.1. Time frames for filing.

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

23.2. 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 to be provided by the Authority which contains the following:

23.2.a. The name of the hospital;

23.2.b. The name of the payer;

23.2.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 total operating expenses, as reported in the most recent rate filing by the hospital with the Authority, minus depreciation and interest;

23.2.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;

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

23.2.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 at least one of the following:

23.2.f.1. The payments under the contract are above cost as defined in subdivision 23.2.c. and therefore provide some contribution to overhead;

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

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

23.2.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;

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

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

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

23.2.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.

23.3. Effective date.

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

23.4. 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.

23.5. Compliance

23.5.a. At the end of each fiscal year, the Authority will 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 23.2.c.

23.5.b. If a discount contract was implemented prior to its approval by the Authority, 20% of the discount shall be applied 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 such cases, the Authority may hold the penalty in abeyance or apply it over several years.

23.5.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 contract will be disallowed in its entirety.

**§65-26-24. 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.

**§65-26-25. 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.

**§65-26-26. 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 will be added if the Authority is requested to make the copies.

## TABLE 26A

## RATE INCREASE SCALE FOR HOSPITALS UNDER THE BENCHMARKING SYSTEM

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

## 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 65-26C

## 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. 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 average charge per nongovernmental discharge for 19x-1 is $5,350 or $350 more than the $5,000 average charge per nongovernmental discharge 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 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.

11/30 12:55 Fax to Charlie Steinert
Fax to Marianne.

Mountain State
BlueCross BlueShield
An Independent Licensee of the
Blue Cross and Blue Shield Association

700 Market Square
P.O. Box 1948
Parkersburg, West Virginia 26102

Local 304 / 424-7700
Toll Free 800 / 344-5514

Writer's Direct Dial Number

November 25, 1998

Marianne Stonestreet, Esquire
General Counsel
West Virginia Health Care Authority
100 Dee Drive
Charleston, WV 25311

Dear Ms. Stonestreet:

We are in receipt of the Legislative Rule 65CSR26 benchmarking and discount contract rule filed by the Health Care Authority.

We are supportive of the general approach this legislative rule takes to an alternative rate setting system for hospitals. We also believe the new system for the review of contracts between hospitals and purchasers or third party payers is a move in the right direction.

We would suggest the following changes to clarify the operation of the rule:

1. Section 25.2f - Modify the introductory paragraph to clarify that only one of the economic benefits list must be demonstrated. The second sentence could be modified to read as follows: "The hospital must justify that the contract provides an economic benefit by demonstrating at least one of the following:"

2. Section 25.4 - Should be rewritten to provide: "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 within 30 days denying approval of the discount contract. If the Chief Executive Officer of the hospital submits a notarized statement of compliance with the provisions of Section 25.2 pursuant to section 25.2h and the Authority does not issue an order within 30 days of submission, the contract shall be deemed approved.

We thank you for the opportunity to comment on this legislative rule.

Sincerely,

Fred

J. Fred Earley, II
General Counsel

GREATER KANAWHA VALLEY
EMPLOYERS' HEALTH CARE COALITION
P.O. BOX 8724
SOUTH CHARLESTON, WV 25303



**COMMENTS REGARDING TITLE 65LEGISLATIVE RULE**
**HEALTH CARE AUTHORITY**
**SERIES 26: BENCHMARKING AND DISCOUNT CONTRACT RULE**

These Comments reflect the views of C. R. Steinmetz on behalf of the Greater Kanawha Valley Health Care Coalition regarding the Benchmarking and Discount Contract proposed rule. In general, the Proposed Rule reflects the decisions and objectives of the Task Force. However, there are several areas in which the language in the Proposed Rule needs to be modified to reliably implement the Task Force's intentions. We are providing comments about selected major sections of the Proposed Rule plus language that we recommend for insertion at the indicated places.

**1. Section 65-26-5: Calculation of Benchmarks**

This Section accurately reflects the deliberations and recommendations of the Task Force.

**2. Section 65-26-6: Variables of the Benchmarking Process**

This Section accurately reflects the deliberations and recommendations of the Task Force. However, it leaves unsettled the question of whether a hospital that passes the benchmarking screens on an "all discharges" basis should be eligible for the benchmarking approach if its adjusted charges are above the 20% threshold when the analysis is done using only non-governmental cases. The Task Force did not address this question. We believe that the Proposed Rule should not leave HCA without some guidance regarding this situation. We recommend that the Proposed Rule should be modified by the addition of the following sentence at the end of the last paragraph of Section 65-26-6: "If the hospital's charges are found to be below the 20% threshold when the analysis is performed using all discharges, but above it when the analysis is performed using non-governmental cases only, the hospital shall not be eligible for the benchmarking process if its non-governmental charges are more than twenty-five percent (25%) above the average adjusted inpatient charge per discharge for non-governmental cases." This approach provides some leeway while giving HCA specific instructions about how to proceed if this discrepancy occurs.

**3. Section 65-26-7: Standard Allowed Increase**

This Section accurately reflects the Task Force's deliberations and recommendations. In order to make sure that there is no ambiguity regarding the computation of the adjustment, the "Allowable Increase" entry in Table 26B (Rate Increase Scale for Hospitals Under the Benchmarking System) for hospitals in the "7.5% above to Top 20% of Each Peer Group" category should be changed from the current entry (which reads "DRI increase - productivity - 1") by adding parentheses as follows: (DRI increase - productivity) - 1%. Otherwise, it is conceivable that the formula could be interpreted to mean that 1% should be subtracted from the productivity factor (thereby lowering it) before it is subtracted from the DRI increase.

### 4. Section 65-26-9: Adjustments

This Section is consistent with the Task Force's deliberations and recommendations. We wish to emphasize, however, that the intention of the Task Force was to require hospitals to justify the reasonableness of any request for an adjustment based on changes in governmental contractual adjustments. A mere determination that an increase in governmental contractual adjustments has occurred or is likely to occur should not be sufficient to warrant approval of the request for a rate adjustment. The hospital should be required to show that its costs are reasonable and that it cannot reasonably be expected to provide care at the cost level required to avoid any increase in the level of government contractual adjustments. Thus, if the hospital's cost per discharge (adjusted for the variables identified above in Section 65-26-6) is above the average for its peer group, or if its casemix-adjusted ALOS is above the state average for its peer group for Medicaid or PEIA patients, or above the national average for Medicare, using the most recent DRG-specific data that are available from the federal government, it should not be eligible for an adjustment based on a change in the level of government contractual adjustments.

