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State Name: West Virginia

State Plan Amendment (SPA) #: 13-006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

AUG 19 2014

Ms. Nancy V. Atkins, RN, MSN, NP-BC, Commissioner
Bureau for Medical Services
WV Department of Health and Human Resources
350 Capitol Street, Room 251
Charleston, WV 25301-3706

RE: State Plan Amendment (SPA) 13-006

Dear Ms. Atkins:

We have completed our review of State Plan Amendment (SPA) 13-006. This amendment modifies the State's methods and standards for reimbursing inpatient hospital services. Specifically, this amendment implements a system of supplemental payments to private and non-State government owned (NSGO) public acute care hospitals.

We conducted our review of this amendment according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Medicaid State plan amendment 13-006 with an effective date of July 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Gary Knight at (304) 347-5723.

Sincerely,

/S/

Cindy Mann
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13 - 006 | 2. STATE: West Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO. REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.271

7. FEDERAL BUDGET IMPACT.
a FFY 2014 $ 51,939,141
b FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT.
Attachment 4.19-A, Page 24e, 24f, 24g
Attachment 4.19-B, Page 1a, 1b, 1c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 4.19-B, Page 1a

10. SUBJECT OF AMENDMENT:
The purpose and rationale for this plan amendment is to generate additional payments to private and non-State government owned and operated acute care PPS hospitals

11. GOVERNOR'S REVIEW (Check One)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED.
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL
/S/

13. TYPED NAME:
Nancy V. Atkins, RN, MSN, NP-BC

14. TITLE:
Commissioner

15. DATE SUBMITTED
9/13/13

16 RETURN TO
Bureau for Medical Services
350 Capitol Street Room 251
Charleston West Virginia 25301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
9/13/2013

18. DATE APPROVED
AUG 19 2013

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME
Penny Thompson

22. TITLE
Deputy Director, Policy + Financial Mgt. CMCS

23. REMARKS:

FORM HCFA-179 (07-92) INSTRUCTIONS ON BACK

Inpatient Hospital Services

M. Access Payments to Private Prospective Payment System (PPS) Hospitals

For services rendered on or after July 1, 2013, the Department will provide Access Payments to enhance payments statewide to all private hospitals participating in the West Virginia-PPS consistent with West Virginia State Code §11-27-38.

A. General Criteria for Hospital Participation

1. Must be a West Virginia licensed inpatient acute care hospital;
2. Must be enrolled as a WV Medicaid provider;
3. Must be a privately owned provider consistent with 42 CFR 447.272(a)(3) and,
4. Must be a participant in West Virginia Medicaid's PPS.

B. Payment Methodology:

1. An Access Payment Pool is established by determining each qualifying hospital's inpatient upper payment limit consistent with 42 CFR 447.272.

   a. In determining a reasonable estimate of Medicaid cost for each hospital, the hospital specific Medicare inpatient cost to charge ratio is derived using the Medicare cost report (2552). For SFY 2014, the Hospital fiscal year end 2011 Medicare cost reports will be utilized. For any hospital for which the 2011 Medicare cost report is not available, the 2010 Medicare cost report will be utilized.
   b. Using the Medicare cost report, hospital specific inpatient Medicare cost to charge ratios will be derived by dividing the sum of all hospital specific Medicare inpatient costs by the sum of all hospital specific Medicare inpatient charges.
   c. The hospital specific Medicare inpatient cost to charge ratio is then multiplied by each hospital's Medicaid inpatient charges to calculate each hospital's inpatient Medicaid cost. Medicaid costs will be inflated by the prorated annual market basket rates from the midpoint of the hospital fiscal year on the cost report utilized to the midpoint of SFY 2014 to estimate costs. The inpatient Medicaid portion of the cost of the .45% tax will also be added to the hospital specific inpatient Medicaid costs.
   d. All hospital specific Medicaid inpatient payments, Medicaid inpatient supplemental payments and applicable third party payments are subtracted from the hospital specific Medicaid cost to determine the upper payment limit gap for each hospital.
   e. The sum of each hospital's upper payment limit gap will constitute the Access Payment Pool.

2. The amount of each hospital's Access Payment will be calculated based on:

Inpatient Hospital Services

a. the percentage of each hospital's Calendar Year ("CY") 2011 total inpatient Medicaid paid claim amounts to the total inpatient Medicaid paid claim amounts for all private PPS hospitals in CY 2011; and,
b. multiplying each hospital's percentage defined in B(2)(a) to the total Access Payment Pool amount described in B(1)(a-e).

3. Each hospital will receive a quarterly Access Payment equal to one-fourth of the amount determined for each hospital in section 2(b).

4. A payment made to a hospital under this provision, when combined with other payments made under the state plan, shall not exceed the limit specified in 42 CFR §447.271 or the limit specified at 42 U.S.C. §1396r-4(g).

N. Access Payments to Public Non-State Government Owned and Operated Hospitals

1. For services rendered on or after July 1, 2013, the Department will provide Access Payments to qualified public, non-state government owned and operated PPS hospitals up to each eligible hospital's cost of providing inpatient hospital services to Medicaid individuals.

