

**Effects of the Balanced Budget Act of 1997  
on Rural West Virginia**

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by

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## **I. Introduction and Background**

This report is about what happens to rural America when financial times get tough and includes summaries of the Balanced Budget Act 1997, key informant interviews, key data for 1997 and 1999, and findings and options.

The intent of the BBA was to reduce Medicare spending by \$130 billion, create incentives for development of managed care plans, encourage enrollment in managed care plans, and limit fee-for-service payment and programs

### ***How savings were to be achieved through the Balanced Budget Act of 1997***

These savings were to be achieved through a number of changes in both program and payment provisions. Incentives toward Medicare managed care would be created through a Medicare + Choice Program. Expansion of beneficiary access to information, and of the types of organizations that can provide managed care to Medicare beneficiaries, would take place. Payment to plans that serve in rural areas would be increased. Further savings would be achieved through moving to Medicare hospital outpatient prospective payment systems (PPSs), reducing payment for some hospital transfers, and reducing hospital inflation updates. Caps would be placed Medicare payment to hospital-based rural health clinics (RHCs). Prospective payment systems would be put in place for Medicare skilled nursing facilities, and Medicare payments for home health and durable medical equipment (DME) would be reduced.

### ***Other BBA provisions***

The Act also was modified to create incentives for states to move into Medicaid managed care changes. Changes in Medicaid give greater flexibility to states and make it easier for a state to test new approaches for delivery system reform.

A BBA major program addition was the creation of Title XXI, the Children's Health Insurance Program (CHIP), a \$24 billion state/federal partnership to expand health insurance to low-income children. Finally, BBA created a new type of hospital through the Medicare rural hospital flexibility program [Critical Access Hospital (CAH) Program].

### ***Outcomes***

Incentives have not been strong enough to achieve the desired increase in Medicare managed care development/enrollment. The percentage of managed care in rural West Virginia is small, and many plans have pulled out of rural areas. Plans have also pulled out of urban areas, and plan failures have increased.

Payment cuts to fee-for-service providers are much higher than anticipated, and there are projections of a large number of hospitals and other providers. The industry

result has been a large number of mergers, both with similar providers and across a wide range of provider types. There has also been increased interest in the CAH program as a solution for rural hospital survival.

***What the West Virginia Hospital Association reports***

BBA's reduced payments have increased potential for hospital closures and, while all hospitals are at risk, mid-size rural hospitals are the most threatened. Salaries are going up and supply costs are going up, while revenues are being cut. In addition, capital investment is needed for aging facilities. Rural West Virginia hospitals are more dependent on government payors than are their counterparts in many other states. The CAH "solution" is the only alternative for some and yet still is not providing adequate revenue. While access is not yet effected, rural hospitals are maintaining quality by losing money.

***What Critical Access Hospitals are saying***

West Virginia, as a recipient of the Health Care Financing Administration (HCFA) Essential Access Community Hospital Program (EACH/PCH) demonstration, was in a good position to quickly convert several hospitals to CAH status. Even so, the BBA created a reduction in their level of payment and, although the State's Medicaid and CHIP programs continue cost-based reimbursement, and the State is providing Disproportionate Share Hospital (DSH) payments as well, they are in a precarious financial condition and are asking the State to eliminate their hospital provider tax.

Balanced Budget Act reduced payments to CAHs. PEIA (Public Employees Insurance Agency) should mirror Medicare and Medicaid reimbursement. The provider tax for CAHs should be eliminated.

### What is a Critical Access Hospital (CAH)?

Eligibility	Current Hospital Hospital that closed in November 1989 or later Hospital that converted to clinic
Location criteria	Rural, or urban with rural characteristics and a 35+-mile drive to hospital or CAH (15 miles in mountains or areas with secondary roads) OR State certifies as a “Necessary Provider”
LOS Limit	Annual average of 96 hours
Size Limit	15 beds (25 with “swing” beds)
Medicare Payment	Cost-based (for hospital inpatient, outpatient, and swing bed services)
Services	<ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Laboratory</li> <li>• Emergency care</li> <li>• Radiology</li> </ul>
Emergency Services	Available 24 hours Staff has emergency services training or experience Staff is on-call and available within 30 minutes
Medical Staff	At least 1 physician (need not be on-site) May include mid-level practitioners
Nursing Staff	RN or LPN on duty when there is an inpatient in the facility
Hours of Operation	24 hours if occupied If not occupied, emergency service made available
Network	Network = at least 1 CAH and 1 hospital If CAH is a member of a network, agreements are maintained the network hospital(s) for: <ul style="list-style-type: none"> <li>Referral and transfer</li> <li>Transportation services</li> <li>Communications</li> </ul> CAH has agreement with network hospital, PRO, or equivalent for: <ul style="list-style-type: none"> <li>Credentialing</li> <li>Quality assurance</li> </ul>