### 5. Section 65-26-10: Compliance

This Section is consistent with the Task Force's deliberations and recommendations. However, it is not reasonable to make adjustments for changes in the casemix index (CMI) as proposed-- i.e., as though all costs are 100% variable. Specifically, Section 65-26-10.3 (Justification for Overcharging) specifically provides, in the example given in the associated Table 65-26C, that if a hospital's CMI were to increase by 3.62%, it would be entitled to a charge increase of 3.62%. This is not reasonable because some portion of a hospital's costs (approximately 50%) is fixed. Similarly, if a hospital's CMI were to drop by 3.62%, it would not be reasonable to require a 3.62% decrease in charges. We recommend that 50% of CMI changes, both positive and negative, be reflected in charge adjustments.

### 6. Section 65-26-24: Discount Contracts

This Section is generally consistent with the Task Force's deliberations and recommendations. However, it needs two changes to perfectly reflect the Task Force's intentions. These two changes are described below.

First, the Section does not specify the time frame during which the HCA will act on discount applications. At various times during the Task Force's meetings, HCA staff indicated that it would act expeditiously on discount applications. Therefore, we believe that the following sentence should be added at the end of Section 65-26-25.4 (Denial of Contract): "Unless the HCA has issued a final order denying approval of the discount contract within thirty (30) days after its receipt of a copy of the discount contract and a properly completed discount contract form, the discount contract shall be deemed approved."

Second, the intention of the Task Force was that discount contracts should be approved if the proposed payment is not below historical cost, minus depreciation and interest; does not result in cost shifting to other purchasers or payers; and provides an economic benefit to the hospital. Unfortunately, Section 25.2.f, as written, would seem to indicate that the discount contract must provide all of the benefits described in Sections 25.2.f.1 through 25.2.f.6 rather than just one of them. Therefore, we believe that it is essential to add the word "or" at the end of each of these subsections to make clear that satisfaction of any of these criteria is sufficient to meet the economic benefit test.

As noted above, we believe that Proposed Rule is, in general, a fair reflection of the Task Force's recommendations. However, we believe the additions or changes specified above are important modifications that are needed to fully represent the objectives of the Task Force.

November 18, 1998

WEST VIRGINIA
HOSPITAL ASSOCIATION

100 Association Drive
Charleston, WV 25311
(304) 344-9231
FAX: (304) 344-9237
Web Page: www.wvha.com

November 25, 1998

D. Parker Haddix, Chairman
West Virginia Health Care Authority
100 Dee Drive - Suite 201
Charleston, West Virginia 25311

Re: **Proposed Legislative Rule 65CSR26**

Dear Parker:

This letter is a follow-up to our meeting on November 12 in which the West Virginia Hospital Association (WVHA) presented suggested changes and/or concerns that WVHA has with the proposed "Benchmarking and Discount Contract Rule," WV 65CSR26. The purpose of this letter is to submit to you, in writing, the comments made at that time.

1. Section 65-26-5 Calculation of Benchmarks

   While we agree with the time period selected for calculating the benchmark, WVHA believes the term "fiscal year" as referenced in this section should be replaced with "year," to reflect the fact that not all hospitals fiscal years end on September 30. In addition, the rule should specify either in this section or the following Section 65-26-6, how a hospital's actual fiscal year cost data will be adjusted to match the time frame in this section used for charges.

2. Section 65-26-6 Calculation of Benchmarks

   Under subsection 6.1.e., we agree with the initial exemption from benchmarking for the Critical Access Hospitals, but need to reiterate our belief that the Rate-setting Subcommittee also voted to exempt these hospitals from the full, standard review process. Your stated intention was to use the Rural Health Systems Program authority to provide this exemption. To date, we have no experience with this exemption being provided under the RHSP.

   Later in this subsection, reference is made to uncompensated care **not** being used as an adjustment factor in calculating the hospital benchmark. We agree with this, and would simply suggest that this comment be deleted. The same suggestion applies to the review of non-governmental cases; if they won't be used for benchmarking, then we believe reference to these cases should be deleted to simplify the rule.

3. Section 65-26-9 Adjustments

   The discussion of potential other adjustments (other than those specified in subsection 6.1.a through 6.1.e) is confusing. Our understanding was that if a hospital desired an increase other than that specified in Table 26B, it would have to go through the standard application process. Under that process, it could potentially use governmental contractual allowances as justification for their higher requested rates. The reference to these adjustments under the streamlined benchmarking process is unclear.

4. Section 65-26-10 Compliance

   WVHA takes strong exception, under subsection 10.7.c, to the continued use of penalties on distinct part units under "other rate applications". It is our belief that the Rate-setting Committee

unanimously recommend the elimination of this penalty under **all** applications, not just the streamlined process.

5. Section 65-26-11 Procedure for Requesting a Rate Increase

While not formally part of the benchmarking rule, WVHA is concerned about the number of forms, and potential detail being requested, under Subsection 11.2. For example, why is inpatient day information necessary when the benchmarking system only calculates per discharge inpatient rates? We would appreciate an in-depth review of these forms prior to their implementation.

6. Section 65-26-24 Discount Contracts

Under subsection 25.2.f., language should be inserted after the word "demonstrating," that **any one of the following** criteria need to be demonstrated by the hospital in order to receive contract approved. As currently written, it appears that all of 25.2.f.1 through 25.2.f.6 are required to be demonstrated.

In addition, under subsection 25.4 (draft rule says 25.4 when it should be 24.4), I believe it would be preferable to specify in the rule the number of days within which the Authority will issue its approval or denial of the contract. If the application is complete, we believe the Authority should issue its order within thirty (30) days.

7. Table 65-26e

Finally, we note that the numerical example provided in this table, does not result in the hospital being able to generate the total revenue approved by the Authority ($7,635,000 approved versus $7,634,648 generated through the example calculations). We believe this can be accomplished as follows:

Inpatient: $3,015,000 ÷ (600 x .6667) = $7,537.50 per discharge (not $7,537.12 as per the example)

Outpatient: $4,620,000 ÷ (15,00 x .6667) = $462.00 per visit (as opposed to $461.98 as per the example)

WVHA looks forward to the Authority's consideration of the above suggested changes in adopting this final rule on a streamlined benchmarking system. If you have any questions, I may be contacted at 344-9744.

