CBM-DC and CBM-DCL

DISCOUNT CONTRACT

INSTRUCTIONS

Pursuant to Policy Statement 2002-1, the Authority's review of hospital discount contracts has changed. This review now utilizes two data forms: (1) Form CBM-DCL, which is produced from an Excel template, and requires each discount contract to be listed along with the percentage discounts, and calculates volume and discount thresholds; and (2) Form CBM-DC, which requires the standard detail for certain discount contracts and non-allowable discounts, and provides a column for combining the remaining discount contracts.

Forms B-DC and B-DCL are required for both projected actual and budget years. Additionally, the Authority requires a notarized verification of the CBM-DC and CBM-DCL forms. This verification form is included as Exhibit D in the rate application checklist.

Please carefully follow the two-step directions in completing the reporting of the discount contract information.

STEP 1: Complete Form CBM-DCL for both the projected actual and budget years in the following manner:

(A) Calculate the cost-to-charge ratio for the respective year by entering the **total** gross patient revenues (CBM-5, line 1, column A) in the first cell of the CBM-DCL template, and the **total** operating expenses (CBM-5, line 6, column A) in the second cell of the template. The template will calculate the hospital's cost-to-charge ratio in the third cell. These revenue and expense amounts must match the respective CBM-5 forms;

(B) Calculate the hospital's volume threshold for each year by entering the respective **total nongovernmental** discharges (CBM-1, Nongovernmental Column, Line 3 or Line 6) in the template cell labeled "Inpatient", and the **total nongovernmental** visits (CBM 1-B, Nongovernmental Column, Line 9 or Line 18) in the template cell labeled "Outpatient." The template will calculate the hospital's five (5) percent volume threshold.

(C) Calculate the utilization volume for each discount contract by adding discharges and visits (one discharge and one outpatient visit is equal to

two (2)). Compare utilization for each contract with the threshold. Any contract that has total utilization that is equal to or greater than the volume threshold amount must be reported separately.

(D) In the middle section of the CBM-DCL which provides for listing of the discount contracts, enter the name of **each** contract **as well as the date the contract expires (if contract has an automatic renewal clause please so indicate by stating auto)** (including Distinct Part Unit contracts) and the respective inpatient and outpatient discounts in the cells as labeled. The shaded columns will indicate whether the contract must be separately reported on the CBM-DC form or whether it can be included in the "combined" column. If **either** the inpatient or outpatient columns indicate that the contract must be reported separately then the **entire** contract must be reported separately on the CBM-DC form.

For the projected actual year the discounts should include any managed care denials. For contracts that are reimbursed on a DRG, Per Diem, or Fee Schedule basis calculate the percentage discount that results from the contract reimbursement and enter in the discount cells.

Note: this top section is for only those contracts that are:

(1) Currently approved by the Authority;

(2) A third-party contract per W. Va. Code §16-29B-20;

(3) Contracts with utilization **less than** the volume threshold; and,

(4) **Not** with an HMO or include any risk based reimbursement.

(E) In the bottom section of the CBM-DCL enter the name of **each** contract or type of discount, granted which does not meet **all** of the criteria listed above for inclusion in the combined column, and enter the inpatient and outpatient discounts in the respective cells. These contracts **must** be reported separately on the CBM-DC form. **Note: Non-allowable discounts, such as administrative adjustments and employee discounts granted under certain situations, must still be reported. (See Policy Statement 2000-4.)**

(F) Be sure that **each** discount contract that the hospital utilized in the projected actual year, and is seeking approval of in the budget year, is listed on the respective CBM-DCL forms. If this information is not listed on the CBM-DCL form for the budget year, approval will not be granted for upcoming year.

(G) A copy of the Form CBM-DCL **must** be included in the rate application for both years.

(H) If more lines are needed in either section of the CBM-DCL then additional pages must be submitted as the template is write-protected and should not be changed.

STEP 2: Complete Form CBM-DC for both the projected actual and budget years in the following manner:

(A) Submit only a **TOTAL** form which includes acute and distinct part unit data. However, if distinct part unit reimbursement is determined by a separate contract it must be reviewed by the Authority as its own contract even though it is with the same payor as the acute contract (e.g. skilled nursing MSBCBS contracts that are not amendments to the acute contract, but are separate legal contracts). Each distinct legal discount agreement must be reviewed on its' own, therefore, each contract must be listed separately on the CBM-DCL and the CBM-DC forms, if it is not subject to combining.

(B) The following instructions apply to the completion of the CBM-DC form for all non-allowed discounts and discount contracts that must be reported **separately**:

Line 1 ***Name of Purchaser or Third Party Payor –*** The name of the purchaser or third party payor that will receive the discount***.***

Line 2 ***Date of Contract*** – The date of the contract is the date the contract was actually executed prior to January 1, 1991, or the date the HCA approved the contract after January 1, 1991.

Line 3 ***Date Contract Expires*** – The date the contract expires, or the date it is renewable. ***However***, if it automatically renews each year unless terminated by a party, you should enter **AUTO** in this space.