#### *What rural hospitals are saying*

They cannot continue current operations without increased reimbursement, and the smaller ones (under 100 beds) believe that conversion to a CAH would mean a drastic reduction in needed community services.

The sole community hospitals (SCH) thinks there is a need for better understanding the essential role of these isolated facilities to their communities and regions, with steps taken to assure access to them. Some of the solutions they pose include:

1) speedier payment of claims by State-administered programs; 2) cost-based reimbursement for all rural hospitals and providers; and 3) DSH payments to the rural safety net. They also suggest a study to demonstrate the additional costs to State programs if their rural hospitals system weren't there.

**West Virginia Rural Hospital Data:  
Characteristics of Rural Hospitals**

	<b>West Virginia</b>	<b>United States</b>
% of hospitals that are rural	71%	41%
Less than 50 beds	46%	42%
Provide skilled nursing care	51%	34%
Provide home health	69%	59%
Provide SNC or home health	84%	72%
Provide SNC and home health	33%	21%

Source: West Virginia Hospital Association (1999); Rural Hospitals: Accomplishments & Present Challenges (1999, Rural Health Research Center, University of Minnesota); AHA Hospital Statistics (2001)

**West Virginia Rural Hospital Data:  
West Virginia Hospital Inpatient Utilization**

	<b>Total Acute Care Inpatient Days</b>		<b>Total Acute Care Discharges</b>		<b>Avg. Length of Stay</b>		<b>Acute Care Occupancy</b>		<b>Staffed Beds</b>	
	<i>1997</i>	<i>1999</i>	<i>1997</i>	<i>1999</i>	<i>1997</i>	<i>1999</i>	<i>1997</i>	<i>1999</i>	<i>1997</i>	<i>1999</i>
Over 100 beds	437,141	460,157	84,745	90,120	5.2	5.1	53.9%	53.1%	2,010	2,125
Under 100 beds	157,565	149,454	36,683	36,320	4.3	4.1	35.4%	33.0%	1,070	1,117
Critical Access	14,643	13,160	4,218	3,836	3.5	3.4	15.9%	17.9%	156	185
Urban	667,538	663,292	132,197	135,405	5.0	4.9	44.2%	43.7%	3,401	3,473

Source: Health Care Authority data (1997,1999)

**West Virginia Rural Hospital Data:  
1997 West Virginia Hospital Gross Revenue by Payor Percentage Rate**

	<b>Medicare</b>	<b>Medicaid</b>	<b>PEIA</b>	<b>Other Gov't</b>	<b>Other</b>
Rural over 100 beds	47.9%	15.7%	4.7%	4.1%	27.6%
Rural under 100 beds	47.0%	19.1%	3.9%	4.1%	25.9%
Critical Access	48.2%	21.0%	2.8%	3.0%	25.0%
Urban	48.9%	12.0%	4.1%	3.0%	32.0%
<b>Total</b>	<b>48.3%</b>	<b>14.3%</b>	<b>4.2%</b>	<b>3.5%</b>	<b>29.7%</b>

Source: West Virginia Hospital Association Financial Data (1977)

**West Virginia Rural Hospital Data:  
West Virginia Hospital Total Net Patient Revenue\***

	<b>1997 Total Net Patient Revenue</b>	<b>1999 Total Net Patient Revenue</b>	<b>Change</b>
Rural over 100 beds	\$808,241,049	\$855,508,636	5.8%
Rural under 100 beds	\$331,089,933	\$337,955,482	2.1%
Critical Access	\$53,216,134	\$56,502,945	6.2%
Urban	\$1,327,021,899	\$1,413,217,782	6.5%
<b>Total</b>	<b>\$2,519,569,015</b>	<b>\$2,663,184,845</b>	<b>5.7%</b>

Source: West Virginia Hospital Association Financial Data (1977, 1979)

\*Total Net Patient Revenue: the net realizable amounts from patients, third-party payers, and others for services rendered.

