Chapter HRSC 3

RATE SETTING

HRSC 3.01 Schedule for annual rate requests (p. 17)
HRSC 3.013 Notice of a rate request (p. 17)
HRSC 3.017 Calculating financial requirements (p. 18)
HRSC 3.02 Rates (p. 24)
HRSC 3.025 Automatic approval of rate requests (p. 25)
HRSC 3.03 Disallowances due to excess revenue (p. 26)
HRSC 3.04 Unfair labor practices (p. 26)
HRSC 3.05 Estimating governmental payments (p. 26)
HRSC 3.07 Incentives (p. 27)
HRSC 3.09 Trend factors (p. 28)
HRSC 3.11 Adjustments for partial-year rate increases (p. 29)
HRSC 3.13 Charge elements (p. 29)

HRSC 3.01 Schedule for annual rate requests. (1) ANNUAL DATE. Each hospital may submit one rate request annually. The rate request may be submitted up to 90 days before a date specified by the commission or at any time during the 12 months following that date. In addition to the annual rate request authorized under this section, any hospital may submit an emergency rate request as provided in s. 54.17 (1m), Stats. Rate review commences on the date the hospital notifies the commission it is requesting a rate increase. If the commission schedules its own review of the hospital's rates, rate review commences on the date scheduled.

(2) FACTORS USED TO SET DATES. The commission shall establish the annual date for submitting requests by each hospital based on the hospital's fiscal year and gross annual patient revenue and on prudent allocation of the commission's resources. The commission shall establish its schedule of dates by order and shall provide this schedule to the public on request.

(3) HOSPITALS SUBJECT TO REGULATION. The commission shall, by order, list the hospitals subject to regulation under chs. HRSC 1 to 5 and shall provide this list to the public on request.

History: Cr. Register, December, 1984, No. 348, eff. 2-1-85; am. (3), Register, October, 1985, No. 358, eff. 11-1-85.

HRSC 3.013 Notice of a rate request. (1) FORMAT OF NOTICE. (a) The commission shall, by order, prescribe the format of notices hospitals are required to publish under s. 54.07 (2), Stats.

(c) Hospitals shall publish notices under this subsection in one or more newspapers likely to give notice to the hospital's patients and payers, such as a newspaper with a major concentration of circulation in the area surrounding the hospital. Each hospital shall also submit a copy of each notice it published to the commission and an affidavit of publication. If a hospital publishes a notice in more than one newspaper, the last date of publication commences the 30-day period in which persons may become parties to the rate review. If a hospital fails to publish this notice the commission is not required to continue reviewing the rate request.

Note: Section 54.07 (2), Stats., requires each hospital that submits its annual rate request to publish a notice within 10 days after the submission. The notice must inform the public of the review, summarize the rate sought and state the process by which interested persons may become parties to the review.

(2) SPECIAL NOTICE TO INTERESTED PERSONS. Any person who wishes to receive a notice of pending rate requests for any particular hospital may submit a letter to the commission indicating the name of each hospi-

tal in which the person is interested. If any person requests notice of pending rate requests for more than one hospital the commission may require payment of a reasonable fee to defray the cost of delivery. The commission shall mail or deliver a notice of a pending rate request to each interested person within 10 days after any of the following occurs:

(a) The hospital in which the person has expressed an interest submits a rate request.

(b) The hospital in which the person has expressed an interest requests the commission to issue an emergency order under sub. (3).

(c) The commission schedules its own review of the hospital's rates.

(3) NOTICE IN EMERGENCIES. (a) If a hospital requests the commission to issue an interim order because of an emergency under s. 54.17 (1m), Stats., the hospital shall publish the notice specified in sub. (1) within 10 days after submitting the request. This notice shall also describe the nature of the emergency involved.

(b) 1. Any person seeking to become a party to the commission's review of an emergency request shall notify the commission in writing within 10 days after the date the notice under sub. (1) is published; a hospital that submits an emergency request shall modify the notice it issues to indicate this deadline.

2. Notwithstanding subd. 1, any person seeking to become a party to the commission's review of an emergency request who receives a special notice under sub. (2) (b) shall notify the commission in writing within 10 days after the date of delivery.

History: Cr. Register, December, 1984, No. 348, eff. 2-1-85; r. and recr. (1) (a), r. (1) (b), am. (2) (intro.), Register, May, 1986, No. 365, eff. 6-1-86.

