4.19 Payments for Remedial Care and Services

ATTACHMENT 4.19-A Inpatient Hospital Services

A. FACILITIES EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM: The prospective payment system applies to most acute care hospitals in West Virginia. Cases treated in excluded facilities are paid under their current payment methodologies. The qualifying provisions for exempt facilities and units that are of relevance are as follows:

1. **Psychiatric Hospitals:** Psychiatric hospitals and distinct-part units must meet the Medicare regulatory definition of a psychiatric hospital or distinct-part unit and be primarily engaged in providing psychiatric treatment of mentally ill patients.

2. **Rehabilitation Hospitals:** Rehabilitation hospitals and distinct-part units may qualify as excluded facilities if they meet the Medicare regulatory definitions and are primarily engaged in furnishing intensive rehabilitation services. Payment for inpatient rehabilitation hospitals is a cost-based retrospective system determined by applying the standards, cost reporting periods, cost reimbursement principles, and method of cost apportionment used under Title XVIII of the Social Security Act, prior to the Social Security Amendment of 1983 (Section 601, Public Law 98-21). That is, payment is to be determined by the current Medicare Principles methodology of cost-based reimbursement.

3. **Essential Access Community Hospitals (EACH) and Rural Primary Care Hospitals (RPCH):** Excluded from PPS are RPCH hospitals that participate in HCFA's EACH/RPCH program.

   (a) Payment for cases treated in RPCH hospitals is based on Medicare's per diem payment methodology.

   (b) For rate year 1996, payment levels for the RPCH hospitals are at their respective Medicare levels.

   (c) EACH hospitals remain within PPS and receive payment as Sole Community Hospitals.

B. **CASES EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM:** The prospective payment system applies to most, but not all, discharges treated in acute care hospitals in West Virginia. The qualifying provisions for exempt cases that are of relevance are as follows:

1. **Rehabilitation Cases:** If rehabilitation treatment is rendered outside a PPS excluded rehabilitation unit or a freestanding rehabilitation hospital, the discharge cannot be assigned to DRG 462, Rehabilitation. Payment will be denied for all cases assigned to this DRG.

2. **Transplant Cases:** Discharges assigned to the following organ transplant DRGs are excluded from PPS:

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(a) DRG 103, Heart Transplant
DRG 302, Kidney Transplant
DRG 480, Liver Transplant
DRG 481, Bone Marrow Transplant
DRG 495, Lung Transplant
Pancreas/Kidney Transplant

(b) The Bureau will pay the DRG payment for organ transplants that have an assigned DRG with an upper limit established at $ 75,000. For those organ transplants not assigned a DRG, payment will be negotiated on a case-by-case basis with an upper limit established at $75,000.

(c) Organ procurement will be reimbursed separately from the DRG. For service description see ATTACHMENT 3.1-E, Page 1. Reimbursement will be made to the hospital. Payment for the organ procurement will be based on the current organ standard acquisition charge, established by the Center for Organ Recovery and Education (CORE).

3. **Low Volume DRGs:** Cases for which stable and reliable weights could not be calculated, as determined in C2, are excluded from the prospective payment system. Discharges assigned to the following DRGs are excluded from PPS in rate year 1996:

(a) DRG 23, Nontraumatic stupor & coma
DRG 117, Cardiac pacemaker revision except device replacement
DRG 118, Cardiac pacemaker device replacement
DRG 199, Hepatobiliary diagnostic procedure for malignancy
DRG 292, Other endocrine, nutrit & metab O.R. procedure W CC
DRG 293, Other endocrine, nutrit & metab O.R. procedure W/O CC
DRG 457, Extensive burns W/O O.R. procedure
DRG 472, Extensive burns W O.R. procedure
DRG 483, Tracheostomy except for face, mouth and neck diagnoses

(b) For cases in low volume DRGs, payment will be based upon the following four-step estimated cost methodology:

(i) Charges for noncovered services are subtracted from total submitted charges.
(ii) The allowed charges on the hospital bill are multiplied by the hospital's total cost-to-charge ratio to obtain an estimated cost.
(iii) The estimated cost is multiplied by 0.90 to obtain a preliminary payment amount. No adjustments to the payment amount is made for wage differences or indirect medical education costs.
(iv) The preliminary payment amount is multiplied by 1.025 to adjust payment for the West Virginia health care related provider tax.