Sincerely,

Michael B. Robbins
Vice President Financial Policy

MBR/jl

# RESPONSE TO COMMENTS

The Health Care Authority received three sets of written comments on the proposed legislative rule, "Benchmarking and Discount Contract Rule". These comments were received from the West Virginia Hospital Association, Mountain State Blue Cross Blue Shield and The Greater Kanawha Valley Employers Health Care Coalition.

The West Virginia Hospital Association (WVHA) suggested changes in section 5 regarding the term "fiscal year" for clarification purposes. This change was made and appears in the amendments to the proposed rule. The WVHA also suggested other items for clarification purposes which also appear as amendments to the proposed rule. These comments include clarification of the reference to uncompensated care in section 6, the deletion of section 9 all together (section 9 was the subject of comment from The Greater Kanawha Valley Employers Health Care Coalition as well), a revamping of former Table 65-26E and clarification of section 24 regarding discount contracts. Section 24 was the subject of comment from all three interested parties and their suggestions for clarification have been adopted by the Health Care Authority. In addition, the Health Care Authority has simplified the language under section 11 dealing with possible forms to be utilized in the benchmarking process as suggested by the WVHA.

The WVHA requested the Authority to deal with two issues which are outside the benchmarking process and therefore outside the scope of this rule. One deals with the treatment of critical access hospitals under standard rate review and the other deals with the treatment of certain penalties under standard rate review. This proposed rule is not the appropriate place to deal with these issues as they relate to matters which are outside the scope of this rule.

The WVHA, as well as the other two interested parties, have requested the Authority to set a thirty (30) day time period in which to issue a decision on the approval of discount contracts. The Authority has rejected this suggestion for the following reasons: (1) the Authority regularly issues these decisions in less than thirty (30) days; (2) decisions which extend beyond this period are the result of hospital errors and/or incomplete information and it is difficult to codify the situations in which the thirty (30) day period would not be applicable; and, (3) the Code does not require the Authority to issue these decisions within a limited time period. Therefore, the Authority has elected not to provide a limited time period in which to review these contracts. Mountain State Blue Cross Blue Shield further requested a "deemer clause" that if the Authority does not approve a contract within thirty (30) days, the contract is automatically approved. The Authority rejects this suggestion for the reasons previously noted.

The Greater Kanawha Valley Employers Health Care Coalition (Coalition) submitted comments which generally reflect those of the other two interested parties. The other comments which do not duplicate the other interested parties are as follows. The Coalition suggests clarification regarding the use of nongovernmental cases in section 6. The Authority has adopted this suggestion and has deleted all language dealing with nongovernmental payors in section 6. The Authority has also adopted the suggestion for clarification in Table 26B which is the rate increase scale for hospitals under the benchmarking system. Finally, the Authority rejects the Coalition's comments regarding section 10 and the calculation of case mix index. The Coalition suggests a calculation which is different from that currently used by the Authority and is generally familiar in the hospital industry. To change the calculation would complicate a system which is designed to streamline rate review.

(1) The general counsel may act to bring and to defend actions on behalf of the board in the courts of the state and in federal courts.

(2) In all adjudicative matters before the board, the general counsel shall advise the board. The staff shall represent itself in all such actions before the board.

(c) The board may contract with third parties, including state agencies, for any services that may be necessary to perform the duties imposed upon it by this article where such contractual agreements will promote economy, avoid duplication of effort or make the best use of available expertise.

(d) The board shall identify which members of the staff of the health care cost review authority [health care authority] shall be exempted from the salary schedules or pay plan adopted by the state personnel board, and further identify such staff members by job classification or designation, together with the salary or salary ranges for each such job classification or designation. This information shall be filed by the board with the director of the division of personnel no later than the first day of July, one thousand nine hundred ninety-one, and thereafter as necessary. (1983, c. 102; 1991, c. 78.)

**Editor's notes.** — The bracketed words in (d) were inserted by the editor. See § 16-29B-5 for change of name.

**Quoted** in United Hosp. Ctr. v. Richardson, 757 F.2d 1445 (4th Cir. 1985).

## § 16-29B-8. Powers generally; budget expenses of the board.

(a) In addition to the powers granted to the board elsewhere in this article, the board may:

(1) Adopt, amend and repeal necessary, appropriate and lawful policy guidelines and rules in accordance with article three [§ 29A-3-1 et seq.], chapter twenty-nine-a of this code: Provided, That subsequent amendments and modifications to any rule promulgated pursuant to this article and not exempt from the provisions of article three, chapter twenty-nine-a of this code may be implemented by emergency rule;

(2) Hold public hearings, conduct investigations and require the filing of information relating to matters affecting the costs of health care services subject to the provisions of this article and may subpoena witnesses, papers, records, documents and all other data in connection therewith. The board may administer oaths or affirmations in any hearing or investigation;

(3) Apply for, receive and accept gifts, payments and other funds and advances from the United States, the state or any other governmental body, agency or agencies or from any other private or public corporation or person (with the exception of hospitals subject to the provisions of this article, or associations representing them, doing business in the state of West Virginia, except in accordance with subsection (c) of this section), and enter into agreements with respect thereto, including the undertaking of studies, plans, demonstrations or projects. Any such gifts or payments that may be received or any such agreements that may be entered into shall be used or formulated only so as to pursue legitimate, lawful purposes of the board, and shall in no respect

inure to the private benefit of a board member, staff member, donor or contracting party;

(4) Lease, rent, acquire, purchase, own, hold, construct, equip, maintain, operate, sell, encumber and assign rights or dispose of any property, real or personal, consistent with the objectives of the board as set forth in this article: Provided, That such acquisition or purchase of real property or construction of facilities shall be consistent with planning by the state building commissioner and subject to the approval of the Legislature;

(5) Contract and be contracted with and execute all instruments necessary or convenient in carrying out the board's functions and duties; and

(6) Exercise, subject to limitations or restrictions herein imposed, all other powers which are reasonably necessary or essential to effect the express objectives and purposes of this article.

(b) The board shall annually prepare a budget for the next fiscal year for submission to the governor and the Legislature which shall include all sums necessary to support the activities of the board and its staff.

