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The Territory of the Virgin Islands would like to pull this page.

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AMOUNT, DURATION AND SCOPE OF ASSISTANCE
MEDICALLY NEEDY GROUP(S): _____

Limitations

1. Inpatient Services

Limited to care in Virgin Islands hospitals operating under the authority of the Hospital and Health Facilities Corporation, except that when medically necessary and with prior authorization by the Medicaid Agency, the recipient may be referred or transferred to a hospital outside the Virgin Islands. Hospitals must have a provider agreement signed with the Medicaid Agency.

2. Outpatient Services

a. Hospital

Limited to services provided by Virgin Islands hospitals operating under the authority of the Hospital and Health Facilities Corporation, except that when medically necessary and with prior authorization by the Medicaid Agency, the recipient may be referred to a hospital outside the Virgin Islands for outpatient hospital services. Hospitals must have a provider agreement signed with the Medicaid Agency.

b. Rural Health Clinics

There are no rural health clinics in the Virgin Islands.

c. Federally Qualified Health Care Centers

Limited to services provided by the Federally Qualified Health Care Centers (as designated by HRSA) located in the Territory of the Virgin Islands. With prior authorization from the Medicaid Agency, recipients may receive services from Federally Qualified Health Care Centers (as designated by HRSA) located in Puerto Rico or the contiguous United States.

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To project rate years costs, the total historical cost (with the exception of capital costs) are trended to the rate year using the Medicare inflation factors. The projected rate year costs are then divided by projected patient days to determine the facility's interim per diem rate.

Reconciling Adjustments

Using actual cost and patient data, the Department of Heath makes reconciling payment adjustments so as to cover actual allowable facility costs in accordance with the provisions of RIM 15-1. All such reconciling adjustment must be performed within 2 years after the end of the rate year. The Territory reserves the right to audit the data and to request that it be audited.

Managing Per Diem Requirements

The reconciled facility payments take into account the rates related to the managing reforms of OBRA 1987 and 1990. Payment rates of nursing facilities take into account cost resulting from complying with subsections (b) (other than paragraph (3) (f)), (c) and (d) of section 1919 of the Social Security Act. Specifically the nursing facility rates cover all general cost categories including: continuing education of nurse aides, nurse staffing requirements, other staffing requirements (e.g. dieticians, pharmacy, dental, medical records, activities personnel, social worker), resident assessment, plans for care, resident personal funds, residents' rights, and the psychosocial well being of residents.*

Out of State Payments

In order to meet the requirements of 42 CFR 431.52, the Virgin Island will utilize the payments rates in effect in the state, territory or commonwealth where the services will be rendered.

Rate Documentation

The Department of Health makes available to all interested parties the back-up documentation used to set rates for NFs. Such Documentation may be obtained by writing to.....

Bureau of Health Insurance and Medical Assistance
210 - 3A Altona, Suite 302
St. Thomas, Virgin Islands 00802

* The costs for initial nurse aide training and abuse registry are administrative costs and not 4.19-D costs.

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Methods and Standards for Establishing Payments

I. Definition of Claim:

The Virgin Islands Medicaid Agency defines a claim as: "a bill for services delivered to a specified beneficiary by an authorized provider."

II. Payment of Claims by Type of Services:

In reimbursing providers for the cost of services provided, the following method is utilized:

A. Inpatient Hospital Services:

For inpatient hospital services rendered in the Virgin Islands, a printout is produced including all information on all recipients receiving services during a particular month. All the necessary information for processing payment of the bill is furnished.

For services rendered outside of the Virgin Islands (in Puerto Rico or in the contiguous United States) a prior authorization is required from the Medicaid Agency. An MA-4 (Authorization Invoice for Services and Disbursement Voucher) is used. It is required that these forms be submitted to the provider prior to the rendering of the specified services. In the future and as directed by the Medicaid Agency at such time as they are able to process electronic claims, the hospital shall submit all claims and any other necessary information for processing payment of the bill electronically.

All services delivered during one inpatient stay constitute one claim and will be processed accordingly.