HRSC 3.017 Calculating financial requirements. (1) SEPARATING NURSING HOME FINANCIAL REQUIREMENTS. (a) If a hospital is jointly operated in connection with a nursing home the commission shall, to the extent practicable, exclude from its calculation of the hospital's financial requirements those financial requirements generated by the nursing home. Either of the methods specified in pars. (b) and (c) may be used to calculate the financial requirements of a hospital that is part of a combined facility.

(b) Hospital financial requirements may be determined based on the combined facility's own separation of its nursing home and hospital financial requirements, if the facility's auditor attests on the most recently audited financial statements to the fact that the facility's method of allocating expenses and revenue between the nursing home and hospital is reasonable for management and rate-setting purposes. The commission is not required to use this method if it shows that the nursing home's expenses materially exceed its revenues.

(c) 1. If the commission rejects the method specified in par. (b) because the method shows that the nursing home's expenses materially exceed its revenues or because the method is unavailable, it may determine the financial requirements of a hospital that is jointly operated in connection with a nursing home as the lesser of the following:

a. The level of gross annual patient revenue a hospital requests for the budget year under review.

b. The commission's estimate of the combined facility's total financial requirements for the budget year under review minus the commission's estimate of the nursing home's budgeted gross annual patient revenue for the nursing home's ensuing fiscal year.

2. The commission is not required to use the formula specified in this paragraph if it would shift nursing home costs to the hospital excessively.

(2) ACCOUNTS RECEIVABLE AND BAD DEBTS. (a) Each medium-sized or large hospital shall, as part of the information it submits under s. HRSC 2.17:

1. Indicate whether it participates in any interim or advance payment program for medicare or other payers and indicate the year-end balance in the account for each program.

Note: Medicare presently uses a periodic interim payment program, a method by which hospitals can reduce delays in billing and standardize cash flow by receiving a portion of the total payment prior to complete processing of their bills.

2. Estimate what dollar amount of bad debts it can reasonably be expected to incur during the budget year. This estimate shall include the controls it will use to limit the dollar amount of bad debts and to collect accounts receivable.

3. Explain its method for determining when to write off an account receivable as a bad debt or charity care and its provision for bad debt and charity care during the budget year. Commencing in 1987, the hospital shall also submit the actual charges billed during the 2nd fiscal year preceding the budget year under review, the payment received from those charges and the average lapse of time involved in receiving payments from each of the 3 categories of payers that generate the hospital's greatest revenue. Each hospital shall calculate the time involved in receiving payments from these payers, calculated commencing with the date of discharge. The hospital shall also break down the payments received from each of these payers by indicating the following information:

a. The total dollar amount of that payer's accounts receivable.

b. That payer's percentage of total accounts receivable.

c. The total dollar amount of that payer's accounts receivable that are in-house, or unbilled; paid within 1 to 30 days; paid within 31 to 60 days; paid within 61 to 90 days; and paid over 90 days.

4. Indicate whether it identifies returning patients with delinquent accounts from prior services and what types of financial counseling or other procedures it provides patients.

(b) Each hospital, whether small, medium-sized or large, shall maintain a sound credit and collection procedure for reducing its accounts receivable and bad debts. The procedure shall include prompt processing of all bills to payers. Commencing in 1986, each hospital shall submit as part of its annual report filed under s. HRSC 2.17 or 2.19 the average lapse of time involved in mailing a bill to each of the 3 categories of payers that generate the hospital's greatest revenue. The time involved in mailing a bill begins with the date the patient is discharged. The commission may disallow as unreasonable any portion of a hospital's unrecovered costs under s. 54.09 (1) (e), Stats., if the commission finds that the

hospital's credit and collection procedure does not effectively control these costs.

(c) After reviewing the hospital's estimate of bad debts, its credit and collection policy for the budget year under review and its historic data on accounts receivable and bad debts in comparison with other hospitals, the commission shall establish reasonable levels of budgeted revenue in accounts receivable and of bad debts for the hospital and include these amounts in its rate-setting order.