(c) Each hospital subject to the provisions of this article shall be assessed by the board on a pro rata basis using the gross revenues of each hospital as reported under the authority of section eighteen [§ 16-29B-18] of this article as the measure of the hospital's obligation. The amount of such fee shall be determined by the board except that in no case shall the hospital's obligation exceed one tenth of one percent of its gross revenue. Such fees shall be paid on or before the first day of July in each year and shall be paid into the state treasury and kept as a special revolving fund designated "health care cost review fund", with the moneys in such fund being expendable after appropriation by the Legislature for purposes consistent with this article. Any balance remaining in said fund at the end of any fiscal year shall not revert to the treasury, but shall remain in said fund and such moneys shall be expendable after appropriation by the Legislature in ensuing fiscal years.

(d) Each hospital's assessment shall be treated as an allowable expense by the board.

(e) The board is empowered to withhold rate approvals, certificates of need and rural health system loans and grants if any such fees remain unpaid, unless exempted under subsection (g), section four [§ 16-2D-4(g)], article two-d of this chapter. (1983, c. 102; 1991, c. 78; 1997, c. 102.)

**Effect of amendment of 1997.** — The amendment, in (a)(1), deleted "and regulations" following "rules"; in (a)(2), in the first sentence, substituted "health care services" for "services in hospitals"; deleted former (d), pertaining to the board's assessment of hospitals prior to July 1, 1984, and redesignated the remaining subsections accordingly; and, in (e), inserted "certificates of need and rural health system loans and grants" following "approvals," and added "unless exempted under subsection (g), section four, article two-d of this chapter" to the end, and made a punctuation change.

**Power to discipline attorneys.** — While an administrative agency does have the power to adopt rules of procedure for those appearing before it, it does not have the power to discipline attorneys. The exclusive authority to define, regulate and control the practice of law in West Virginia is vested in the supreme court of appeals. Christie v. West Virginia Health Care Cost Review Auth., 176 W. Va. 420, 345 S.E.2d 22 (1986).

(d) All reports filed under any provisions of this article, except personal medical information personally identifiable to a purchaser and any tax return, shall be open to public inspection and shall be available for examination at the offices of the board during regular business hours.

(e) Whenever a further investigation is deemed necessary or desirable to verify the accuracy of any information set forth in any statement, schedule or report filed by a health care provider or related organization under the provisions of this section, the board may require a full or partial audit of the records of the health care provider or related organization. (1983, c. 102; 1991, c. 78; 1997, c. 102.)

**Effect of amendment of 1997.** — The amendment, in (a), substituted "health care provider" for "hospital," and inserted "and article five-f of this chapter" and "reports required by such article five-f"; and, in (e), substituted "health care provider" for "hospital" twice.

**Editor's notes.** — Acts 1991, c. 78 became effective March 6, 1991.

## § 16-29B-19. Rate-setting powers generally.

(a) The board shall have power: (1) To initiate reviews and investigations of hospital rates and establish and approve such rates; (2) to initiate reviews and investigations of hospital rates for specific services and the component factors which determine such rates; (3) to initiate reviews and investigations of hospital budgets and the specific components of such budgets; and (4) to approve or disapprove hospital rates and budgets taking into consideration the criteria set forth in section twenty [§ 16-29B-20] of this article.

(b) In the interest of promoting the most efficient and effective use of hospital service, the board may adopt and approve alternative methods of rate determination. The board may also adopt methods of charges and payments of an experimental nature which are in the public interest and consistent with the purpose of this article.

(c) The board shall examine the need for an alternative to the current rate-setting method as a means of controlling hospital costs and submit the findings, recommendations and any proposed drafts of legislation, if necessary, in a report to the legislative oversight commission on health and human resources accountability and the governor on or before the first day of August, one thousand nine hundred ninety-eight. (1983, c. 102; 1987, c. 61; 1997, c. 102.)

**Effect of amendment of 1997.** — The amendment added (c).

## § 16-29B-19a. Additional legislative directives; studies, findings and recommendations.

(a) The Legislature finds and declares that changing market forces require periodic changes in the regulatory structure for health care providers and hereby directs the board to study the following:

(1) The certificate of need program, including the effect of any changes on managed care and access for uninsured and rural consumers; determining

which services or capital expenditures should be exempt and why; and the status of similar programs in other states;

(2) The hospital rate-setting methodology, including the need for hospital rate-setting and the development of alternatives to the cost-based reimbursement methodology;

(3) Managed care markets, including the need for regulatory programs in managed care markets; and

(4) Barriers or obstacles, if any, presented by the certificate of need program or standards in the state health plan to health care providers' need to reduce excess capacity, restructure services and integrate the delivery of services.

(b) The board may form task forces to assist it in addressing these issues and it shall prepare a report on its findings and recommendations, which is to be filed with the governor, the president of the Senate and the speaker of the House of Delegates on or before the first day of October, one thousand nine hundred ninety-eight, identifying each problem and recommendation with specificity and the effect of each recommendation on cost, access and quality of care. The task forces, if formed, shall be composed of representatives of consumers, businesses, providers, payors and state agencies.

(c) The board shall report quarterly to the legislative oversight commission on health and human resources accountability regarding the appointment, direction and progress of the studies. (1991, c. 78; 1997, c. 102.)

**Effect of amendment of 1997.** — The amendment rewrote the section.

## § 16-29B-20. Rate determination.

(a) Upon commencement of review activities, no rates may be approved by the board nor payment be made for services provided by hospitals under the jurisdiction of the board by any purchaser or third-party payor to or on behalf of any purchaser or class of purchasers unless:

(1) The costs of the hospital's services are reasonably related to the services provided and the rates are reasonably related to the costs;

(2) The rates are equitably established among all purchasers or classes of purchasers within a hospital without discrimination unless federal or state statutes or rules and regulations conflict with this requirement. On and after the effective date of this section, a summary of every proposed contract, or amendment to any existing contract, for the payment of patient care services between a purchaser or third-party payor and a hospital shall be filed by the hospital for review by the board, which reviews shall occur no less frequently than each calendar quarter: (A) If the contract establishes a discount to the purchaser or third-party payor, it shall not take effect until approved by the board. For purposes of this article, a risk-bearing contract is reviewable as a discount contract and the amount computed as the discount percentage by the provider on the board shall be the approved amount of the discount. The difference, if any, between the actual discount percentage and amount and the approved amount, shall not be considered for rate-setting purposes; (B) the board may promulgate rules, in accordance with the provisions of section eight

