STATE OF WEST VIRGINIA

PRELIMINARY PERFORMANCE REVIEW OF THE

HEALTH CARE COST REVIEW AUTHORITY

HCCRA is Controlling Costs

Audit Division is Not Staffed

Overcharging Hospitals for Services

Advisory Council Never Appointed

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July 10, 1996

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Gentlemen:

Pursuant to the West Virginia Sunset Law, we are transmitting the Preliminary Performance Review of the Health Care Cost Review Authority, which will be reported to the Joint Committee on Government Operations on Sunday, July 14, 1996. The issues covered herein are "HCCRA is Controlling Costs; Audit Division is not Staffed; Overcharging Hospitals for Services; and Advisory Council Never Appointed."

Sincerely,

Antonio E. Jones

AEJ/wsc

Enclosure

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Executive Summary

The Health Care Cost Review Authority (HCCRA) was created in 1983 to be an autonomous agency within the Department of Health and Human Resources. The purpose of HCCRA's creation is to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate acute care hospital services.

The Performance Evaluation and Research Division (PERD) examined four issue areas in this preliminary performance review of HCCRA which include 1) savings and avoidance of health care costs, 2) the audit division not being staffed, and 3) surplus funds within HCCRA's budget, and 4) the HCCRA advisory council has not been appointed.

ISSUE AREA 1: HCCRA is Controlling Hospital Rate Increases in West Virginia.

HCCRA has authority to approve rate increase requests by the hospital industry and any Certificate of Need requests. Since Fiscal Year 1987, HCCRA has allowed increases of 5.6% versus the hospital industry's requested increases of 8.0%. These figures have provided a savings of 2.4% for the comparison period. The agency denied $45,228,545 in Certificate of Need requests, which are new institutional health services, during the calendar years of 1991 - 1995.

West Virginia ranks among the top five states with the lowest average annual growth of medical expenses from 1980 - 1991. West Virginia ranks 46th out of the 50 states with 8.9% total average annual growth. Also, the state is below the national average in median net hospital discharge costs. In 1993, which was the most recent year for the figures provided, the national average was $4,925 compared to West Virginia which was $4,352. PERD was unable to determine whether HCCRA's actions were responsible for West Virginia's lower rates, but the data appears to demonstrate the possible effectiveness of the agency.

ISSUE AREA 2: HCCRA has Not Staffed Its Audit Division.

The Authority received funding from the Legislature for fiscal year 1996 to create an Audit Division. Over eight months have passed and only an office assistant has been hired. Positions for four auditors and one director are still not filled. HCCRA asserts that none of the applicants were qualified for these positions because they lacked experience in auditing health care facilities. The auditing of hospitals is very important to determine compliance with HCCRA's orders. If compliance is not known then the risk of having hospitals charging high rates for its services is more likely to take place. The auditing of hospitals is meant to assure that HCCRA's orders are being complied with. Unless compliance is measured, hospitals will lack the incentive to comply with HCCRA's orders. HCCRA must become more aggressive in recruiting applicants and staff the Audit Division as soon as possible. HCCRA also has the resources to train auditors who may lack specific kinds of auditing experience.

ISSUE AREA 3: The Health Care Cost Review Authority Overcharges Hospitals For the Services It Provides.

Hospitals are required to pay HCCRA a yearly fee based on their gross revenues. This fee is the basis for HCCRA's funding and is currently set at .1% of these gross revenues. Hospitals also have to pay a fee when applying for a Certificate of Need from the agency. However, HCCRA is charging hospitals higher assessment fees and Certificate of Need fees than necessary to support its budget. Since FY 1993, HCCRA has charged $4,109,251.45 over its operating costs. While HCCRA attempts to prevent hospitals from overcharging patients, it is apparent that they are overcharging the hospitals, which may impact the customers.

ISSUE AREA 4: The Health Care Cost Review Council Was Never Appointed.

The Health Care Cost Review Council, a statutorily required advisory body to the board, has not been in existence since at least 1991. Since then HCCRA has replaced the advisory function of this council with the use of ad hoc committees. HCCRA has not claimed any negative effects of not having this council in place. Therefore, the council is probably no longer needed and should be sunsetted.

Review Objective, Scope and Methodology

This review of the Health Care Cost Review Authority (HCCRA) was conducted in accordance with the West Virginia Sunset Law, Chapter 4, Article 10, Section 11 of the West Virginia Code, as amended. Preliminary performance reviews are intended to assist the Joint Committee on Government Operations in making one of five recommendations. These recommendations include:

- The department, agency or board be terminated as scheduled;
- The department, agency or board be continued and reestablished;
- The department, agency or board be continued and reestablished, but the statutes governing it be amended in specific ways to correct ineffective or discriminatory practices or procedures, burdensome rules and regulations, lack of protection of the public interest, overlapping of jurisdiction with other governmental entities, unwarranted exercise of authority either in law or fact or any other deficiencies;
- A performance audit be performed on the department, agency or board on which a preliminary review has been completed; or
- The department, agency or board be continued for a period of time not to exceed one year for the purpose of completing a full performance audit.