B. Outpatient Services:

For Physician Services, Laboratory and X-ray Services rendered within the Department of Health and Hospital and Health Facilities Corporation facilities and by private providers, a printout is produced including all the necessary information for processing payments of the bill. In the future and as directed by the Medicaid Agency at such time as they are able to process electronic claims, the hospital shall submit all claims and any other necessary information for processing payment of the bill electronically.

All services delivered during one outpatient visit constitute one claim and will be processed accordingly.

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Methods and Standards for Establishing Payments (Continued)

C. Home Health Services:

For Home Health Services, a Form MA-2 (Provider Billing for Inpatient Outpatient and Other Services) is used. All services provided during one visit constitute a bill. For Physical Therapy refer to Outpatient Services, item B.

D. Prescribed Drugs and Eyeglasses

Since the Virgin Islands Medicaid Program does not have "Freedom of Choice," the Medicaid beneficiary must use the governmental facilities. When drugs are delivered at the governmental facilities a printout is produced. When the drug prescribed is not available at the governmental facility an MA-3 (Prescription and Pharmacist's Invoice and Disbursement voucher) authorizing the services is given to the recipient to obtain the prescribed drug at a Medicaid authorized provider.

For eyeglasses and MA-3 is used. The service is rendered by a private optometrist who has a signed agreement with the Medicaid Agency. If more than one item is prescribed on a MA-3 form, then the MA-3 form will constitute a single bill. (Each form is considered a bill.)

E. Specialized Services

For specialized services such as prosthetic devices and durable equipment, an MA-4 (Authorization, Invoice and Disbursement Voucher) is used, authorizing the services per item. If more than one item is authorized, the form MA-4 is considered a single bill.

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Methods and Standards for Establishing Payment Rates – Inpatient Care

Virgin Islands Hospitals

For government hospitals, as certified by the Territory government, payment amounts and expenditures will be determined in accordance with the protocol described on Attachment 4.19A pages 1.1 through 1.6.

All facilities must have a signed provider agreement with the Medicaid Agency.

Hospitals in Puerto Rico and the Contiguous United States

Facilities in Puerto Rico or in the contiguous United States are reimbursed at the Medicaid rate of the state or commonwealth in which the facility is located.

All facilities must have a signed provider agreement with the Medicaid Agency.

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Methods and Standards for Establishing Payment Rates – Inpatient Care (Continued)

Inpatient psychiatric facilities providing services to children under age 21 that are located in Puerto Rico or the contiguous United States will be reimbursed the Medicaid rate for the same service of the state or territory in which the facility is located.

All facilities will be accredited in accordance with CFR 441.151(a)(2) and will have a signed provider agreement with the Medicaid Agency.

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Certification of Public Expenditures (CPE) Protocol and Interim Per-Diem Payment System - Inpatient Hospital Services

Cost and Interim Per-Diem Rate Calculations

For the hospitals that the MAP determines are eligible to certify public expenditures/costs, and do certify in accordance with 42 CFR 433.51(b), the expenditures claimable for Federal Financial Participation (FFP) will be the hospital's allowable costs incurred in serving Medicaid inpatients as determined in accordance with Medicare cost principles. This cost assignment exercise will be performed on an annual basis.

For the *payment year* the routine per-diems and ancillary cost-to-charge ratios for the applicable cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare fiscal intermediary (the year for which the cost report is filed is thereafter referred to in this document as the *base year*). The per-diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs are identified from Worksheet B Part I Column 27. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total inpatient days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each inpatient routine cost center, a per-diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per-diem, in accordance with CMS-2552 worksheet D-1, is computed by including

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observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non-medically-necessary private room differential costs from the A&P costs.

The inpatient per-diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid inpatient routine cost center costs for the payment year, the hospital's inpatient Medicaid days by cost center as obtained from validated fee-for-service claims data submitted to MAP for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per-diems from Step 3 for each routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only applicable hospital routine cost centers and their associated costs and days are used - cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded from this computation.

Step 5

To determine Medicaid ancillary cost center costs for the payment year, the hospital's inpatient Medicaid allowable charges as obtained from validated fee-for-service claims data submitted to MAP for the period covered by the as-filed cost report will be used. Medicaid allowable charges for observation beds must be included in line 62. These Medicaid allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid allowable costs for each cost center. The Medicaid allowable charges used are those which pertain to inpatient hospital services only, and exclude charges pertaining to outpatient hospital services, any professional services, or non-hospital component services such as hospital-based providers.