A. General Criteria for Hospital Participation:

1. Must be a West Virginia licensed hospital;
2. Must be enrolled as a West Virginia Medicaid provider;
3. Must be a non-state government owned and operated provider consistent with 42 CFR 447.272(a)(2); and,
4. Must be a participant in West Virginia Medicaid's PPS.

B. Payment Methodology:

The Access Payments will be calculated by determining each qualifying hospital's cost of furnishing inpatient hospital services to Medicaid individuals consistent with 42 CFR 447.272 .

a. For each public non-State government owned and operated PPS hospital calculate the reasonable estimate of the Medicaid cost for inpatient hospital services provided to Medicaid individuals and the amount otherwise paid for the services by the Medicaid program.
b. In determining a reasonable estimate of Medicaid cost for each hospital, the hospital specific inpatient total hospital cost to charge ratio is derived using the Medicare cost report (2552). For SFY 2014 the Hospital fiscal year end 2011 Medicare cost reports will be utilized. For any hospital for which the 2011 Medicare cost report is not available, the 2010 Medicare cost report will be utilized.

Inpatient Hospital Services

c. Using the Medicare cost report, each hospital's specific inpatient total hospital cost to charge ratios will be derived by dividing the sum of all hospital specific inpatient costs by the sum of all hospital specific inpatient charges.

d. The hospital specific inpatient total hospital cost to charge ratio is then multiplied by each hospital's Medicaid inpatient charges to calculate each hospital's inpatient Medicaid cost. Medicaid costs will be inflated by the prorated annual market basket rates from the midpoint of the hospital fiscal year on the cost report utilized to the midpoint of SFY 2014 to estimate SFY 2014 costs.

e. All hospital specific Medicaid inpatient payments, Medicaid inpatient supplemental payments and applicable third party payments are subtracted from the hospital specific Medicaid cost to determine the unreimbursed Medicaid cost for each hospital.

2. All hospital specific Medicaid cost gap estimates calculated in 1(B)(e) will be summed to equal the "aggregate non-State government owned (NSGO) UPL gap". All eligible hospitals' hospital specific Medicaid cost gap estimates calculated in 1(B)(e) will be summed to equal the "aggregate eligible hospital gap". If the aggregate NSGO UPL gap is less than the aggregate eligible hospital gap, due to excluded hospitals already receiving payments in excess of Medicaid cost, then the total payments to eligible hospitals will be reduced to not exceed the aggregate NSGO UPL gap. If the aggregate NSGO UPL gap is negative then no payments will be made.

3. Each eligible hospital with unreimbursed Medicaid cost will receive a payment equal to the lesser of:

   A. The hospital's unreimbursed Medicaid cost as calculated in 1(B)(e); and
   B. The ratio of aggregate NSGO UPL gap to the aggregated eligible hospital gap multiplied by the hospital's unreimbursed Medicaid cost as calculated in 1(B)(e).

4. Quarterly Access Payments will be made to all eligible hospitals with unreimbursed Medicaid cost equal to one-fourth of the amount determined for each hospital in section 1(B)(e).

c. Multiplying the proportion determined in 2.b. above by the aggregate upper payment limit amount for all such hospitals, as determined in accordance with 42 CFR §447.321 less all payments made to such hospitals other than under this section. This amount will be adjusted for TPL, beneficiary co-payments and professional physician fees.

3. Supplemental payments made under this section will be made on a quarterly basis to state owned facilities subject to final settlement.

4. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR § 447.321 or the limit specified at 42 USC § 1396r-4(g). Any payment otherwise payable to hospitals under this section, but for this paragraph, shall be distributed to other hospitals in accordance with proportions determined under b.2. above.

2. c. Access Payment to Private Prospective Payment System (PPS) Hospitals

For services rendered on or after July 1, 2013, the Department will provide Access Payments to enhance payments to qualified private PPS hospitals consistent with the terms of West Virginia Code §11-27-38 .

1. General Criteria for Hospital Participation:

(a) Must be a West Virginia licensed outpatient acute care hospital;
(b) Must be enrolled as a West Virginia Medicaid provider;
(c) Must be a privately owned provider consistent with 42 CFR 447.272(a)(3) and,
(d) Must be a participant in WV Medicaid's PPS

2. Payment Methodology:

An Access Payment Pool is established by determining each qualifying hospital's outpatient upper payment limit consistent with 42 CFR 447.371 as follows:

(a) In determining a reasonable estimate of Medicaid cost for each hospital, a hospital specific total hospital outpatient cost to charge ratio is calculated.
(b) The hospital specific total hospital outpatient cost to charge ratio is derived using the Medicare cost report (2552). For SFY 2014 the hospital fiscal year end 2011 Medicare cost reports will be utilized. For any hospital for which the 2011 Medicare cost report is not available, the 2010 Medicare cost report will be utilized.
(c) Using the Medicare cost report, each hospital's specific outpatient total hospital cost to charge ratios will be derived by dividing the sum of all hospital specific outpatient costs by the sum of all hospital specific outpatient charges

(d) The hospital specific total hospital outpatient cost to charge ratio is then multiplied by each hospitals' Medicaid outpatient charges to calculate each hospital's outpatient Medicaid cost. Medicaid costs will be inflated by the prorated annual market basket rates from the midpoint of the hospital fiscal year on the cost report utilized to the midpoint of SFY 2014 estimate the SFY 2014 costs. . The outpatient Medicaid portion of the cost of the .45% tax will also be added to hospital specific outpatient Medicaid costs.