A preliminary performance review as defined in Chapter 4, Article 10, Section 3 of the West Virginia Code, as amended, is to determine the goals and objectives of a department, agency, or board and to determine the extent to which the plan of a department, agency or board has met or is meeting those goals and objectives. The criteria for a preliminary performance review set forth in Chapter 4, Article 10, Section 11 of the West Virginia Code, as amended, enable the determination of the following:

- If the department, board or agency was created to solve a problem or provide a service;
- If the problem has been solved or the service has been provided;
- The extent to which past board or agency activities and accomplishments, current projects and operations, and planned activities and goals for the future are or have been effective;
- The extent to which there would be significant and discernible adverse effects on the public, health, safety or welfare if the board or agency were abolished; and
- Whether or not the board or agency operates in a sound fiscal manner.

This preliminary performance review of the HCCRA began with a planning process. The planning process proceeded with a risk analysis of the commission's mission in which the possible risks associated with that purpose were defined. The risk analysis included an assessment of the following components:

1. Savings and/or avoidance of health care costs.

2. The lack of staffing of the Auditing Division.

3. The surplus of funds in HCCRA's budget.

The time period covered by the preliminary review includes the years 1989 through 1995. Information about the Authority was obtained through: interviews and telephone interviews with the Authority's executive director, bordering states' equivalent agencies, the Health Care Financing Administration in Washington, D.C., and the West Virginia Hospital Association; review of relevant statutes in the *West Virginia Code*; review of relevant legislative rules; and review of various documents provided by the Authority.

MISSION OF THE HEALTH CARE COST REVIEW AUTHORITY

The Health Care Cost Review Authority was created by Chapter 102 of the 1983 Acts of the Legislature. The Authority is currently governed by Chapter 16, Article 29B of the West Virginia Code, as amended. The Authority is an autonomous agency within the Department of Health and Human Resources and is responsible for enforcing Chapter 16, Article 2D pertaining to Certificate of Need and Chapter 16, Article 5F pertaining to Health Care Disclosure. The Authority's mission is to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate acute care hospital services (WVC §16-29B-1).

The Authority is led by a three member board of directors. The board is advised by a 13 member Health Care Cost Review Council. Members of both the board and the council are appointed by the governor, with the exception of the five government members of the council, and must meet various qualifications as to partisanship and professional background.

The administrative portion of HCCRA provides legal, financial and support services. The rest of the Authority is led by an executive director who oversees the agency's various divisions. These divisions and their duties are as follows:

- Certificate of Need Division - Regulates capital expenditures on new health care facilities or services.
- Rate Review Division - Reviews hospital rates for excessive charges.
- Research, Development and Data Division - In charge of constructing and maintaining all database functions of the agency.
- Planning Unit - Responsible for updating the State Health Plan. This division was created in July 1995 and is partially staffed. It currently has a director and a health and human resource specialist and has vacancies for a data analyst and an office assistant.
- Audit Unit - Responsible for conducting full hospital audits and monitoring the repayment of overages. This Division was created in July 1995 and is not yet staffed except for one office assistant. (See Issue 2, page 13).

ISSUE AREA 1: HCCRA is Controlling Hospital Rate Increases in West Virginia.

In order for hospitals to increase the rates of services provided, they must first obtain approval from the Health Care Cost Review Authority (HCCRA). Documents analyzed by the Performance Evaluation and Research Division indicate that, due to this requirement, hospital costs in West Virginia are below the national average.

Table 1 below presents the increases requested by hospitals from 1987 through 1994. On the average during this period HCCRA has allowed an increase of 5.6%. The increases requested by various hospital organizations throughout the state were 8.0%. The highest increase allowed was in 1989 when the industry requested an 11.7% increase, and allowed a 10.7% increase. The lowest increase request occurred in 1992 when the industry requested a 4.9% increase and only received an increase of 0.7%.