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Step 6

The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid routine cost center costs from Step 4 and the Medicaid ancillary cost center costs from Step 5.

Step 7

For purposes of calculating interim per-diem payments, *net costs* must be derived and used. To arrive at net costs, costs which are eligible for certification are equal to the Medicaid allowable costs described in Step 6 less Medicaid payments for hospital inpatient services made independent of the payment system described herein.

Step 8

Net costs are trended forward to payment year based on data in the most recent Global Insight Healthcare Cost Review[1].

Step 9

Interim per-diem payment rates specific to each hospital are derived by dividing hospital net costs by the sum of Medicaid days identified in Step 4.

Method of Payment – Interim Per-Diem Payments

MAP will make monthly payments to each hospital based on the interim per-diem payment rates computed in Step 9 times the number of Medicaid days reported to MAP by the hospital for the service month during the payment year; a summary spreadsheet of Medicaid days by hospital attached to paper-based or electronically submitted CMS-1450 claim forms for each Medicaid hospital stay will be used to report Medicaid days to MAP. Payments to the hospitals will be made in accordance with federal and local prompt payment standards.

[1] Table 6.3 Hospital Market Basket.

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First Interim Payment Reconciliation

Interim per diem payments made through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If at the end of the interim reconciliation process it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Conversely, if an underpayment is determined the MAP will submit the applicable claim to the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from validated fee-for-service claims data submitted to MAP for hospital inpatient services rendered during the payment year are used.

Step 6

Medicaid payments that are made independent of the Medicaid inpatient hospital per-diem for Medicaid inpatient services for which costs are already included in the Medicaid inpatient hospital cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid inpatient hospital per-diem) under this interim reconciliation process. Additionally, the MAP will take steps to ensure that payments associated with pending fee-for-service claims for Medicaid services included in the current spending year cost report are properly accounted for in this reconciliation.

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Final Cost Report Reconciliation

Once the CMS 2552 cost report for the payment year has been finalized by the Medicare FI with the issuance of a Notice of Program Reimbursement, a reconciliation of the finalized amounts will be carried out. Subsequent reconciliations and adjustments to the CPE claims are also performed for any cost report appeal resolution (including PRRB appeals and intermediary hearings) or cost report reopening that impacts the CPE computation as prescribed in this protocol. The same method as described for the interim reconciliation will be used except that the updated Medicaid program and payment data and finalized CMS 2552 amounts will be substituted as appropriate.

In the final reconciliation, Medicaid cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per-diem for each routine cost center and applying the applicable Medicaid inpatient days from credible claims data to the per-diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per-diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly exempt for Medicaid.

If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. If it is determined that a hospital received an underpayment, MAP will submit the applicable claim to the federal government.

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For hospitals whose cost report year is different from the Territory's fiscal year, MAP will proportionally allocate the costs of two cost report periods encompassing the payment year. To do so, MAP will obtain the actual Medicaid fee-for-service days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid fee-for-service cost for the reporting periods; this Medicaid fee-for-service cost will then be proportionally allocated. All allocations will be made based upon number of months. For example, for a hospital reporting period ending 12/31/09, the Medicaid fee-for-service cost and days/charges from that period encompass three-fourths of the Territory fiscal year ending 9/30/2009, and one-fourth of the Territory fiscal year ending 9/30/2010. To fulfill reconciliation requirements for Territory fiscal year 2009, the hospital would match three-fourths of the Medicaid fee-for-service costs from its reporting period ending 12/31/2009, and one-fourth of the Medicaid fee-for-service costs from its reporting period ending 12/31/2008, to the Territory fiscal year. MAP will ensure that the total costs claimed in a Territory fiscal year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

Fee-for-Service Claim Data Validation Procedures

MAP has claims management processes in place to verify MAP eligibility and service coverage as part of the adjudication of claims for all services. Additionally, MAP will systematically review the records associated with fee-for-service inpatient hospital claims submitted to MAP to ensure the validity of the claims data being submitted and used in the calculations described in this Protocol. Moreover, MAP has utilization management procedures and controls which are employed to prior-authorize (or, following an emergency admission, to timely authorize) all inpatient hospitalizations.