**West Virginia Rural Hospital Data:  
West Virginia Hospitals Patient Margin Analysis\***

	<b>1997 Patient Margin %</b>	<b>1999 Patient Margin %</b>
Rural over 100 beds	4.0%	-0.7%
Rural under 100 beds	-0.2%	-3.7%
Critical Access	-6.1%	-9.8%
Urban	1.2%	-2.3%
<b>Total</b>	<b>1.7%</b>	<b>-2.1%</b>

Source: West Virginia Hospital Association Financial Data (1977, 1979)

\*Patient Margin Analysis: measure of hospital patient profit or loss; it is calculated by taking (total profit or loss - total other revenue) / (total net patient revenue)

***What nursing home representatives are saying***

The prospective payment system has reduced revenue for long-term care institutions. Many nursing home chains had leveraged all their capital, and the Balanced Budget Act reduced their cash flows. 35% of nursing home facilities in West Virginia are operating in these chain bankruptcies with no current threat of closure. Some of the closures are due to the Balanced Budget Act; some are due to bad business decisions. Another current problem here, as elsewhere, is the increased difficulty in securing adequate staffing.

**West Virginia Long-Term Care Data  
Number of Beds and Occupancy Rate**

	<b>1997</b>		<b>1999</b>		<b>Change</b>	
	<b>Rural</b>	<b>Urban</b>	<b>Rural</b>	<b>Urban</b>	<b>Rural</b>	<b>Urban</b>
Licensed	5,990	3,985	5,924	4,055	-1.1%	1.8%
Occupancy Rate	90.9%	86.9%	91.6%	92.8%	0.8%	6.8%

Source: Annual Report of Nursing Homes (1997, 1999) Nursing Home Component Only.

**West Virginia Long-Term Care Data  
Number of Days**

	1997		1999		Change	
	Rural	Urban	Rural	Urban	Rural	Urban
Medicare	84,942	94,117	100,371	110,634	18.2%	17.5%
Medicaid	1,583,324	871,045	1,582,858	956,5567	0.0%	9.8%
VA	21,221	6,413	14,522	8,651	-31.6%	34.9%
Self-Pay	292,492	285,273	277,013	279,583	-5.3%	-2.0%
Other 3 <sup>rd</sup> Party	6,058	7,854	5,409	16,633	-10.7%	111.8%
PEIA*	NA	NA	243	544	NA	NA
Other Gov't*	NA	NA	508	391	NA	NA
Other Payor*	NA	NA	0	382	NA	NA
<b>Total</b>	<b>1,988,037</b>	<b>1,264,702</b>	<b>1,980,924</b>	<b>1,373,385</b>	<b>-0.4%</b>	<b>8.6%</b>

\*These categories were not included in the 1997 data set

Source: Annual Report of Nursing Homes (1997, 1999) Nursing Home Component Only

**West Virginia Long-Term Care Data  
Patient Margin Analysis**

	1997 Patient Margin %	1999 Patient Margin %
Rural	3.1%	-1.0%
Urban	5.3%	0.9%
<b>Total</b>	<b>4.0%</b>	<b>-0.2%</b>

Source: Annual Report of Nursing Homes (1997, 1999) Nursing Home Component Only

\*Patient Margin Analysis: measure of nursing home patient profit or loss; it is calculated by taking (total profit or loss) – (other operating revenue and non-operating revenue) / (the total net patient revenue)

***What home health is saying***

Twenty-four agencies have closed and over 1,000 jobs have been lost. Not-for-profits, mostly public health units, have been hit the hardest. Revenue reductions in public health have impacted other services. There is no obvious payor to pick up the slack after these huge cuts.