Table 1
Comparison of Requested Increases and Increases Allowed

Fiscal Year	Difference Between Revenue Requested and Allowed	Requested Percentage Increase	Allowed Percentage Increase	Percentage Savings
1987	$8,268,478	8.2%	5.8%	2.4%
1988	$1,053,508	9.7%	9.5%	.2%
1989	$4,975,627	11.7%	10.7%	1%
1990	$7,863,092	8.3%	6.8%	1.5%
1991	$5,612,867	7.2%	6.3%	.9%
1992	$20,504,916	4.9%	0.7%	4.2%
1993	$8,783,276	7.6%	4.8%	2.8%
1994	$27,020,960	6.4%	-0.4%	6.8%
Totals	$84,082,724	8.0%	5.6%	2.4%

Certificate of Need

In addition to reviewing hospital rate increase requests, HCCRA also must approve Certificate of Need requests which are new institutional health services. New institutional health services include:

1. The construction, development, acquisition or other establishment of a new health

care facility or health maintenance organization;

2. The partial or total closure of a health care facility or health maintenance organization with which a capital expenditure is associated;

3. Any obligation for a capital expenditure incurred by or on behalf of a health care facility.

HCCRA, from calendar years 1991 through 1995, denied a total of $45,228,545, while approving $333,699,512 in Certificate of Need requests. The denials during this time period were approximately 12% of the amounts requested by the hospital industry for new institution health services. The amount denied could be considered a possible savings for the citizens of West Virginia in that rates could have possibly been raised to compensate for funding of these new services. Table 2 below displays the totals denied from 1991 through 1995.

Table 2
Certificate of Need Capital Expenditure Summary (1991 - 1995)

	1991 Denied	1992 Denied	1993 Denied	1994 Denied	1995 Denied	Totals Denied
Totals	$16,156,300	$7,074,500	$13,369,104	$6,601,812	$2,026,829	$45,228,545

State Comparisons

According to figures provided by the Council of State Governments, West Virginia is ranked 46th out of the 50 states in total average annual growth for hospital care, physician services, and prescription drug purchases between the years of 1980 - 1991. **PERD was unable to determine whether this is due to the actions of HCCRA,** but the data appears to demonstrate the possible effectiveness of the agency. West Virginia's total average annual growth for that period was 8.9%. As shown in Table 3 below, annual hospital growth in WV was 8.4%; average physician services 9.6%; and average prescription charges 10%. [1] In comparison, New Hampshire was the highest with an increase in hospital care of 12.4%; physician services 15.7%; prescription drugs 12.8%; and a total average annual growth of 13.4% for the period. Table 4 displays the top five states with the highest annual average growth.

[1] A survey of the five bordering states was conducted and no agency was found to be easily comparable to HCCRA, however, there are simularities among these agencies.

Table 3
Top Five States with Lowest Average Annual Growth (1980-1991)

State	Hospital Care	Physician Services	Prescription Drugs	Total
Illinois	7.5%	9.4%	10.7%	8.2%
Michigan	8.2%	8.7%	10.5%	8.6%
Wyoming	9.4%	8.2%	7.2%	8.9%
Iowa	8.7%	9.3%	9.0%	8.9%
West Virginia	8.4%	9.6%	10.0%	8.9%

Note HCCRA has no control over Physician Services or Prescription Drugs (§16-29b-10). Its control of Hospital Care may, however, have an indirect effect on these areas.

Table 4
Top Five States with Highest Average Annual Growth (1980-1991)

State	Hospital Care	Physician Services	Prescription Drugs	Total
New Hampshire	12.4	15.7	12.8	13.4
Florida	12.0	13.3	12.5	12.5
Georgia	12.2	13.3	11.5	12.5
Nevada	10.8	14.7	12.6	12.4
South Carolina	12.7	12.4	10.9	12.4

According to the annual report "Health Care Industry Trends" for hospitals published by the Virginia Health Services Cost Review Council and the David G. Williamson Institute for Health Studies, Virginia Commonwealth University, the median net hospital discharge costs for West Virginia from 1989 through 1993 were lower than the national average. In 1993, West Virginia's discharge costs were lower by almost $600 than the national figures. While overall costs may be lower, in 1991 and 1993 the median net hospital charge in West Virginia increased dramatically by 29.2 and 14.6 percent respectively. Costs did go down in 1992 by 8.8%. The data is displayed in Table 5. In 1989, the average median net hospital discharge costs in West Virginia were $3,084, and increased a total of 41% by 1993 to $4,352. Nationally, the average was $3,743 and increased by only 32% to $4,925 by 1993. This shows that HCCRA may be

effective in maintaining some overall costs at lower levels.

Table 5
Comparison with National Average of Median Net Hospital Discharge (1989-1993)

	1989 Median	1990 Median	1991 Median	1992 Median	1993 Median
National	$3,743	$4,097 +9.5%	$4,489 +9.6%	$4,729 +5.3%	$4,925 +4.1%
West Virginia	$3,084	$3,222 +4.5%	$4,163 +29.2%	$3,797 -8.8%	$4,352 +14.6%

Recommendation 1

HCCRA should continue to review hospital rate increase requests and attempt to keep West Virginia health care costs below the national average.