[§ 16-29B-8] of this article, that establish the criteria for review of discount contracts, which shall include that: (i) No discount shall be approved by the board which constitutes an amount below the cost to the hospital; (ii) the cost of any discount contained in the contract will not be shifted to any other purchaser or third-party payor; (iii) 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 (iv) the discount is based upon criteria which constitutes a quantifiable economic benefit to the hospital. The board may define by rule what constitutes "cost" in subparagraphs (i) and (ii) of this paragraph; "purchaser" in subparagraph (iii) of this paragraph; and "economic benefit" in subparagraph (iv) of this paragraph. Any rules promulgated pursuant to this subsection may be filed as emergency rules. All information submitted to the board shall be certified by the hospital's chief executive officer and chief financial officer as to its accuracy and truthfulness;

(3) The rates of payment for medicaid are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated hospitals subject to the provisions of this article. The rates shall take into account the situation of hospitals which serve disproportionate numbers of low income patients and assure that individuals eligible for medicaid have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality;

(4) The rates are equitable in comparison to prevailing rates for similar services in similar hospitals as determined by the board; and

(5) In no event shall a hospital's receipt of emergency disaster funds from the federal government be included in the hospital's gross revenues for either rate-setting or assessment purposes.

(b) In the interest of promoting efficient and appropriate utilization of hospital services, the board shall review and make findings on the appropriateness of projected gross revenues for a hospital as the revenues relate to charges for services and anticipated incidence of service.

(c) When applying the criteria set forth in subsections (a) and (b) of this section, the board shall consider all relevant factors, including, but not limited to, the following: The economic factors in the hospital's area; the hospital's efforts to share services; the hospital's efforts to employ less costly alternatives for delivering substantially similar services or producing substantially similar or better results in terms of the health status of those served; the efficiency of the hospital as to cost and delivery of health care; the quality of care; occupancy level; a fair return on invested capital, not otherwise compensated for; whether the hospital is operated for profit or not for profit; costs of education; and income from any investments and assets not associated with patient care, including, but not limited to, parking garages, residences, office buildings, and income from related organizations and restricted funds whether or not associated with patient care.

(d) Wages, salaries and benefits paid to or on behalf of nonsupervisory employees of hospitals subject to this article are not subject to review unless the board first determines that the wages, salaries and benefits may be

unreasonably or uncustomarily high or low. This exemption does not apply to accounting and reporting requirements contained in this article, nor to any that may be established by the board. The term "nonsupervisory personnel", for the purposes of this section, means, but is not limited to, employees of hospitals subject to the provisions of this article who are paid on an hourly basis.

(e) Reimbursement of capital and operating costs for new services and capital projects subject to article two-d [§ 16-2D-1 et seq.] of this chapter shall not be allowed by the board if the costs were incurred subsequent to the eighth day of July, one thousand nine hundred seventy-seven, unless they were exempt from review or approved: (i) By the state health planning and development agency prior to the first day of July, one thousand nine hundred eighty-four; or (ii) thereafter, pursuant to the provisions of article two-d of this chapter.

(f) The board shall consult with relevant licensing agencies and may require them to provide written findings with regard to their statutory functions and information obtained by them in the pursuit of those functions. Any licensing agency empowered to suggest or mandate changes in buildings or operations of hospitals shall give notice to the board together with any findings.

(g) A hospital shall file a complete rate application with the board on an annual basis a minimum of seventy-five days prior to the beginning of its fiscal year. If the application is filed and determined to be complete by the board sixty days prior to the beginning of the hospital's fiscal year, and no hearing is requested on the application, the board shall set the rates in advance of the year during which they apply and shall not adjust the rates for costs actually incurred: Provided, That if the board does not establish rates by the beginning of the hospital's fiscal year, and a hearing has not been requested, the board shall establish rates retroactively to the beginning of the hospital's fiscal year: Provided, however, That if the board does not establish rates by the beginning of the hospital's fiscal year, and a hearing has been requested, the board may establish rates retroactively to the beginning of the fiscal year. This subsection shall not apply to the procedure set forth in subsection (c), section twenty-one [§ 16-29B-21(c)] of this article.

(h) No hospital may charge for services at rates in excess of those established in accordance with the requirements of and procedures set forth in this article.

(i) Notwithstanding any other provision of this article, the board shall approve all requests for rate increases by hospitals which are licensed for one hundred beds or less and which are not located in a standard metropolitan statistical area where the rate of increase is equal to or less than the lowest rate of inflation as established by a recognized inflation index for either the national or regional hospital industry. The board may, by rule, impose reporting requirements to ensure that a hospital does not exceed the rate of increases permitted in this section.

(j) Notwithstanding any other provision of this article, the board shall develop an expedited review process applicable to all hospitals licensed for more than one hundred beds or that are located in a standard metropolitan

statistical area for rate increase requests which may be based upon a recognized inflation index for the national or regional hospital industry.

(k) The board may require hospitals to file such additional information as it deems necessary to evaluate a market-driven system of rate setting. (1983, c. 102; 1987, c. 61; 1989, c. 87; 1991, c. 78; 1996, c. 138; 1997, c. 102.)

**Effect of amendment of 1996.** — The amendment inserted "rules and" preceding "regulations" in (a)(2); in (c), substituted "associated with patient care" for "so associated"; and made other stylistic changes.

**Effect of amendment of 1997.** — The amendment, in (a)(2), in the second sentence, inserted "or amendment to any existing contract" and deleted "with its rate application" near the beginning, and rewrote the last three sentences; in (b), deleted the second sentence; in (g), substituted "seventy-five" for "sixty" in the first sentence; deleted former (h), pertaining to the prospective nature of the board's determinations, orders and decisions, and redesignated the remaining subsections accordingly; and added (k).

**Editor's notes.** — This section, as amended by Acts 1991, c. 78, became effective March 6, 1991.

Concerning the reference in (a)(2) to "the effective date of this section," Acts 1991, c. 78, which added this language, became effective March 6, 1991. Acts 1996, c. 138, which amended and reenacted this section, passed March 9, 1996, and became effective 90 days from passage. Acts 1997, c. 102, which amended and reenacted this section, passed April 12, 1997, and became effective 90 days from passage.