(e) All hospital specific Medicaid outpatient payments, Medicaid outpatient supplemental payments, and applicable third party payments are subtracted from the hospital specific Medicaid cost to determine the upper payment limit gap for each hospital.

(f) The sum of each hospital's upper payment limit gap will constitute the Access Payment Pool.

2. d. Access Payment to Private Prospective Payment System (PPS) Hospitals

1. The amount of each hospital's Access Payment will be calculated based on:

(a) the percentage of each hospital's Calendar Year ("CY") 2011 total outpatient Medicaid paid claim amounts to the total outpatient Medicaid paid claim amounts for all private PPS hospitals in CY 2011; and,

(b) multiplying each hospital's percentage defined in 2(d)(1)(a) to the total Access Payment Pool amount described in 2(c)(2)(a-f)

2. Each hospital will receive a quarterly Access Payment equal to one-fourth of the amount determined for each hospital in section 2(d)(1)(b).

3. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR §447.271 or the limit specified at 42 U.S.C §1396r-4(g).

2. e. Access Payment to Public Non-State Government Owned and Operated Hospitals

For services rendered on or after July 1, 2013, the Department will provide for Access Payments to qualified public non-state government owned and operated PPS hospitals up to each eligible hospital's cost of providing outpatient hospital services to Medicaid individuals.

1. General Criteria for Hospital Participation:

(a) Must be a West Virginia licensed hospital;

(b) Must be enrolled as a West Virginia Medicaid provider;
(c) Must be a non-state government owned and operated provider consistent with 42 CFR 447.272(a)(2); and,
(d) Must be a participant in WV Medicaid's PPS.

2. Payment Methodology:

The Access Payments will be calculated by determining each qualifying hospital's cost of furnishing outpatient hospital services to Medicaid individuals consistent with 42 CFR 447.371 as follows:

(a) For each public non-State government owned and operated hospital calculate the reasonable estimate of the Medicaid cost for outpatient hospital services provided to Medicaid individuals and the amount otherwise paid for the services by the Medicaid program.
(b) In determining a reasonable estimate of Medicaid cost for each hospital, the hospital's cost to charge ratio is derived using the Medicare cost report (2552). For SFY 2014 , the Hospital fiscal year end 2011 Medicare cost reports will be utilized. For any hospital for which the 2011 Medicare cost report is not available, the 2010 Medicare cost report will be utilized.
(c) Using the Medicare cost report, hospital specific outpatient total hospital cost to charge ratios will be derived by dividing the sum of all hospital specific outpatient costs by the sum of all hospital specific outpatient charges.
(d) The hospital specific outpatient total hospital cost to charge ratio is then multiplied by each hospitals' Medicaid outpatient charges to calculate each hospital's outpatient Medicaid cost. Medicaid costs will be inflated by the prorated annual market basket rates from the midpoint of the hospital fiscal year on the cost report utilized to the midpoint of SFY 2014 to estimate SFY 2014 costs.
(e) All hospital specific Medicaid outpatient payments, Medicaid outpatient supplemental payments, and applicable third party payments are subtracted from the hospital specific Medicaid cost to determine the unreimbursed Medicaid cost for each hospital.

3. All hospital specific Medicaid cost gap estimates calculated in 2(e) will be summed to equal the "aggregate non-State government owned (NSGO) UPL gap". All eligible hospitals' hospital specific Medicaid cost gap estimates calculated in 2(e) will be summed to equal the "aggregate eligible hospital gap". If the aggregate NSGO UPL gap is less than the aggregate eligible hospital gap, due to excluded hospitals already receiving payments in excess of Medicaid cost, then the total payments to eligible hospitals will be reduced to not exceed the aggregate NSGO UPL gap. If the aggregate NSGO UPL gap is negative then no payments will be made.

4. Each eligible hospital with unreimbursed Medicaid cost will receive a payment equal to the lesser of:

   (a) The hospital's unreimbursed Medicaid cost as calculated in 2(e); and
   (b) The ratio of aggregate NSGO UPL gap to the aggregated eligible hospital gap multiplied by the hospital's unreimbursed Medicaid cost as calculated in 2(e)

5. Quarterly Access Payments will be made to all eligible hospitals with unreimbursed Medicaid cost equal to one-fourth of the amount determined for each hospital in section 4.

6. A payment made to a hospital under this provision, when combined with other payments made under the state plan, shall not exceed the limit specified in 42 CFR §447.271 or the limit specified at 42 U.S.C §1396r-4(g).