ISSUE AREA 2: HCCRA Has Not Staffed Its Audit Division.

It is within the power of HCCRA, through §16-29B-18 of the *West Virginia Code,* to audit hospitals within the state in order to determine that they are in compliance with state law. In the past, HCCRA carried out its auditing functions by requiring hospitals to contract with qualified accounting firms to conduct the audits to determine compliance with HCCRA's orders. These audits dealt only with the monitoring of the repayment of overages. Over time these firms began working for the hospitals. Now, HCCRA asserts that all qualified accounting firms that do business in the state have existing contractual relationships or are seeking such relationships with hospitals and thus have potential conflicts of interest. This has caused HCCRA to have difficulty in getting hospitals to contract with qualified accounting firms that are not already affiliated with hospitals in some way.

It should be noted that HCCRA has not ceased auditing hospitals while in the process of trying to staff its Audit Division. Six audits have been completed since July 1, 1995, with three soon to be completed. The accounting firms doing these audits have begun working for hospitals in the state and can no longer do audits on behalf of HCCRA due to a conflict of interest.

To combat this problem, HCCRA created its own Audit Division to do the audit function. In addition to monitoring the repayment of overages, the Audit Division will also conduct full hospital audits. The 1995 Legislature provided funds for six new audit positions. Those positions include a supervisor, two audit teams consisting of two members each and one support staff member for a total of six positions.[2] This funding went into effect July 1, 1995. Eight months later the Audit Division remains unstaffed except for the one support staff position.

HCCRA's explanation for not staffing the Audit Division is that it is unable to find qualified individuals to fill these positions; Interviews were conducted in August and September of 1995 for these positions. Although it interviewed approximately thirty applicants, none were sufficiently qualified in auditing and/or health care experience.

HCCRA is still in the process of recruiting for these positions; their plan is to hire the director first. The Authority is looking for CPA's with broad based auditing experience and experience auditing health care facilities. The Authority will train the director, organize the office's function, and develop an audit guide for the division prior to hiring the remaining staff. The Authority hopes to have this division fully staffed within the next few months.

HCCRA has had eight to nine months to staff the auditing office. HCCRA states that the applicants for the auditing positions (Auditor II) as well as that of the director (Auditor III) were not qualified. These positions are non-exempt positions and therefore must go through the classification process exercised by the Division of Personnel. Applicants for civil service positions must meet strict qualifications as to education and work experience as prescribed by

[2] HCCRA's planed salaries for these positions are: $35,000 for the Director and $25,000 for the Auditor positions. A phone survey of local auditing firms indicated that salaries for comparable privated sector jobs were: $45,000 to $60,000 for a director and $25,000 to $35,000 for staff auditors.

the Division of Personnel. Therefore, applicants who meet the qualifications for Auditor II and Auditor III should be capable of doing the level of auditing tasks that HCCRA needs. Presently, there are seven people on the roster for Auditor II in Kanawha County and 29 persons on the roster statewide for Auditor III.

Therefore, HCCRA's claim that the applicants do not meet the qualifications for these positions is not supported. They have met the qualifications for these positions set by the Division of Personnel. It is also not mandatory that these applicants have extensive auditing experience with health care facilities. HCCRA has stated that it will train a new director, and new auditors could also be trained by HCCRA.[3]

CONCLUSION

The auditing of hospitals to monitor compliance is a key part in the duties of HCCRA. Without this function taking place it is unable to determine if hospitals are in compliance of their orders. An effect of this inability to conduct audits would be that health care recipients may be paying too much for services since HCCRA would have no way of identifying and stopping the charging to patients of excessive rates for health care services. If HCCRA is not satisfied with the quality of the applicants for these positions, it needs to become more aggressive in its recruiting efforts and provide internal training.

***Recommendation* 2**

HCCRA should complete its staffing of the Auditing Division as soon as possible. The Authority should use the resources it has to train the recipients of these positions in order to compensate for any deficiencies they may have in the area of auditing health care facilities.

[3] HCCRA has skilled training resources in its Chief Financial Officer who is well known to have a great deal of experience in auditing health care facilities and its Executive Director who was at one time a hospital administrator just to name a few. If HCCRA wishes not to train in-house, it has sufficient funds in its budget that could be used to pay for training for its auditors at an outside professional development institution or similar facility.

ISSUE AREA 3: The Health Care Cost Review Authority Overcharges Hospitals For the Services It Provides.