## § 16-29B-21. Procedure for obtaining initial rate schedule; adjustments and revisions of rate schedules.

(a) No hospital subject to this article may change or amend its schedule of rates except in accordance with the following procedures:

(1) Any request for a change in rate schedules or other changes must be filed in writing to the board with such supporting data as the hospital seeking to change its rates considers appropriate, in the form prescribed by the board. Upon receipt of notice, the board, if it considers necessary, may hold a public hearing on the proposed change. Such hearing shall be held no later than forty-five days after receipt of the notice. The review of the proposed change may not exceed an overall period of one hundred eighty days from the date of filing to the date of the board's order. If the board fails to complete its review of the proposed change within the time period specified for the review, the proposed change shall be deemed to have been approved by the board. Any proposed change shall go into effect upon the date specified in the order. The review period is complete upon the date of the board's final order notwithstanding an appeal of the order to the agency of the state designated by the governor, a circuit court, or the supreme court of appeals by an affected party;

(2) Each hospital shall establish, in a written report which shall be incorporated into each proposed rate application, that it has thoroughly investigated and considered:

(A) The economic and social impact of any proposed rate increase, or service decrease, on hospital cost containment and upon health care purchasers, including classes of purchasers, such as the elderly and low and fixed income persons;

(B) State-of-the-art advances in health care cost containment, hospital management and rate design, as alternatives to or in mitigation of any rate increase, or service decrease, which report shall describe the state-of-the-art

(1) The general counsel may act to bring and to defend actions on behalf of the board in the courts of the state and in federal courts.

(2) In all adjudicative matters before the board, the general counsel shall advise the board. The staff shall represent itself in all such actions before the board.

(c) The board may contract with third parties, including state agencies, for any services that may be necessary to perform the duties imposed upon it by this article where such contractual agreements will promote economy, avoid duplication of effort or make the best use of available expertise.

(d) The board shall identify which members of the staff of the health care cost review authority [health care authority] shall be exempted from the salary schedules or pay plan adopted by the state personnel board, and further identify such staff members by job classification or designation, together with the salary or salary ranges for each such job classification or designation. This information shall be filed by the board with the director of the division of personnel no later than the first day of July, one thousand nine hundred ninety-one, and thereafter as necessary. (1983, c. 102; 1991, c. 78.)

**Editor's notes.** — The bracketed words in (d) were inserted by the editor. See § 16-29B-5 for change of name.

**Quoted** in United Hosp. Ctr. v. Richardson, 757 F.2d 1445 (4th Cir. 1985).

## § 16-29B-8. Powers generally; budget expenses of the board.

(a) In addition to the powers granted to the board elsewhere in this article, the board may:

(1) Adopt, amend and repeal necessary, appropriate and lawful policy guidelines and rules in accordance with article three [§ 29A-3-1 et seq.], chapter twenty-nine-a of this code: Provided, That subsequent amendments and modifications to any rule promulgated pursuant to this article and not exempt from the provisions of article three, chapter twenty-nine-a of this code may be implemented by emergency rule;

(2) Hold public hearings, conduct investigations and require the filing of information relating to matters affecting the costs of health care services subject to the provisions of this article and may subpoena witnesses, papers, records, documents and all other data in connection therewith. The board may administer oaths or affirmations in any hearing or investigation;

(3) Apply for, receive and accept gifts, payments and other funds and advances from the United States, the state or any other governmental body, agency or agencies or from any other private or public corporation or person (with the exception of hospitals subject to the provisions of this article, or associations representing them, doing business in the state of West Virginia, except in accordance with subsection (c) of this section), and enter into agreements with respect thereto, including the undertaking of studies, plans, demonstrations or projects. Any such gifts or payments that may be received or any such agreements that may be entered into shall be used or formulated only so as to pursue legitimate, lawful purposes of the board, and shall in no respect

inure to the private benefit of a board member, staff member, donor or contracting party;

(4) Lease, rent, acquire, purchase, own, hold, construct, equip, maintain, operate, sell, encumber and assign rights or dispose of any property, real or personal, consistent with the objectives of the board as set forth in this article: Provided, That such acquisition or purchase of real property or construction of facilities shall be consistent with planning by the state building commissioner and subject to the approval of the Legislature;

(5) Contract and be contracted with and execute all instruments necessary or convenient in carrying out the board's functions and duties; and

(6) Exercise, subject to limitations or restrictions herein imposed, all other powers which are reasonably necessary or essential to effect the express objectives and purposes of this article.

(b) The board shall annually prepare a budget for the next fiscal year for submission to the governor and the Legislature which shall include all sums necessary to support the activities of the board and its staff.

(c) Each hospital subject to the provisions of this article shall be assessed by the board on a pro rata basis using the gross revenues of each hospital as reported under the authority of section eighteen [§ 16-29B-18] of this article as the measure of the hospital's obligation. The amount of such fee shall be determined by the board except that in no case shall the hospital's obligation exceed one tenth of one percent of its gross revenue. Such fees shall be paid on or before the first day of July in each year and shall be paid into the state treasury and kept as a special revolving fund designated "health care cost review fund", with the moneys in such fund being expendable after appropriation by the Legislature for purposes consistent with this article. Any balance remaining in said fund at the end of any fiscal year shall not revert to the treasury, but shall remain in said fund and such moneys shall be expendable after appropriation by the Legislature in ensuing fiscal years.

(d) Each hospital's assessment shall be treated as an allowable expense by the board.

(e) The board is empowered to withhold rate approvals, certificates of need and rural health system loans and grants if any such fees remain unpaid, unless exempted under subsection (g), section four [§ 16-2D-4(g)], article two-d of this chapter. (1983, c. 102; 1991, c. 78; 1997, c. 102.)

**Effect of amendment of 1997.** — The amendment, in (a)(1), deleted "and regulations" following "rules"; in (a)(2), in the first sentence, substituted "health care services" for "services in hospitals"; deleted former (d), pertaining to the board's assessment of hospitals prior to July 1, 1984, and redesignated the remaining subsections accordingly; and, in (e), inserted "certificates of need and rural health system loans and grants" following "approvals," and added "unless exempted under subsection (g), section four, article two-d of this chapter" to the end, and made a punctuation change.