(d) 1. Each hospital shall, regardless of whether it submits a rate request during the year, annually complete and submit to the commission a report identifying annual patient service revenue and accounts receivable for each of the following categories of payers:

a. Medicare, inpatient and outpatient.

b. Medicaid, inpatient and outpatient.

c. Blue Cross/Blue Shield United.

d. Health maintenance organizations.

e. Other commercial insurers.

f. Community mental health or developmental disabilities boards under s. 51.42 or 51.437, Stats. Only specialty hospitals are required to identify annual patient service revenue and accounts receivable for these payers.

g. Self payers.

h. Other payers.

i. Medicaid patient service revenue and accounts receivable, for any nursing home owned or operated by the hospital.

j. Self payer and other payer patient service revenue and accounts receivable, for any nursing home owned or operated by the hospital.

2. a. Each hospital whose fiscal year ends between January 1 and June 30 shall submit its accounts receivable report by September 30. The commission shall update its standard, based on data received from these reports, and shall use this updated standard for all hospitals whose fiscal years end between January 1 and June 30.

b. Each hospital whose fiscal year ends between July 1 and December 31 shall submit its accounts receivable report by March 31. The commission shall update its standard, based on data received from these reports, and shall use this updated standard for all hospitals whose fiscal years end between July 1 and December 31.

(e) 1. The commission shall analyze hospital accounts receivable by arraying hospital days in accounts receivable for each payer category from low to high, based on average daily revenue of the previous 365 days. It shall then calculate the mean and standard deviation for each category, removing from the array data of any hospital whose days in accounts receivable are below the mean minus one standard deviation or above the mean plus one standard deviation. Of the remaining range, the 60th percentile is the accounts receivable screen for any individual payer.

2. The commission shall calculate the accounts receivable standard for any hospital as the sum of the average daily revenue times the accounts receivable screen for each of the hospital's payers.

(f) The commission shall apply the accounts receivable standard as follows:

1. Any hospital exceeding the standard is subject to a disallowance of financial requirements under s. 54.13 (1) (e), Stats., unless it can provide compelling justification of the excess.

2. Any hospital whose accounts receivable days outstanding fell below the standard in its previous rate review:

a. May not increase its accounts receivable days outstanding more than the increase in the standard days from year to year, or 25% of the amount by which the hospital's accounts receivable days outstanding in the previous rate review were less than the standard used in that review, whichever is greater. The hospital may only increase its accounts receivable days outstanding by more than this amount if it provides justification of the excess to the commission's satisfaction.

b. Shall reduce its accounts receivable days outstanding by at least 75% of the change in the accounts receivable standard, if the standard decreases during its next rate review. The hospital may only reduce its accounts receivable days outstanding by less than this amount if it provides justification of the excess to the commission's satisfaction.

Note: Section 54.21 (2) (b) 1, Stats., requires the commission to establish by rule appropriate levels of budgeted revenue in accounts receivable for hospitals. In addition, s. 54.09 (1) (e), Stats., authorizes the commission to disapprove as a financial requirement debts that a hospital has failed to recover due to unsound credit and collection policies. This rule establishes a method for determining reasonable levels of budgeted revenue in accounts receivable and for establishing the soundness of each hospital's credit and collection policy.

(3) EDUCATION OR RESEARCH PROGRAM PROPOSALS. The commission may require any hospital to submit information describing medical education, allied education or research programs whose costs the hospital seeks to include in its financial requirements under s. 54.09 (1) (c), Stats. Unless the commission requires additional information, any hospital with a program accredited by a competent body need only provide the commission with the accrediting body's name in order to include the costs of the program in its financial requirements. Hospitals shall describe each unaccredited program to the commission, including a definition of the program's purpose and a statement of the program's direct and indirect costs. The commission may disapprove part or all of any program that it finds is not directly related to patient care services, overly expensive, duplicative or otherwise unnecessary.

(4) EXCESS CAPACITY. (a) 1. The commission may disregard as a financial requirement costs associated with excess bed capacity of a hospital, as specified in par. (b). In order that the commission may determine a hospital's occupancy rate and its bed capacity level, each hospital shall include with its annual report filed under s. HRSC 2.17 or 2.19 a statement indicating the number of approved beds that the hospital reported to the department of health and social services as allocated to its medical/surgery unit, its pediatric unit, its obstetrics unit, its intensive care/critical care unit, its psychiatric unit and its alcohol and other drug abuse unit, if any, and the hospital's peak and average daily census in each of these units during the fiscal year preceding the budget year under review.

The commission shall calculate the hospital's occupancy rate for each of these units and compare the actual rate with the occupancy standard specified in subd. 2.