**West Virginia Home Health Agency Data:  
Number of Home Health Agencies**

	<b>1997</b>	<b>1999</b>	<b>Change</b>
West Virginia HHAs	107	65	-39.3%
National Medicare-Certified HHAs	10,444	7,747	-25.8%

Source: West Virginia Health Care Authority Home Health Data (1997, 1999)

**West Virginia Home Health Agency Data:  
Number of Home Health Agencies**

	<b>1997</b>	<b>1999</b>	<b>Change</b>
Unduplicated County	39,708	23,040	-42.0%
Urban	19,359	12,520	-35.3%
Rural	20,349	10,520	-48.3%
Total Visits	2,061,042	604,102	-70.7%
Urban	900,148	267,207	-70.3%
Rural	1,160,894	336,895	-71.0%

Source: West Virginia Health Care Authority Home Health Data (1997, 1999)

**West Virginia Home Health Agency Data:  
Total Visits by Provider Type**

	<b>1997</b>	<b>1999</b>	<b>Change</b>
Skilled Nursing	829,590	278,885	-66.4%
Home Health Aide	1,028,657	212,045	-79.4%
Physical Therapy	116,488	73,715	-36.7%
Speech Pathology	9,456	4,037	-57.3%
Occupational Therapy	12,696	7,899	-37.8%
Medical Social Services	15,190	5,198	-65.8%
Other Therapeutic Services	5,490	139	-97.5%
<b>Total*</b>	<b>2,017,567</b>	<b>581,918</b>	<b>-71.2%</b>

Source: West Virginia Health Care Authority Home Health Data (1997, 1999)

\*Total does not match previous table due to the fact that some home health agencies did not submit this report in 1997 or 1999.

**BBA effect on the Family of Home Health Agencies,  
a Consortium of Public Health Departments**

	<b>1997</b>	<b>1999</b>	<b>Change</b>
Occupational Therapy	765	689	-9.9%
Medical Social Worker	1,608	669	-58.4%
Home Health Aide	186,182	45,402	-75.6%
<b>Total</b>	<b>331,902</b>	<b>113,336</b>	<b>-65.9%</b>

Source: West Virginia Family of Home Health Agencies, Inc. (1997,1999)

**West Virginia Family of Home Health Agencies, Inc.  
Medicare Charges**

	<b>1997</b>	<b>1999</b>	<b>Change</b>
Medicare Charges	\$17,535,144	\$6,949,152	-60.4%

Source: West Virginia Family of Home Health Agencies, Inc. (1997,1999)

***What public health is saying***

The Balanced Budget Act requires change and new solutions, but change is difficult to achieve for most providers. 15-20 hospitals could close if they don't become CAHs, but the Critical Access Hospital option is still not economically secure. There is a need to focus on the criteria of what constitutes an essential provider and place resources for the essential providers and services.

**II. Findings**

Home health services have been cut by more than 50%, and revenues are down over 60%. Rural not-for-profit agencies are hardest hit, and most rural not-for-profits are in public health.

70% of patients in rural hospitals are insured by Medicare, Medicaid or PEIA—all government plans. Another 10 – 15% of patients are uninsured. Rural hospitals under 100 beds that do not convert to CAH are at much greater risk.

For certain providers, data is inadequate to allow the State to assess whether funding is being used effectively. Data collection efforts need greater levels of standardization and reliability. Even so, data does not allow understanding of the impact on overall access to care, since the ability of small rural providers to use Medicare to cross-subsidize care to uninsured and underinsured populations is further limited by the BBA cuts. The importance of building partnering relationships that can seek new efficiencies is heightened.

### **III. Options for Exploration**

The State should explore federal matching opportunities for drawing down additional health funds. The State could explore federal matching opportunities through changes and waivers in the Medicaid program, and through CHIP expansions, to appropriately address assuring access to care throughout rural West Virginia

The State should look at creating reimbursement incentives to network development. Network development should assure market-appropriate services—a mix of those services—in West Virginia’s rural communities, tying community-based need to the economic viability of rural network.

One solution to the financial stability problems would be to form partnerships, like consortia or collaborative arrangements that would allow the providers to seek efficiencies from a larger patient base.

The first step is to understand rural market patterns. Current out-migration patterns for hospitals and primary care facilities in rural markets in distress should be studied.

## **GLOSSARY**

## Legislative/Regulations

**Rural/Urban Definition Used by Medicare:** The designation of an entity as being located in an urban or rural area is based on whether the provider is located in a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA). The MSAs and NECMAs are defined by the Office of Management and Budget. A provider's location in an MSA or NECMA is used as a proxy for an urban location, and an entity not located in such designated areas is considered rural. A hospital may be redesignated by the Medicare Geographic Review Board.