**Power to discipline attorneys.** — While an administrative agency does have the power to adopt rules of procedure for those appearing before it, it does not have the power to discipline attorneys. The exclusive authority to define, regulate and control the practice of law in West Virginia is vested in the supreme court of appeals. Christie v. West Virginia Health Care Cost Review Auth., 176 W. Va. 420, 345 S.E.2d 22 (1986).

(d) All reports filed under any provisions of this article, except personal medical information personally identifiable to a purchaser and any tax return, shall be open to public inspection and shall be available for examination at the offices of the board during regular business hours.

(e) Whenever a further investigation is deemed necessary or desirable to verify the accuracy of any information set forth in any statement, schedule or report filed by a health care provider or related organization under the provisions of this section, the board may require a full or partial audit of the records of the health care provider or related organization. (1983, c. 102; 1991, c. 78; 1997, c. 102.)

**Effect of amendment of 1997.** — The amendment, in (a), substituted "health care provider" for "hospital," and inserted "and article five-f of this chapter" and "reports required by such article five-f"; and, in (e), substituted "health care provider" for "hospital" twice.

**Editor's notes.** — Acts 1991, c. 78 became effective March 6, 1991.

## § 16-29B-19. Rate-setting powers generally.

(a) The board shall have power: (1) To initiate reviews and investigations of hospital rates and establish and approve such rates; (2) to initiate reviews and investigations of hospital rates for specific services and the component factors which determine such rates; (3) to initiate reviews and investigations of hospital budgets and the specific components of such budgets; and (4) to approve or disapprove hospital rates and budgets taking into consideration the criteria set forth in section twenty [§ 16-29B-20] of this article.

(b) In the interest of promoting the most efficient and effective use of hospital service, the board may adopt and approve alternative methods of rate determination. The board may also adopt methods of charges and payments of an experimental nature which are in the public interest and consistent with the purpose of this article.

(c) The board shall examine the need for an alternative to the current rate-setting method as a means of controlling hospital costs and submit the findings, recommendations and any proposed drafts of legislation, if necessary, in a report to the legislative oversight commission on health and human resources accountability and the governor on or before the first day of August, one thousand nine hundred ninety-eight. (1983, c. 102; 1987, c. 61; 1997, c. 102.)

**Effect of amendment of 1997.** — The amendment added (c).

## § 16-29B-19a. Additional legislative directives; studies, findings and recommendations.

(a) The Legislature finds and declares that changing market forces require periodic changes in the regulatory structure for health care providers and hereby directs the board to study the following:

(1) The certificate of need program, including the effect of any changes on managed care and access for uninsured and rural consumers; determining

which services or capital expenditures should be exempt and why; and the status of similar programs in other states;

(2) The hospital rate-setting methodology, including the need for hospital rate-setting and the development of alternatives to the cost-based reimbursement methodology;

(3) Managed care markets, including the need for regulatory programs in managed care markets; and

(4) Barriers or obstacles, if any, presented by the certificate of need program or standards in the state health plan to health care providers' need to reduce excess capacity, restructure services and integrate the delivery of services.

(b) The board may form task forces to assist it in addressing these issues and it shall prepare a report on its findings and recommendations, which is to be filed with the governor, the president of the Senate and the speaker of the House of Delegates on or before the first day of October, one thousand nine hundred ninety-eight, identifying each problem and recommendation with specificity and the effect of each recommendation on cost, access and quality of care. The task forces, if formed, shall be composed of representatives of consumers, businesses, providers, payors and state agencies.

(c) The board shall report quarterly to the legislative oversight commission on health and human resources accountability regarding the appointment, direction and progress of the studies. (1991, c. 78; 1997, c. 102.)

**Effect of amendment of 1997.** — The amendment rewrote the section.

## § 16-29B-20. Rate determination.

(a) Upon commencement of review activities, no rates may be approved by the board nor payment be made for services provided by hospitals under the jurisdiction of the board by any purchaser or third-party payor to or on behalf of any purchaser or class of purchasers unless:

(1) The costs of the hospital's services are reasonably related to the services provided and the rates are reasonably related to the costs;

(2) The rates are equitably established among all purchasers or classes of purchasers within a hospital without discrimination unless federal or state statutes or rules and regulations conflict with this requirement. On and after the effective date of this section, a summary of every proposed contract, or amendment to any existing contract, for the payment of patient care services between a purchaser or third-party payor and a hospital shall be filed by the hospital for review by the board, which reviews shall occur no less frequently than each calendar quarter: (A) If the contract establishes a discount to the purchaser or third-party payor, it shall not take effect until approved by the board. For purposes of this article, a risk-bearing contract is reviewable as a discount contract and the amount computed as the discount percentage by the provider on the board shall be the approved amount of the discount. The difference, if any, between the actual discount percentage and amount and the approved amount, shall not be considered for rate-setting purposes; (B) the board may promulgate rules, in accordance with the provisions of section eight

[§ 16-29B-8] of this article, that establish the criteria for review of discount contracts, which shall include that: (i) No discount shall be approved by the board which constitutes an amount below the cost to the hospital; (ii) the cost of any discount contained in the contract will not be shifted to any other purchaser or third-party payor; (iii) 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 (iv) the discount is based upon criteria which constitutes a quantifiable economic benefit to the hospital. The board may define by rule what constitutes "cost" in subparagraphs (i) and (ii) of this paragraph; "purchaser" in subparagraph (iii) of this paragraph; and "economic benefit" in subparagraph (iv) of this paragraph. Any rules promulgated pursuant to this subsection may be filed as emergency rules. All information submitted to the board shall be certified by the hospital's chief executive officer and chief financial officer as to its accuracy and truthfulness;

(3) The rates of payment for medicaid are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated hospitals subject to the provisions of this article. The rates shall take into account the situation of hospitals which serve disproportionate numbers of low income patients and assure that individuals eligible for medicaid have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality;

(4) The rates are equitable in comparison to prevailing rates for similar services in similar hospitals as determined by the board; and

(5) In no event shall a hospital's receipt of emergency disaster funds from the federal government be included in the hospital's gross revenues for either rate-setting or assessment purposes.