The Health Care Cost Review Authority (HCCRA) is charged with protecting the health and well being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate acute care hospital services. In order to accomplish this goal, the agency is authorized to assess hospitals for processing rate increase requests of any medical services and for Certificates of Need for new buildings or equipment. Hospitals are required to pay HCCRA a yearly fee based on their gross revenues. This fee is the basis for HCCRA's funding and is currently set at .1% of these gross revenues.[4] Hospitals also have to pay a fee when applying for a Certificate of Need from the agency. However, HCCRA is charging hospitals higher assessment fees and Certificate of Need fees than necessary to support its budget. In fact, the agency has assessed hospitals over a million dollars more each fiscal year for the last three fiscal years than what was needed to operate the agency.

Agency Costs

A review of HCCRA's revenues and expenditures for FY 93, 94 and 95 revealed that revenues from hospital assessments and Certificate of Need applications greatly exceed expenditures. Table 6 below demonstrates how this overcharging has allowed the agency to accumulate excess funds of over $4 million.

Table 6
HCCRA Appropriations and Expenditures (FY 1993 - 1995)

Fiscal Year	Hospital Assessment	Appropriation	Expenditures	CON Applications	Appropriation	Expenditures
1993	$2,864,329	$2,528,987	$1,491,380	$103,820	$100,000	$75,153
1994	$2,880,976	$2,565,580	$1,518,643	$380,225	$100,000	$66,648
1995	$2,622,739	$2,624,332	$1,814,332	$322,031	$160,000	$98,713

[4] This rate of .1% of a hospital's gross revenues is the maximum limit allowed by law.

HCCRA assesses each hospital on a pro rata basis using the gross revenues of each hospital as the measure of the hospital's obligation. The amount of the fee is determined by the board and cannot exceed one tenth of one percent of the gross revenue of the hospital assessed. According to the Executive Director, the surplus occurred due to a variety of reasons. He listed the following:

> ***-The amount assessed hospitals exceeded the appropriation each year.***
> ***-HCCRA has requested and received essentially the same appropriation the last four years.***
> ***-Plans to expend funds are not implemented for a variety of reasons.***
> ***-HCCRA sought to build a computer capability and a "uniform report-rate setting" database and supporting system which did not occur in 1991,1992, and 1993 as expected.***
> ***-Outgoing chairman was reluctant to commit to purchases of expanded systems development or fill vacancies.***

Board members of HCCRA are full time employees and should be aware of the amount of the funds in these accounts. The Board never reduced the rate charged to hospitals giving the appearance that the growth of the account was intentional. Similar appropriations were requested the last three years which greatly exceeded the operating funds utilized by HCCRA. Table 7 documents the actual amount the agency over budgeted for the last three fiscal years.

Table 7
Total Amounts Over Operating Costs (FY 1993 - 1995)

Fiscal Year	Amount Over Operating Costs Account 5375	Amount Over Operating Costs Account 5376	Total Over Operating Costs
93	$1,372,949	$28,666	$1,401,616
94	$1,362,333	$313,576	$1,675,909
95	$808,406	$223,318	$1,031,725
Totals	$3,543,688	$565,560	$4,109,250

Note: These years only document $4,109,251. Prior to the 1996 Legislative Session the balances for these accounts were $7,353,427 for account 5375 and $716,808 for account 5376. Funds amounting to $5,752,610 were reappropriated by the Legislature: $3,500,000 to DHHR for the Colin Anderson Center, $150,000 to the Commission on Aging, $114,400 to the Aeronautics Commission, $200,000 to Shepherd College and $1,788,200 to HCCRA for the Rual Health Systems Transition Program.

Conclusion

HCCRA attempts to prevent hospitals from overcharging patients; however, it is apparent that HCCRA is overcharging its hospitals. The agency was unable to provide minutes of

meetings or votes regarding the utilization of excess funds. The impact of the overcharge is that hospitals must pass the costs to customers. Part of doing business is preparing and proposing rate increases and certificates of need.

Recommendation 3:

HCCRA should reduce the rate it charges hospitals to bring the amount of funds in line with the agency's expenditures.

ISSUE AREA 4: The Health Care Cost Review Council Was Never Appointed.

HCCRA is required to have in place the Health Care Cost Review Council under §16-29B-6 of the *West Virginia Code*. This body is to act as an advisory council to the board. The council is made up of 13 members. Five of the members are to be the Secretary of the Department of Health and Human Resources, the Workers' Compensation Commissioner or the successor to his or her duties and responsibilities, the Director of the Public Employees Insurance Agency, the Commissioner of Insurance, and the Director of the Division of Vocational Rehabilitation, or their respective designated representatives. Eight members are to be nongovernment members, appointed by the Governor, with the advice and consent of the Senate. These nongovernment members must meet various membership criteria. The council is required to meet at least four times during a calendar year. The council must submit an annual report to the board, the Governor and the Legislature.