Line 4 ***Inpatient Discharges*** –- The estimated amount of discharges for each purchaser or third party payor for the projected actual and budget years. **Utilization must be provided in order for the Authority to evaluate a discount contract.**

Line 5 ***Gross Inpatient Revenue*** – The estimated amount of gross inpatient revenue expected to be generated from each

purchaser or third party payor in the projected actual and budget years.

Line 6 ***Inpatient Discount Percent*** – For the **projected actual year** enter the contractual percent of discount the purchaser or third party payor will receive. For the **budget year**, the percent of discount must match the discount stated in the contract***. NOTE:*** If the contract is reimbursed on a per diem, DRG or Fee Schedule basis, convert to a percentage discount.

Line 7 ***Total Amount of Inpatient Discount –*** This line equals the difference between the gross charge amount and what is received by the hospital as payment for the patient care services as provided for in the discount contract.

Line 8 ***Net Inpatient Revenue –*** This line equals the amount that is paid to the hospital for inpatient services as a result of the discount contract. Amount must equal Line 5 minus Line 7.

Line 9 ***Inpatient Cost*** – This amount should typically be calculated from the overall cost-to-charge ratio on Line 12 and applied to the gross revenue on Line 5. ***NOTE***: Hospitals that have the capability to track the cost for each purchaser or third party may do so provided that the supporting documentation is submitted and provided the hospital utilizes full costing in its calculations.

Line 10 ***Inpatient Charge Per Discharge*** – Calculate the charge per discharge for each discount contract by dividing Line 5 by Line 4.

Line 11 ***Inpatient Cost Per Discharge*** – Calculate the cost per discharge for each discount contract by dividing Line 9 by Line 4.

Line 12 ***Cost to Charge Ratio*** – Calculate the overall cost-to-charge ratio. This ratio must match the cost to charge ratio that could be calculated using the data on the respective CBM-5 form.

Line 13 ***Outpatient Visits*** – The estimated amount of outpatient visits for each purchaser or third party payor in the projected actual and budget years. Two examples of outpatient visits are: (1) an emergency room patient who receives multiple ancillary services would be counted as one outpatient visit;

and, (2) a recurring patient would have one visit recorded for each day treatment is provided.

Line 14 ***Gross Outpatient Revenue*** – The estimated amount of gross outpatient revenue expected to be generated from each purchaser or third party payor in the projected actual and budget years.

Line 15 ***Outpatient Discount Percent*** – For the **projected actual** year the contractual percent of discount the purchaser or third party will receive. For the **budget** year the percent of discount must match the discount stated in the contract.

Line 16 ***Total Amount of Outpatient Discount*** – This line equals the difference between the gross charge amount and what is received by the hospital as payment for the patient care services as provided for in the discount contract.

Line 17 ***Net outpatient Revenue*** – This line equals the amount that is paid to the hospital for outpatient services as a result of the discount contract. Amount must equal Line 14 minus Line 16.

Line 18 ***Outpatient Cost*** – This amount should typically be calculated from the **total** cost-to-charge ratio on Line 21 and applied to the gross revenue on Line 14. ***NOTE***: Hospitals that have the capability to apportion cost to each purchaser or third party may do so provided that the supporting documentation is submitted and provided the hospital utilizes full costing in its calculations.

Line 19 ***Outpatient Charge Per Visit*** – Calculate the charge per outpatient visit for each discount contract by dividing Line 14 by Line 13.

Line 20 ***Outpatient Cost Per Visit*** – Calculate the cost per outpatient visit for each discount contract by dividing Line 18 by Line 13.

Line 21 ***Cost-to-Charge Ratio*** – Calculate the **total** Cost to Charge Ratio. This ratio must match the ratio that could be calculated using the data on the CBM-5.

Line 22 ***Projected Actual/Budget Medicare and Medicaid Percent***– The percentage is computed on the amount of Medicare, Medicaid and Uncompensated Care revenue

divided by total gross patient revenue for the respective year.

Line 23–25 These questions are from the WV Code §16-29B-20(a)(2). Circle the appropriate answer for each purchaser or third party payor.

Line 26-27 Complete for existing contracts that have been approved by the Authority.

(C) For the **combined** contract column, Lines 4-9 and Lines 13-18 enter the total amounts of the combined discount contracts as per the instructions for each line given above.

(D) For the **total** column, Lines 4, 5, 7-9, 13, 14, and 16-18, enter the total of the combined and individual contract columns. For Lines 12 and 21 determine the amounts per the instructions above. **Note: The total contractual allowances on Lines 7 and 16 must match the respective inpatient and outpatient contractual allowances on the total CBM-5 form.**

(E) Submit a copy of all **new and/or revised** contracts for approval. Each contract must be a fully executed and complete contract (including any schedules, attachments or other documents incorporated by reference in the contract).

ATTENTION

The CBM-DC forms limit the number of contracts that can be placed on a page. The first page, which contains the total column, and a column for the combining of eligible contracts, allows for only three (3) individually reported contracts on that page. On subsequent pages the total column and combined column have been removed and allows for only five (5) contracts per page. ***Any modified forms will be returned.***