(b) In the interest of promoting efficient and appropriate utilization of hospital services, the board shall review and make findings on the appropriateness of projected gross revenues for a hospital as the revenues relate to charges for services and anticipated incidence of service.

(c) When applying the criteria set forth in subsections (a) and (b) of this section, the board shall consider all relevant factors, including, but not limited to, the following: The economic factors in the hospital's area; the hospital's efforts to share services; the hospital's efforts to employ less costly alternatives for delivering substantially similar services or producing substantially similar or better results in terms of the health status of those served; the efficiency of the hospital as to cost and delivery of health care; the quality of care; occupancy level; a fair return on invested capital, not otherwise compensated for; whether the hospital is operated for profit or not for profit; costs of education; and income from any investments and assets not associated with patient care, including, but not limited to, parking garages, residences, office buildings, and income from related organizations and restricted funds whether or not associated with patient care.

(d) Wages, salaries and benefits paid to or on behalf of nonsupervisory employees of hospitals subject to this article are not subject to review unless the board first determines that the wages, salaries and benefits may be

unreasonably or uncustomarily high or low. This exemption does not apply to accounting and reporting requirements contained in this article, nor to any that may be established by the board. The term "nonsupervisory personnel", for the purposes of this section, means, but is not limited to, employees of hospitals subject to the provisions of this article who are paid on an hourly basis.

(e) Reimbursement of capital and operating costs for new services and capital projects subject to article two-d [§ 16-2D-1 et seq.] of this chapter shall not be allowed by the board if the costs were incurred subsequent to the eighth day of July, one thousand nine hundred seventy-seven, unless they were exempt from review or approved: (i) By the state health planning and development agency prior to the first day of July, one thousand nine hundred eighty-four; or (ii) thereafter, pursuant to the provisions of article two-d of this chapter.

(f) The board shall consult with relevant licensing agencies and may require them to provide written findings with regard to their statutory functions and information obtained by them in the pursuit of those functions. Any licensing agency empowered to suggest or mandate changes in buildings or operations of hospitals shall give notice to the board together with any findings.

(g) A hospital shall file a complete rate application with the board on an annual basis a minimum of seventy-five days prior to the beginning of its fiscal year. If the application is filed and determined to be complete by the board sixty days prior to the beginning of the hospital's fiscal year, and no hearing is requested on the application, the board shall set the rates in advance of the year during which they apply and shall not adjust the rates for costs actually incurred: Provided, That if the board does not establish rates by the beginning of the hospital's fiscal year, and a hearing has not been requested, the board shall establish rates retroactively to the beginning of the hospital's fiscal year: Provided, however, That if the board does not establish rates by the beginning of the hospital's fiscal year, and a hearing has been requested, the board may establish rates retroactively to the beginning of the fiscal year. This subsection shall not apply to the procedure set forth in subsection (c), section twenty-one [§ 16-29B-21(c)] of this article.

(h) No hospital may charge for services at rates in excess of those established in accordance with the requirements of and procedures set forth in this article.

(i) Notwithstanding any other provision of this article, the board shall approve all requests for rate increases by hospitals which are licensed for one hundred beds or less and which are not located in a standard metropolitan statistical area where the rate of increase is equal to or less than the lowest rate of inflation as established by a recognized inflation index for either the national or regional hospital industry. The board may, by rule, impose reporting requirements to ensure that a hospital does not exceed the rate of increases permitted in this section.

(j) Notwithstanding any other provision of this article, the board shall develop an expedited review process applicable to all hospitals licensed for more than one hundred beds or that are located in a standard metropolitan

statistical area for rate increase requests which may be based upon a recognized inflation index for the national or regional hospital industry.

(k) The board may require hospitals to file such additional information as it deems necessary to evaluate a market-driven system of rate setting. (1983, c. 102; 1987, c. 61; 1989, c. 87; 1991, c. 78; 1996, c. 138; 1997, c. 102.)

**Effect of amendment of 1996.** — The amendment inserted "rules and" preceding "regulations" in (a)(2); in (c), substituted "associated with patient care" for "so associated"; and made other stylistic changes.

**Effect of amendment of 1997.** — The amendment, in (a)(2), in the second sentence, inserted "or amendment to any existing contract" and deleted "with its rate application" near the beginning, and rewrote the last three sentences; in (b), deleted the second sentence; in (g), substituted "seventy-five" for "sixty" in the first sentence; deleted former (h), pertaining to the prospective nature of the board's determinations, orders and decisions, and redesignated the remaining subsections accordingly; and added (k).

**Editor's notes.** — This section, as amended by Acts 1991, c. 78, became effective March 6, 1991.

Concerning the reference in (a)(2) to "the effective date of this section." Acts 1991, c. 78, which added this language, became effective March 6, 1991. Acts 1996, c. 138, which amended and reenacted this section, passed March 9, 1996, and became effective 90 days from passage. Acts 1997, c. 102, which amended and reenacted this section, passed April 12, 1997, and became effective 90 days from passage.

## § 16-29B-21. Procedure for obtaining initial rate schedule; adjustments and revisions of rate schedules.

(a) No hospital subject to this article may change or amend its schedule of rates except in accordance with the following procedures:

(1) Any request for a change in rate schedules or other changes must be filed in writing to the board with such supporting data as the hospital seeking to change its rates considers appropriate, in the form prescribed by the board. Upon receipt of notice, the board, if it considers necessary, may hold a public hearing on the proposed change. Such hearing shall be held no later than forty-five days after receipt of the notice. The review of the proposed change may not exceed an overall period of one hundred eighty days from the date of filing to the date of the board's order. If the board fails to complete its review of the proposed change within the time period specified for the review, the proposed change shall be deemed to have been approved by the board. Any proposed change shall go into effect upon the date specified in the order. The review period is complete upon the date of the board's final order notwithstanding an appeal of the order to the agency of the state designated by the governor, a circuit court, or the supreme court of appeals by an affected party;

(2) Each hospital shall establish, in a written report which shall be incorporated into each proposed rate application, that it has thoroughly investigated and considered:

(A) The economic and social impact of any proposed rate increase, or service decrease, on hospital cost containment and upon health care purchasers, including classes of purchasers, such as the elderly and low and fixed income persons;

(B) State-of-the-art advances in health care cost containment, hospital management and rate design, as alternatives to or in mitigation of any rate increase, or service decrease, which report shall describe the state-of-the-art