Since the statutes for HCCRA were amended in 1991, the council has never met and none of the nongovernment members have been appointed by the Governor. This council was designed as a mechanism to enhance coordination among various state agencies in the control of health care costs. The council was created to serve as an advisory body to the board and perform the following duties: (1) Develop health care cost containment policy, strategies and methods; (2) Review policies and make recommendations on such policy, strategies and methods as well as state-of-the-art concepts in health care policy at the national, state and local level and their application to the deliberations of the board; (3) Serve as a conduit for the collection and transmission of information to the board regarding the consequences of board policy upon health care cost containment and upon hospitals that are subject to regulations of HCCRA.; (4) Serve as a means of coordinating health care cost containment policy among agencies of state government; and (5) Review decisions of the board and make public comments on such decisions as it sees fit.

In the absence of this council, HCCRA has solicited the input from ad hoc committees to assist it in creating health care cost control policy. Examples of such ad hoc committees include the Cost-Based Rate-Review Task Force, Subacute Care Task Force, Working Group on PET Standards, and the Work Group for Behavioral Health Standards. The membership of these committees come from health care providers, trade associations, consumers, payors, other state agencies, and the Legislature. HCCRA believes that these ad hoc committees have been just as effective as the council would have been. In addition to the ad hoc committees, HCCRA is part of the Governor's Intergovernmental Health Committee which is set up to coordinate state agencies in the area of health care issues and meets on a monthly basis.

CONCLUSION

Although mandated by §16-29b-6 of the West Virginia Code, the Health Care Cost Review Council has never been appointed. This is in direct conflict with the wishes of the Legislature. The council could be a mechanism to enhance coordination among the state agencies that are involved in the control of health care costs in some form. However, it should

be noted that in the absence the council, HCCRA's ad hoc committees were created to provide input on specific subject matter within the area of health care cost control.
Recommendation 4:

The Legislature should consider repealing §16-29B-6 of the West Virginia Code thus sunsetting the Health Care Cost Review Council.

APPENDIX A

Gaston Caperton
Governor

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

HEALTH CARE COST REVIEW AUTHORITY

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May 8, 1996

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Dear Dr. Jones:

We first wish to compliment and thank you and your staff for the thorough and fair evaluation of the Health Care Cost Review Authority. Likewise we appreciate the opportunity to review and offer for your consideration a few potential adjustments.

EXECUTIVE SUMMARY ISSUE AREA 1: HCCRA is controlling Hospital Rate Increases in West Virginia.

In the Executive Summary, last sentence in the first paragraph of Issue Area 1 on page 3, an apparent typographical error causes a gross understatement of the potential cost of certificate of need applications which have been denied by the HCCRA. The draft reflects $45,228.54 in denials when the actual figure was $45,228,545, as you correctly noted in the final paragraph of Table 1 on page 10 of the draft.

It also may be appropriate to include in the section that the deterrent effect of the review process, despite an inability to quantify, does result in questionable projects not being initiated that otherwise may have been. The associated cost avoidance probably far exceeds the potential cost of denied applications.

MISSION OF THE HEALTH CARE COST REVIEW AUTHORITY

On page 7 of the draft, in the first paragraph, you may want to include two other responsibilities the Legislature has given the HCCRA in the past year. In 1995 the State Health Planning responsibility was added *[WV Code §16-2D-5 (b)(l) and (m)]* and, in 1996, responsibility was added to administer a rural health system transition program of technical

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assistance, loans and grants *[WV Code §16-2D-5(n)]*. (Health planning responsibility is mentioned in the bullets at the bottom of page 7).

ISSUE AREA 1: HCCRA is controlling Hospital Rate Increases in West Virginia.

At the bottom of page 9 and on the top of page 10, it may be significant to note that certificate of need encompasses all health care providers, except private practitioners. Also the description of a "new institutional health service" goes well beyond the three points noted in the draft under 1, 2, and 3 on page 10. The statute includes six other matters that constitute health services under sections (d), (e), (f), (g), (h), and (i) of WV Code §16-2D-3 and are consequently subject to certificate of need review. A copy of the relevant pages of the statute are enclosed and the referenced sections highlighted for your convenience.

ISSUE AREA 2: HCCRA Cannot Determine Compliance with its Rate Decisions.

Issue Area 2 on page 13 of the draft deals with the HCCRA inability, to this point, to recruit an audit staff. The following is submitted for your consideration as a clarification both of the role of the Audit Division and the reason for our high expectations for candidates for the auditor positions. We do agree with the conclusions you have reached for Issue 2.

Although the audit function would be an important addition to the HCCRA, it is not absolutely essential to determine if hospitals are in compliance of HCCRA orders. There are a number of ways that the HCCRA uses to determine an individual hospital's compliance with its orders. Among them are the annual financial audit prepared by the hospital's independent auditing firm; the annual uniform financial report prepared for the HCCRA; the annual Medicare cost report prepared for the Health Care Finance Administration and submitted through an intermediary, which in our case is Trigon Blue Cross of Virginia.