4. **Invalid DRGs:** Discharges cannot be assigned to the following DRGs:

(a) DRG 109, Not Valid
DRG 438, Not Valid
DRG 469, Principle Diagnostic Not Valid as Discharged Diagnosis
DRG 470, Ungroupable
DRG 474, Not Valid

(b) Payment will be denied for all cases assigned to one of the listed DRGs.

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5. **Same-day, Live Discharges:** Cases with extremely short lengths of stay that involve a live discharge are excluded from PPS.

   (a) **Definition:** A case is defined as a same-day, live discharge when the patient is admitted to the hospital for 24 hours or less, even if it involves an overnight stay, and is discharged alive.

   (b) Cases assigned to DRG 391, Normal Newborn, and DRGs 370 through 375, the maternity DRGs, are excluded from this policy.

   (c) Cases that meet the same-day, live discharge criteria will be denied under PPS. These cases will be paid as outpatients.

C. **METHODS USED TO ESTABLISH DRG PAYMENT WEIGHTS:** The Bureau followed HCFA's current methodology for creating DRG weights. As of January 1, 1996, Medicare's Version 13 GROUPER will be used to assign cases to DRGs. The Bureau will continue to use the most current version of Medicare's GROUPER, which is updated annually.

1. **Development of DRG Weights:** The West Virginia Health Care Cost Review Authority's (HCCRA) UB-82 discharge data for the three public payers for the years 1992 and 1993 were used to derive the Bureau's DRG weights and to calculate hospital-specific case-mix indices. The following methodology was used to calculate the DRG weights:

   (a) All discharges were assigned to a DRG using the Medicare Version 13 GROUPER.

      (1) Cases in which charges exceeded three standard deviations above and below the geometric mean charge for each DRG were deleted prior to calculation of the DRG weights.

      (2) Cases that are excluded from the Bureau's prospective payment system were excluded from the HCCRA billing data prior to calibration of the weights. They are:

         (i) cases treated in PPS exempt facilities as specified in A;
         (ii) transfer cases of sending hospitals, except those cases assigned to DRGs 385 and 456;
         (iii) organ transplants;
         (iv) cases assigned to low volume DRGs; and
         (v) same-day, live discharge cases.

   (b) Two direct adjustments to the hospital charges were made before calculating the DRG weights.

      (1) Charges were standardized for area wage differences by dividing the labor-related portion of charges by the hospital's wage index (see section E1).

(2) Charges from teaching hospitals were standardized for the indirect costs associated with providing medical education by dividing charges by a hospital-specific indirect medical education adjustment factor (see section E2).

(c) Calculation of the DRG weights proceeded as follows:

(1) All charges were totaled for a two year (1992-1993) period across all PPS hospitals and put on an average charge per discharge basis. This became the denominator in the calibration of relative values.

(2) Charges for all cases within each DRG were summed and also put on an average charge per discharge basis. This became the numerator in the calibration of relative values.

(3) DRG-specific charges per discharge were divided by the overall average charge per discharge to produce the DRG relative values.

(4) Each DRG weight is reduced by the proportion of outlier to total PPS payments expected to be made to patients in each DRG as specified in Section F.

(5) All debited weights are normalized by the new average case-mix index value as specified in F3(d).

2. **Identification of Low Volume DRGs:** The Bureau recognized during the process of creating the DRG weights that there were a number of DRGs that did not have sufficient annual volume to construct valid DRG weights.

(a) To identify low volume DRGs, the Bureau used two methods, HCFA's original and current method, for identifying low volume DRGs .

(i) The first method establishes a statistical precision criterion for the DRG weight. The estimated average charge of a DRG had to be within ± 10 percent of its true mean 90 percent of the time. Using this statistical criterion, a minimum number of cases required to ensure a reliable and valid DRG average cost estimate was specified. DRGs that do not have the requisite number of cases were considered as potential low volume DRGs.