2. The commission shall compare the hospital's actual occupancy rate for each of the units specified in subd. 1 against the occupancy standard established by the department of health and social services in its rules or its state medical facilities plan, created under s. 150.83, Stats.

(b) Any hospital whose actual occupancy rate falls below the occupancy standard specified in par. (a) 2 shall suggest alternate uses for underused portions of the facility that are consistent with occupancy improvement plans the hospital is required to submit to the department of health and social services under ch. 150, Stats., and that will either produce sufficient revenue to pay some or all of the costs related to these underused portions, reduce hospital financial requirements or are otherwise reasonable. If the hospital does not suggest alternate uses it shall explain why such uses are not feasible. The commission may find the costs associated with the underused portions to be unreasonable and disregard these costs as financial requirements.

(c) If the commission finds that a hospital with an occupancy rate below the occupancy standard specified in par. (a) is a sole provider in its acute care service area, it may find part or all of the costs associated with the underused portions to be reasonable if the hospital's underused capacity is required to maintain a reasonable mix of services in the area. In this paragraph, "acute care service area" has the meaning specified by the department of health and social services in the rules it promulgates under s. 150.83, Stats.

Note: Section HRSC 3.017 (4) incorporates occupancy standards established by DHSS in its Wisconsin State Medical Facilities Plan for general acute care hospitals and short-term specialty hospitals. This rule also allows the commission to provide special consideration for small, rural hospitals and other hospitals that are sole providers in their acute care service areas.

(5) PENALTY PAYMENTS. No hospital may include as a financial requirement any fine, forfeiture or other penalty whose value exceeds $5,000.

(6) DISCOUNTS. (a) If a hospital enters into a contract to provide health care services at a rate that is discounted below normal billed charges, the commission may include additional financial requirements for the hospital in its rate-setting deliberations only in order to prevent shifting the savings generated by the contract to other payers. These additional financial requirements may not exceed the value of the savings generated by the contract and may only be included if the hospital demonstrates to the commission's satisfaction that the savings resulting from the contract equal or exceed the loss in revenue. The commission may not consider any loss of hospital revenue due to rate differentials under the discounted contract as justification for additional charges to other groups of patients.

(b) Paragraph (a) does not apply to charity care discounts offered by any hospital.

(c) Paragraph (a) does not apply to discounts required by medicare, medical assistance or general relief unless the governmental payer contracts with a health maintenance organization to provide service to its

beneficiaries and the size of the discount exceeds the discount customarily demanded by governmental fee-for-service reimbursement. Paragraph (a) does apply to that portion of such a discount that exceeds the customary governmental fee-for-service discount.

(7) CAPITAL. (a) For the purpose of interpreting s. 54.09 (1) (i), Stats:

1. "Capitalized interest" means interest expenses incurred during construction of a capital asset that are added to the cost of the asset and depreciated over the useful life of the asset. "Capitalized interest" does not include interest costs that are recognized as operating expenses.

2. "Commitments for capital requirements" means expenditures that meet both of the following conditions:

a. The expenditure is budgeted, at the beginning of the hospital's fiscal year preceding the budget year under review, to be expended during the remaining portion of the fiscal year that has not yet occurred as of the date that rate review commences.

b. The hospital has a contractual obligation to pay for the budgeted expenditure.

3. "Debt retirement" means payments of principal on loans outstanding for plant or equipment.

(b) For the purposes of interpreting the restrictions on income assignment and on calculation of available funds under ss. 54.09 (1) (b) and (i) 1, Stats., donor-restricted or income-assigned donations do not include donations to a hospital on which the hospital imposes its own restrictions or assignments.

(c) In lieu of creating a separate 3-year capital expenditure plan for submission under s. 54.09 (1) (i) 1, Stats., any hospital may submit to the commission a copy of its most recent proposed 5-year capital budget report required under s. 150.81, Stats.

Note: The capital expenditure review program of DHSS (formerly, the certificate of need program) requires that hospitals annually submit a 5-year proposed capital budget report. The commission will accept this report as sufficient to meet one of the conditions necessary for approval of prospective accumulations that finance future capital projects.

(8) ENERGY COSTS. The commission may determine any portion of a hospital's energy costs to be unnecessary if the commission required, in a previous rate-setting order, that the hospital be audited by an independent energy auditor but the hospital failed to comply with this requirement.