When HCCRA establishes the per discharge rate for an acute care hospital, it requires the hospital to file a revised budget and a revised schedule of rates (called the charge master), which lists every price the hospital will charge. These two items are required to be filed within 20 days of receipt of the rate order.

In addition to the items mentioned above, the hospital is also required to file a Monitor and Variance Report each quarter. This report displays the hospital's **actual** utilization and **actual** charge per discharge and per outpatient visit. These charges are compared to the allowed charges to determine whether the hospital is in compliance with

the rate order. If the hospital is not in compliance, a letter is sent advising it of the noncompliance. In some instances these letters are followed up with phone conversations or meetings with hospital representatives so that the hospital can take the appropriate action to come into compliance with the rate order.

Another internal device we use is called an "Audit Analysis Report". In this report we accumulate the actual information from prior year Uniform Financial Reports, the budget information used by the hospital to request its rate and the projected actual information that is prepared for the hospital's "current" year. These reports are used to check the hospital's compliance with its approved rates. The "audit analyses" are prepared for the following categories:

a. Revenues
b. Contractual Allowances
c. Utilization
d. Operating Expenses and Profitability
e. Bad Debt and Charity
f. Inpatient and Outpatient Revenue

When the hospital's actual charge per discharge and/or charge per outpatient visit is greater than the allowed charge per discharge and/or the allowed charge per outpatient visit at the time of filing for a new rate increase, the requested amounts are reduced by any such overages.

Thus, the HCCRA has means of determining whether hospitals comply with rate orders but, without an audit capability, must depend on independent hospital auditors to verify financial information submitted by hospitals. That verification is particularly important in situations in which hospitals submit inconsistent and incompatible information in their applications at the beginning of the rate setting period and their uniform report after the rate setting period has ended. Also, audits to assure compliance with rebate orders require on site auditing of hospitals' actions. Such audits were prominent in carrying out the rebate orders on the Humana Hospitals you reviewed and several others we listed. Also, verification of statistical data is needed on a prompt basis since utilization is a significant factor in determining per discharge and per visit charges. Medicare audits provide such verifications, but well after HCCRA rate decisions are made.

The Performance Evaluation Division's report on the HCCRA also discusses the qualifications of Auditors to fill the positions in our Audit Division. For several reasons, one of the major concerns we have with respect to filling these positions is that we need CPA's who are familiar with the complexities of the health care industry. One of the major reasons is the work of the Audit Division will undoubtedly bring it into an adversarial

position with the provider and the hospital's auditing firm. The hospital's outside auditors will always have CPA's who are managers and/or partners in charge of the engagement, and it will be extremely difficult for non CPA's and non health care experts to argue the finer points of auditing standards and/or generally accepted accounting principals, if they are not well trained in these areas.

We recognize that we can train individuals to perform the necessary audit functions, but it takes a number of years of experience to know the generally accepted accounting principles, which have been changing rather rapidly over the last ten years, and to be able to apply those in various health care audit situations.

ISSUE AREA #3: The Health Care Cost Review Authority overcharges hospitals for the services it provides

The HCCRA, since its inception in late 1983, has been charging hospitals anywhere from .00063% to .001% of gross revenues per year. Over time the HCCRA accumulated an excess of approximately $5,800,000 which during the 1996 Legislative session was reappropriated to other state agencies.

A number of changes have taken place in the healthcare field as well as the HCCRA which will have an impact on our budget. The HCCRA has targeted two areas which we feel need to be addressed during the fiscal year ending June 30, 1997 - data collection and the assistance in the form of technical as well as financial support to small and rural communities. Legislation was passed during the 1996 session which will allow us to assist small and rural communities to help shape the future of the provision of healthcare in those communities. We have budgeted significant resources and monies to help the large number of providers who will need assistance.

The HCCRA has also made a commitment to expend monies to bring its data collection capabilities on level with other states. We feel this area will be the backbone of this agency as we move forward. Without timely, clean and reliable data we can not assist or regulate hospitals in the future, nor provide data and analysis to evaluate cost and quality through anticipated changes that will occur in health care services.

With the above changes, as well as the additional staff which we plan to bring on during fiscal year 1997, we estimate all of the appropriated funds allocated to us in the 1996-1997 budget will be expended. During the budget process for fiscal year ending June 30, 1998, we will review how the above two projects are proceeding and if any adjustments need to be made in the assessment amounts charged to the hospitals, we will do so.

It should also be noted that the HCCRA Fiscal Officer now supplies each board member with a monthly budget analysis which is reviewed and any discrepancies are corrected.