**BBA 97:** The law passed by Congress in 1997, which was designed to balance the federal budget and included 130 billion dollars in Medicare payment reductions.

## Healthcare Finance

**Managed Care:** Refers to a broad and constantly changing array of health plans which attempt to control the cost, quality and access to care by coordinating medical and other health-related services. The vast majority of Americans with private health insurance are currently enrolled in managed care plans.

**Fee for Service:** A payment system by which providers are paid a specific amount for each service performed.

**Medicare + Choice:** The Medicare option under which a beneficiary can enroll in the Medicare managed care program offered by private insurance companies. Enrollment in this program usually includes restrictions set by the plan and may also provide extra benefits such as coverage of prescription drugs.

**Prospective Payment System (PPS):** Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for the coming year and the programs are paid these amounts regardless of the costs they actually incur.

**Children's Health Insurance Program (CHIP):** A program to enable States to initiate and expand child health assistance to uninsured, low-income children. Such assistance should be provided primarily through either or both of two methods: 1) a program to obtain health insurance coverage that meets requirements in Section 2103 relating to the amount, duration, and scope of benefits; or 2) expanding eligibility for children under the State's Medicaid program. In order to be eligible for funds, States must submit to, and obtain approval from, the Secretary for a State Child Health Plan. This program is a capped entitlement for States.

## Special Rural Provider Reimbursement Types

**Rural Health Clinic:** A clinic that is located in a rural underserved area and meets federal guidelines and is designated to receive enhanced reimbursement for the treatment of Medicare and Medicaid beneficiaries.

**Provider Based Rural Health Clinics:** A clinic that is owned and operated by a hospital or nursing home or home health agency and is located in a rural underserved area and meets federal guidelines and is designated to receive enhanced reimbursement for the treatment of Medicare and Medicaid beneficiaries.

**Federally Qualified Health Centers:** A community-licensed health center that provides a comprehensive set of health care and social services, and treats the uninsured, and meets federal guidelines, and is therefore designated to receive enhanced reimbursement for services to Medicaid and Medicare beneficiaries.

**Disproportionate Share Hospital (DSH):** Hospitals that treat a large proportion of Medicare and Medicaid patients and are designated to receive enhanced reimbursement for doing so.

**Rural Referral Center:** A hospital that must meet certain criteria and is therefore designated to receive enhanced inpatient reimbursement:

- Located in a rural area and if has greater than 275 beds it must meet certain referral requirements based on percentage of discharges and mileage requirements or meets requirements based on case-mix index, number of discharges, medical staff, source of inpatients, volume of referrals. For further information see the Certified Federal Register (CFR) 412.96.

**Sole Community Hospital:** A hospital that meets the following criteria and is therefore designated to receive enhanced inpatient reimbursement:

- Located more than 35 miles from other like hospitals OR
  - Located in a rural area and meets 1 of the following conditions:
    1. Located 25-35 miles from other like hospitals and meets criteria based on percentage of Medicare inpatients admitted to other hospitals within certain mileage radius, number of beds, unavailability of specialty services and inaccessibility of other hospitals due to topography or weather.
    2. Located 15-20 miles from other like hospitals but because of prolonged severe weather the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.
    3. Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.
- See CFR 412.92.

**Medicare Dependent Hospital:** a hospital that is located in a rural area and meets the following criteria in order to receive enhanced reimbursement:

- Has 100 or fewer beds during the cost reporting period.
- Is not also classified as a sole community hospital.

At least 60% of inpatient days or discharges were attributable to individuals receiving Medicare part A benefits in 2 of the 3 most recently settled cost report periods.

See CFR 412.08.

**Critical Access Hospital (CAH) :** A type of provider, created in BBA 97, that provides outpatient, emergency and limited inpatient services. A CAH must be a rural public, private, or not-for-profit facility and be located more than a 35 mile drive (15 miles in mountainous terrain or on secondary roads) from a hospital or other CAH unless it is certified by the state as a “necessary provider” of services. A CAH is limited to a maximum of 25 beds, of which no more than 15 can be acute care, all having an average length of stay up to 96 hours. CAH’s are reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare beneficiaries when certified based upon a state plan. In the 2000 Benefit Improvement Protection Act (BIPA), for profit hospitals were allowed to become CAHs.