(9) RELATED CHARITABLE ORGANIZATIONS. (a) The commission may impute to a hospital the assets and liabilities of a foundation or other charitable organization that is related to the hospital under:

1. The criteria specified in s. HRSC 2.17 (17) (a) 1.

2. The criteria specified in s. HRSC 2.17 (17) (a) 2.

3. The criteria specified both in s. HRSC 2.17 (17) (a) 5 and in either s. HRSC 2.17 (17) (a) 3 or 4.

(b) Under this subsection the commission may apply the income from unrestricted donations to offset interest expenses, as provided in s. 54.09 (2), Stats., or to offset the cost of capital purchases proposed during the

budget year under review. The commission may not apply the corpus of an unrestricted donation to offset interest expenses or the cost of proposed capital purchases and may only use donor-restricted gifts for the purposes specified by the donor. If a hospital has signed over to a foundation any donations that were not donor-restricted the commission may, regardless of whether the hospital is related to the foundation, also apply the income the hospital would reasonably have been capable of earning from those funds to offset interest expenses or the cost of capital purchases proposed for the budget year under review.

(10) CONDITIONS IMPOSED. In its rate review deliberations the commission may, by order, apply any conditions consistent with chs. HRSC 1 to 5 that were imposed by the Wisconsin hospital rate review program as part of a hospital's rate and that remain in effect on or after February 1, 1985, and may establish additional conditions pursuant to s. 54.17 (4) (f), Stats.

(11) EMPLOYE COMPENSATION. When the commission calculates a hospital's operating expenses it shall examine increased payroll costs of nonsupervisory employes, including increases due to collective bargaining, increases that correct for past lags in compensation or increases that correct for past discrimination, even when the resultant costs exceed levels the commission would otherwise apply.

History: Cr. Register, December, 1984, No. 348, eff. 2-1-85; emerg. cr. (2) (d) to (f), eff 2-7-85; am. (10), Register, October, 1985, No. 358, eff. 11-1-85; cr. (2) (d) to (f), Register, May, 1986, No. 365, eff. 6-1-86.

HRSC 3.02 Rates. (1) TOTAL BUDGET. The commission shall establish a total budget for each hospital. The total budget shall consist of the gross patient revenue and net patient revenue the hospital may generate during the budget year under review.

(2) CHARGE ELEMENT RATES. (a) The commission shall list 100 charge elements whose rates must be submitted by each hospital for its approval. After the commission sets a hospital's total budget under sub. (1), the hospital shall submit to the commission its proposed rate for each of these charge elements and its proposed method of applying the price increase granted to the remaining charge elements.

(am) With its submission of proposed rates, the hospital shall state the actual volume for each of the 100 charge elements listed under par. (a) for the fiscal year preceding the budget year under review. If the commission issues its rate-setting order prior to 15 days after the hospital's fiscal year end, the hospital may state the projected year-end volume instead of the actual volume.

(b) A hospital that does not bill its payers for a charge element listed by the commission under par. (a) is not required to create a rate for that charge element and submit the rate to the commission for approval. If a hospital charges a rate for a charge element that is reasonably similar but not identical to a charge element listed by the commission, the hospital shall submit the information required for that charge element under par. (a) to the commission but shall note the difference between its charge element and the listed charge element.

(c) If the commission finds that the hospital's rates proposed in par. (a) will generate annual patient revenue that does not exceed the amount authorized under sub. (1) it shall approve these rates. The commission

may require a hospital to submit volume or other information regarding its charge elements in order to make this finding.

(3) RATE OVERCHARGES. Except as provided in this subsection, no hospital may charge rates for charge elements that exceed the rates the commission approved under sub. (2) (c). Any hospital may adjust its rate for a charge element listed under sub. (2) (a) if it receives the commission's approval prior to implementing the rate change. A hospital that decides to adjust the rate for any other charge element may do so without prior commission approval, if it uses the method previously approved by the commission to make the adjustment. The commission may disallow a rate change proposed under sub. (2) or this subsection that it finds will increase hospital rates, as defined in s. HRSC 1.01 (9r) (b), in the aggregate unless the proposed rate change conforms with the application of a method approved by the commission.

History: Cr. Register, December, 1984, No. 348, eff. 2-1-85; am. (2) (a), (am) and (3), cr. (2) (am), Register, May, 1986, No. 365, eff. 6-1-86.