(ii) The second method reflects HCFA's simplified and current approach to identifying low volume DRGs; any DRG with fewer than 10 discharges per annum is considered a potential low volume DRG.

(b) Using the 1992/1993 data from HCCRA, weights were calculated for all but 50 DRGs that met either criterion.

(c) Representatives from several hospitals were asked to evaluate the low volume DRG weights relative to other DRG weights in the same MDC for their ability to reasonably

compensate acute care hospitals for the care provided to the insured population. The evaluations were reviewed and if two or more concurred that a DRG 's weight did not appear reasonable, then that DRG was identified as a low volume DRG. The following list of DRGs are excluded from PPS:

(i) DRG 23, Nontraumatic stupor & coma
(ii) DRG 117, Cardiac pacemaker revision except device replacement
(iii) DRG 118, Cardiac pacemaker device replacement
(iv) DRG 199, Hepatobiliary diagnostic procedure for malignancy
(v) DRG 292, Other endocrine, nutrit & metab O.R. procedure W CC
(vi) DRG 293, Other endo., nutrit & metab O.R. procedure W/O CC
(vii) DRG 457, Extensive burns W/O O.R. procedure
(viii) DRG 472, Extensive burns W O.R. procedure
(ix) DRG 483, Tracheostomy except for face, mouth and neck diagnoses

(d) The Bureau modified the following three DRGs' weights based upon recommendations of the hospital representatives:

(i) DRG 61's weight was set equal to DRG 62's weight;
(ii) DRG 146's weight was set equal to DRG 148's weight; and
(iii) DRG 147's weight was set equal to DRG 149's weight.

(e) Following the removal of low volume DRGs, the DRG weights were recalculated using the method described in C1.

3. **Development of Case Mix Index :** To develop a DRG payment system, each hospital must have an overall case mix index (CMI). The index is used to adjust hospital costs to make them more comparable prior to calculating standardized operating and capital payment amounts. Case mix indices were established using the following methodology:

(a) The DRG weights established in Sections C1 and C2 were used to create these case mix indices.

(b) 1992 and 1993 HCCRA UB-82 billing data for the three public payers were used and assigned to a DRG using the Medicare Version 12 GROUPER.

(c) The proportion of discharges in each DRG for each hospital was calculated.

(d) The DRG-specific proportion of discharges was multiplied by its appropriate DRG weight and summed across all DRGs at the hospital level. This creates the numerator.

(e) The denominator is the average of C3(d) across all hospitals and DRGs divided by the total number of W. Virginia PPS hospitals.

(f) Each hospital's CMI is developed by dividing the product calculated in C3(d) by the

overall average calculated in C3(e), thereby resulting in a statewide average value of 1.0 in West Virginia.

4. **Recalibrating DRG Weights:** The Bureau will calibrate the DRG weights annually using the most currently available HCCRA discharge data for the W. Virginia three public payers.

(a) HCCRA data for the most recent two year time period will be used by Bureau to recalibrate the DRG weights.

(b) The recalibration will occur during the last calendar quarter of each rate year.

(i) The discharge data will be assigned to the Medicare GROUPER that takes effect on October 1 of the current rate year.

(ii) The recalibrated weights will be constructed following the methodology as described in Section C1.

(iii) The recalibrated weights will be effective on January 1 of the new rate year.

D. **METHODS USED TO ESTABLISH PROSPECTIVE OPERATING PAYMENT RATE:** The Bureau has established two standardized operating payment amounts: one standardized amount for large urban hospitals and another standardized amount for all other hospitals. For consistency, the Bureau will implement a uniform single-payer standardized amount with the other two state public payers using inpatient PPS (Public Employees Insurance Agency and Worker's Compensation) for operating and capital costs in rate year 2001.

1. **Basis of the Standard Operating Payment Amounts:** The Bureau uses Medicare's definition of allowable costs associated with each discharge as the basis for the standardized payment amounts for operating costs. However, the level of allowable costs for the most costly hospitals is capped at the hospital's 80th percentile average allowable cost per case.