Table 6 in Issue 3 on page 15 contains hospital assessment amounts that reflect slight differences from our records. Our records indicate the following assessments:

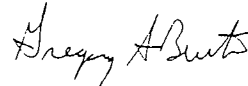
	Assessment	*Collected*
FY 1993	*2,732,941.86*	*2,726,792.62**
FY 1994	*2,974,704.99*	*2,967,072.41**
FY 1995	*3,176,491.23*	*3,169,659.63***

** Less was collected than assessed because of the financial distress and eventual closure of Weirton Osteopathic Hospital.*
***Assessment was not collected from Richwood Area Medical Center because it was purchased in 1995 "out of bankruptcy" by a new entity.*

Also in Issue Area 3, the footnote on page 16 has an apparent typographical error with respect to the amount reappropriated from the HCCRA account to the Aeronautics Commission. The footnote shows that amount to be $1,114,000; the correct reappropriation is $114.400.

We again thank you for the opportunity to suggest these items for your consideration. Although we essentially agree with the conclusion you have reached, we believe the matters we have addressed will clarify the report.

Sincerely,



Gregory A. Burton
Chairman

GAB/DWF/RVS:lh

Enclosures

§16-2D-3. Certificate of need.

Except as provided in section four of this article, any new institutional health service may not be acquired, offered or developed within this state except upon application for and receipt of a certificate of need as provided by this article. Any new provider of personal care service offered by any person, facility, corporation or entity, other than an agency of the state, may not be offered or developed in this state, if the service is to be funded in whole, or in part, by state or federal medicaid funds, except upon application for and receipt of a certificate of need as pro

11 vided in section six of this article: *Provided,* That a certif-
12 icate of need shall not be required for a person providing
13 specialized foster care personal care services to one indi-
14 vidual and those services are delivered in the provider's
15 home. Whenever a new institutional health service for
16 which a certificate of need is required by this article is
17 proposed for a health care facility for which, pursuant to
18 section four of this article, no certificate of need is or was
19 required, a certificate of need shall be issued before the
20 new institutional health service is offered or developed.
21 No person may knowingly charge or bill for any health
22 services associated with any new institutional health service
23 that is knowingly acquired, offered or developed in viola-
24 tion of this article, and any bill made in violation of this
25 section is legally unenforceable. For purposes of this
26 article, a proposed "new institutional health service" in-
27 cludes:

28 (a) The construction, development, acquisition or
29 other establishment of a new health care facility or health
30 maintenance organization;

31 (b) The partial or total closure of a health care facility
32 or health maintenance organization with which a capital
33 expenditure is associated;

34 (c) Any obligation for a capital expenditure incurred
35 by or on behalf of a health care facility, except as exempt-
36 ed in section four of this article, or health maintenance
37 organization in excess of the expenditure minimum or
38 any obligation for a capital expenditure incurred by any
39 person to acquire a health care facility. An obligation for
40 a capital expenditure is considered to be incurred by or on
41 behalf of a health care facility:

42 (1) When a contract, enforceable under state law, is
43 entered into by or on behalf of the health care facility for
44 the construction, acquisition, lease or financing of a capital
45 asset;

46 (2) When the governing board of the health care facil-

47 ity takes formal action to commit its own funds for a con-
48 struction project undertaken by the health care facility as
49 its own contractor; or

50 (3) In the case of donated property, on the date on
51 which the gift is completed under state law;

52 (d) A substantial change to the bed capacity of a
53 health care facility with which a capital expenditure is
54 associated;

55 (e) (1) The addition of health services which are of-
56 fered by or on behalf of a health care facility or health
57 maintenance organization and which were not offered on
58 a regular basis by or on behalf of the health care facility
59 or health maintenance organization within the
60 twelve-month period prior to the time the services would
61 be offered; and

62 (2) The addition of ventilator services for any nursing
63 facility bed by any health care facility or health mainte-
64 nance organization;

65 (f) The deletion of one or more health services, previ-
66 ously offered on a regular basis by or on behalf of a
67 health care facility or health maintenance organization
68 which is associated with a capital expenditure;

69 (g) A substantial change to the bed capacity or health
70 services offered by or on behalf of a health care facility,
71 whether or not the change is associated with a proposed
72 capital expenditure, if the change is associated with a pre-
73 vious capital expenditure for which a certificate of need
74 was issued and if the change will occur within two years
75 after the date the activity which was associated with the
76 previously approved capital expenditure was undertaken;

77 (h) The acquisition of major medical equipment;

78 (i) A substantial change in an approved new institu-
79 tional health service for which a certificate of need is in
80 effect. For purposes of this subsection, "substantial

81 change" shall be defined by the state agency in regulations
82 adopted pursuant to section eight of this article.