HRSC 3.025 Automatic approval of rate requests. (1) DEFINITIONS. For the purpose of interpreting s. 54.21 (2), Stats., and in this section:

(a) "Complete review" is a rate review by the commission, during which it is authorized to disallow financial requirements under s. 54.13 (1), Stats. A hospital that received approval of its rates under s. 54.21 (2), 1983 Stats., or under s. 54.21 (2), Stats., has not had a complete review of its rates. A hospital that withdraws its rate request has not had a complete review of its rates. The commission's review of a hospital's request to adjust the rates of its charge elements under s. HRSC 3.02 (3) is not a complete review of the hospital's rates.

(b) "Last fiscal year" means the most recent complete fiscal year for which audited financial statements are available.

(2) AVAILABILITY OF AUTOMATIC APPROVAL. (a) If the commission initiates a review of a hospital's rates under s. 54.07 (1), Stats., the hospital may not prevent the commission from completing this review of the hospital's rates and financial requirements by subsequently requesting automatic approval.

(b) In situations where the commission initiates a rate review for the purpose of reducing rates under s. 54.17 (4) (bm) 4, Stats., the limitation on use of automatic approval under par. (a) applies only if the commission, using the hospital's audited financial statements, finds that the hospital's actual total annual revenue exceeds its actual total financial requirements by more than 10% for each of 3 successive years and these years occur at some time after the hospital has received a complete review.

History: Cr. Register, December, 1984, No. 348, eff. 2-1-85; r. and recr. Register, May, 1986, No. 365, eff. 6-1-86.

HRSC 3.03 Disallowances due to excess revenue. (1) CALCULATING THE DISALLOWANCE. The commission may determine if a hospital is subject to a disallowance because the hospital's patient revenue exceeds its budgeted patient revenue by more than the amount authorized under s. 54.13 (1) (b), Stats., by determining the extent that the hospital's actual net patient revenue for the most recent fiscal year that audited information on actual net patient revenue is available exceeds the hospital's budgeted net patient revenue for that year.

(2) ADJUSTING THE DISALLOWANCE. Any hospital may petition the commission to determine the relative percentages of the hospital's fixed costs and variable costs. Any hospital seeking a determination that its variable costs exceed 65% of its total costs shall submit to the commission all relevant information based on available data. If the commission finds that a hospital subject to the disallowance specified in s. 54.13 (1) (b), Stats., has variable costs exceeding 65% of its total costs, the commission shall reduce the disallowance percentage using the following formula:

Variable cost % − 65% = V%

40% − V% = Disallowance percentage to be used in s. 54.13 (1) (b), Stats.

History: Cr. Register, December, 1984, No. 348, eff. 2-1-85.

HRSC 3.04 Unfair labor practices. If a hospital has committed any of the unfair labor practices or prohibited practices regulated under s. 111.18, Stats., the commission shall disallow from the hospital's financial requirements payments to persons for the activity that constituted the unfair labor practice.

Note: Section 111.18, Stats., regulates certain unfair labor practices and prohibited practices, if those practices include payment to any person for services rendered with respect to concerted activity engaged in by the hospital's employes for purposes of collective bargaining.

History: Cr. Register, December, 1984, No. 348, eff. 2-1-85.

HRSC 3.05 Estimating governmental payments. (1) ACCEPTABLE METHODS. Acceptable methods that hospitals may use to estimate annual medicare, medical assistance or general relief payments under s. 54.17 (1) (a), Stats., are:

(a) A hospital may estimate its annual medicare payment for the budget year under review by using either of the following methods:

1. Submitting to the commission a completed copy of commission workpapers for projecting medicare reimbursement or otherwise relying on federal law and regulations.

2. Submitting to the commission its own method of projecting medicare reimbursement. The hospital may propose any method it chooses but shall justify its superiority over the method specified in subd. 1 by documenting both the method and the result. The commission shall compare any method submitted under this subdivision with its own method, relying on federal law and regulations, in order to determine if the method proposed is reasonable for rate-setting purposes.

(b) A hospital may estimate its annual medical assistance payment for the budget year under review by using either of the following methods:

1. Submitting to the commission a completed copy of commission workpapers for projecting medical assistance reimbursement or otherwise relying on federal and state law, rules and regulations.

2. Submitting to the commission its own method of projecting medical assistance reimbursement. The hospital may propose any method it chooses but shall justify its superiority over the method specified in subd. 1 by documenting both the method and the result. The commission shall compare any method submitted under this subdivision with its own