(a) Costs for PPS-excluded hospitals or units as specified in Section A and for PPS-excluded cases as specified in Section B are not included in the PPS standardized payment amounts. Furthermore, the following types of costs were removed before the base operating costs were calculated:

(i) direct medical education costs,
(ii) capital related costs,
(iii) kidney acquisition costs, and
(iv) services provided by CRNAs.

(b) The operating cost per discharge is determined by converting each claim's charges to cost. The following steps outline the process:

(i) 1992 HCCRA hospital billing date for Medicaid patients were used to estimate the base year cost per discharge.

(ii) Charges and utilization data on claims were converted into costs using data from audited Medicare Cost Reports from federal fiscal year 1991.

(ii) All services and charges excluded from coverage were removed from the claims data.

(c) Two types of costing factors were developed for each hospital in order to convert the charges on individual claims into costs:

(i) cost-to-charge ratios for each of the ancillary departments; and

(ii) nursing (room and board) cost per inpatient day by type of accommodation.

(d) Ancillary charges, by department, were multiplied by their applicable cost-to-charge ratios to determine ancillary costs.

(e) The number of days indicated on the claim for each type of accommodation were multiplied by their applicable nursing cost per inpatient day to determine total nursing costs for the inpatient stay.

(f) Total ancillary costs and total nursing costs were added together to obtain the total costs for each claim.

(g) The standardized operating payment amounts provide reimbursement to hospitals for all services provided during the entire inpatient stay and for all outpatient services, including all preadmission diagnostic and nondiagnostic services, provided on the day of admission.

2. **Hospital-Specific Adjustments to Costs:** Adjustments were made to the estimated hospital costs to remove the effect of case mix, wage differences and indirect medical education costs prior to calculation of the average standardized cost per discharge within each peer group.

(a) **Case Mix Adjustment:** Hospital costs are standardized to account for case mix by dividing the hospital's average cost per case, as determined in D3, by its respective case mix index as determined in C3.

(b) **Wage Difference Adjustment:** Hospital labor-related costs are standardized to account for differences in wages across the state by dividing each hospital's average cost per case, as determined in D3, by its respective geographic wage adjustment factor, as determined in Section E1.

(c) **Indirect Medical Education Adjustment:** Teaching hospitals' costs were standardized to remove indirect costs associated with training physicians, by dividing each teaching hospital's average cost per case, as determined in D3, by its respective indirect medical education adjustment factor, as determined in E2.

3. **Establishing Maximum Operating Cost Thresholds:** The Bureau established maximum average

operating costs per discharge thresholds for each peer group of hospitals and across all hospitals using the following methodology:

(a) A 1992 average standardized operating cost per case was estimated for each hospital by summing standardized operating costs, as specified in Sections D1 and D2, to the hospital level and dividing by the hospital's total number of cases.

(b) Within each peer group, hospitals were arrayed from highest to lowest average standardized cost per case.

(c) The 80th percentile hospital's 1992 average standardized cost per case was used as the threshold in each peer group.

(i) The threshold for the large urban peer group was established at $2,533.

(ii) The threshold for the all other peer group was established at $2,684.

(d) The costs of hospitals exceeding these thresholds were capped at the threshold for purposes of calculating the standardized amounts.

(e) A statewide cap was established by arraying all hospitals from highest to lowest average standardized cost per case.

(f) The 80th percentile hospital's average standardized cost per case was used as the statewide threshold.

(i) The statewide threshold for rate year 1992 was established at $2,701.

(g) Sole Community Hospitals' own 1992 operating costs are not capped at the 80th percentile for payment purposes if the hospital elects to receive payment as a Sole Community Hospital.

4. **Calculation of 1992 Peer Group Average Standardized Cost Per Case:** The 1992 base year standardized average cost per case was determined as follows:

(a) Hospital-specific average standardized operating costs per case were determined, as specified in Sections D1, D2 and D3.

(b) Within each peer group, an overall average standardized operating cost was determined by:

(i) multiplying each hospital's average standardized operating cost by its number of discharges;

(ii) summing across all hospitals within the peer group; and

(iii) dividing through by the total number of discharges across all hospitals within the peer group.