## **Providers**

**Medicare Skilled Nursing Facility:** An institution which is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

**Medicare Home Health Services:** Health services rendered to an individual as needed in the home. Such services are provided to aged, disabled, or sick or convalescent individuals who do not need institutional care. Under Medicare, such services must be provided by a home health agency.

**Hospital:** An institution whose primary function is to provide inpatient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals are classified by length of stay (short-term or long-term); as teaching or nonteaching; by major type of service; and by control. The hospital system is dominated by the short-term general, non-profit community hospital, often called a voluntary hospital.

**Durable Medical Equipment:** Equipment which can withstand repeated use (i.e., could normally be rented, and used by successive patients); is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient’s home.

## **Financial Analytic Tools**

**Net Patient Revenue:** the net realizable amounts from patients, third-party payers, and others for services rendered.

**Patient Margin:** measure of profit or loss

## **Technology**

**Telemedicine:** The use of telecommunications and information technologies to provide health services, training, and information to health care providers and consumers. The essence is the delivery of services and information to individuals in their own communities instead of the movement of people to the centers of health expertise.

## West Virginia Hospital Classification

### All Rural Hospitals

Beckley Appalachian Regional Hospital  
Bluefield Regional Medical Center  
Boone Memorial Hospital  
Braxton County Memorial Hospital  
Broaddus Hospital Association  
Davis Memorial Hospital  
Fairmont General Hospital  
Grafton City Hospital  
Grant Memorial Hospital  
Greenbrier Valley Medical Center  
Guyan Valley Hospital  
Hampshire Memorial Hospital  
Jackson General Hospital  
Logan General Hospital  
Man Appalachian Regional Hospital  
Minnie Hamilton Health Care Center  
Monongalia General Hospital  
Montgomery General Hospital  
Morgan County War Memorial Hospital  
Plateau Medical Center  
Pleasant Valley Hospital, Inc.  
Pocahontas Memorial Hospital, Inc.  
Preston Memorial Hospital Corp.  
Princeton Community Hospital  
Raleigh General Hospital  
Richwood Area Community Hospital  
Roane General Hospital  
Saint Joseph's Hospital of Buckhannon  
Saint Luke's Hospital  
Sistersville General Hospital  
Stonewall Jackson Memorial Hospital  
Summers County Appalachian Regional Hospital  
Summersville Memorial Hospital  
United Hospital Center  
Webster County Memorial Hospital  
Welch Emergency Hospital  
West Virginia University Hospitals, Inc.  
Wetzel County Hospital  
Williamson Memorial Hospital

## **Rural Hospitals Under 100 Beds**

Boone Memorial Hospital  
Grant Memorial Hospital  
Greenbrier Valley Medical Center  
Hampshire Memorial Hospital  
Jackson General Hospital  
Man Appalachian Regional Hospital  
Montgomery General Hospital  
Morgan County War Memorial Hospital  
Plateau Medical Center  
Pleasant Valley Hospital, Inc.  
Pocahontas Memorial Hospital, Inc.  
Preston Memorial Hospital Corp.  
Saint Joseph's Hospital of Buckhannon  
Saint Luke's Hospital  
Stonewall Jackson Memorial Hospital  
Summers County Appalachian Regional Hospital  
Summersville Memorial Hospital  
Welch Emergency Hospital  
Wetzel County Hospital  
Williamson Memorial Hospital

## **Critical Access Hospitals**

Braxton County Memorial Hospital  
Broaddus Hospital Association  
Grafton City Hospital  
Guyan Valley Hospital  
Minnie Hamilton Health Care Center  
Richwood Area Community Hospital  
Roane General Hospital  
Sistersville General Hospital  
Webster County Memorial Hospital

## **Urban Hospitals**

Cabell Huntington Hospital	Saint Mary's Hospital
Camden Clark Memorial Hospital	Thomas Memorial Hospital
Charleston Area Medical Center	Weirton Medical Center
City Hospital, Inc.	Wheeling Hospital
Eye & Ear Clinic of Charleston, Inc.	
Jefferson Memorial Hospital	
Ohio Valley Medical Center	
Potomac Valley Hospital	
Putnam General Hospital	
Reynolds Memorial Hospital	
Saint Francis Hospital	
Saint Joseph's Hospital	

Source: West Virginia Hospital Association