5. **Establishment of Rate Year 1996 Standardized Operating Payment Amounts:** The 1992 base year peer group average cost per case estimates were trended forward to rate year 1996 by the DRI/McGraw Hill PPS Hospital Index to account for (a) input price inflation from 1992 to 1996 and (b) anticipated DRG coding changes from 1992 to 1996.

(a) The 1992 base year peer group average costs were trended forward to rate year 1996 to account for price inflation using the DRI/McGraw Hill PPS Hospital Market Basket Index.

(b) The 1996 standardized operating costs were adjusted downward to account for an estimate of DRG coding improvement that is expected to be reflected in 1996 claims relative to 1992 claims, and that is unrelated to real case mix changes. Data obtained from the W. Virginia Health Care Cost and Review Authority (HCCRA) were used to estimate both real case mix change and case mix change due to more complete coding. The following methodology was used:

(i) The annual change in case mix across all W. Virginia discharges, including Medicare, was 1.12% for the years 1991 through 1995. The Bureau determined that this was a reasonable estimate of real case mix change.

(ii) The annual change in case mix across Medicaid discharges was approximately 5% between 1992 and 1994.

(iii) Subtracting 1.12% in real annual growth from 5% nominal annual growth leaves a 3.88% annual change in case mix. The Bureau decided to treat 50% of this annual change, or 1.9%, as real case mix change and 50%, or 1.9%, as representing improvements in coding not reflected in the 1.12%.

(iv) The 1.9% change in case mix due to coding improvements was compounded annually over four years, 1992 - 1996, to yield an 8% adjustment factor.

(v) 1996 updated standardized operating payment amounts were reduced by 8% to account for expected DRG coding improvements that are projected to occur during the 1992 through 1996 rate years.

(vi) The 1996 updated standardized payment amounts were further reduced by 4% to finance the expected additional payments to hospitals for high cost outlier cases.

6. **Standardized Operating Payment Amounts for Rate Year 1996:** The Bureau has established two standardized operating payment amounts: one standardized amount for large urban hospitals and another standardized amount for all other hospitals. Hospitals located in the following three counties receive the higher large urban standardized amount: Kanawha, Cabell and Putnam counties.

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(a) For rate year 1996, the updated 1992 standardized amount for hospitals in large urban areas is $2,213.00.

(b) For rate year 1996, the updated 1992 standardized amount for hospitals not in large areas is $2,095.52.

(c) For rate year 1996, the updated 1992 statewide standardized amount is $2,135.

(d) The Bureau will phase out the two separate standardized operating amounts, moving to one statewide standardized amount in rate year 2000, using the schedule in Attachment A.

(e) For consistency, the Bureau will implement a uniform single-payer standardized amount with the other two state public payers using inpatient PPS (Public Employees Insurance Agency and Workers' Compensation) for operating and capital costs in rate year 2001.

7. **Payment for Sole Community Hospitals:** The Bureau gives special payment consideration to small rural or "isolated" hospitals through it's sole community provider program.

(a) Medicare-determined Sole Company Hospitals (SCH) will be paid on a DRG per case basis using the same rules as other acute care hospitals.

(b) SCH's own costs were standardized for case mix, wage difference and indirect medical education costs.

(c) For rate years 1996 through 1999, a SCH's standardized payment amount is based on a 50-50% blend of the non-large urban peer group amount and its own 1992 average allowable costs per discharge updated through the rate year using the DRI/McGraw Hill PPS Hospital Index.

(d) For rate years beginning 2000, a SCH's standardized payment amount is a 50-50% blend of the statewide standardized amount and its own 1992 average allowable cost per discharge updated through the rate year using the HCFA Hospital market basket as reported in the Federal Register. The Bureau will offset the payment amount for 2000 by national productivity improvements percentage as estimated by the Medicare Payment Advisory Commission. More specifically, the 3.6% increase in the HCFA market basket for the 18 months, January 1998 - June 1999, that was used for RY2000 was reduced by 2.025% based on MedPAC's estimate of national hospital productivity gains.

(e) For rate years beginning 2001, the Bureau will use both national productivity improvements and West Virginia hospital productivity improvement and site of service change in determing the update. The productivity gain estimate will be based on an analysis of trends in (a) patient lengths of stay, site of care, and case-mix-adjusted operating costs per case, (b) case-mix-adjusted discharges per employee and hourly wages, and (c) hospital operating and total margins. The percent growth in the DRI Hospital Index will be reduced by the estimated percent increase in overall hospital industry productivity. In addition, the Bureau will adjust the labor portion of the national market basket to reflect the West Virginia labor market as measured using ES 202 date. In past years, national trends in hospitals-related wages have been used in DRI's Hospital Index of input costs, i.e. the market basket. Beginning in 2001, West Virginia specific trends ES 202 wage date will be substituted in constructing the DRI market basket. West Virginia trends in wages have been systematically lower than trends nationally. For example, assume that wages and salaries are 70% of market basket costs. Further assume that the forecasted wage index based on national data was 104 (on a base of 100) while the West Virginia wage index was 103. Then, assuming non-salary costs rose 2% (to 102), the nationally-based market basket inflation factor would grow 3.4% (=.7*104 + .3*103)versus only 2.7% (=7*103 - 3* 102) using West Virginia wage trends. In calculating the allowed market basket update component, the DRI labor-nonlabor weights will be used.

(f) Sole Community Hospitals will be offered a one-time choice to elect payments as a regular prospective payment system hospital.

8. **Payment of West Virginia Health Care-Related Tax**: The standardized operating payment amounts are multiplied by 1.025 to adjust payment for West Virginia health care-related tax.

(a) The West Virginia health care-related tax is a Medicare allowable cost.

(b) The West Virginia health care-related tax was not included in the FY 1992 Medicare cost reports nor the 1992 HCCRA hospital billing data that were used to calculate the standardized operating payment amounts.

9. **Updating Beyond Rate Year 1996:** The peer group operating costs and the Sole Community Hospitals' own operating costs will be updated beyond rate year 1996 by the DRI/McGraw Hill PPS Hospital Index.

(a) For rate year 2000, the peer group operating costs and the SCH's own operating costs will be updated by the HCFA hospital market basket as reported in the Federal register offset based upon national productivity improvements as estimated by the Medicare Payment Advisory Commission. Beginning with rate year 2001, the Bureau will consider both national productivity improvement and West Virginia hospital productivity improvement and site of service change in determining the update. In addition, the Bureau may adjust the labor portion of the national market basket to reflect the West Virginia labor market as measured using ES 202 data.

E. **HOSPITAL ADJUSTMENTS TO STANDARDIZED OPERATING RATE PAYMENTS**: The prospective operating payments are adjusted at the point of discharge for wage differences and indirect medical education costs.

1. **Wage Difference Adjustment:** Adjustments are made to the labor-related portion of the operating payment amounts to reflect differences in wages across the state.

(a) Three rural markets and three urban labor markets have been defined based on counties with similar average hospital wages. Hospitals located in counties in each of these market areas will have the labor portion of the standardized payment amount adjusted by the wage index value that is assigned to their respective market area.

(b) Wage data were obtained from the HCFA Wage Index Computer File; Federal Register, Sept. 1, 1994, pp. 45937-46447, and represent fiscal year 1991 Medicare cost report filings.

(c) The six markets wage index values were developed as follows:

(i) This discharge-weighted average hourly wage of hospitals in each geographic area was calculated. This represents the numerator in the index value.

(ii) A statewide discharge-weighted average hourly wage of hospitals was calculated. This represents the denominator in the index value.

(iii) Each market area's average hourly wage was divided by the statewide average hourly wage to create the six wage index values. The six market areas and their index values are as follows:

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Area	Counties	Average Adjusted Hourly Wage	Wage Index Value
1.	McDowell, Logan, Mingo Boone, Wayne, Lincoln, Wyoming	$14.14	0.95766
2.	Cabell, Putnam, Kanawha, Fayette, Raleigh, Summers, Mercer, Monroe, Greenbrier	15.47	1.04742
3.	Wood, Mason	14.23	0.96342
4.	Jackson, Roane, Clay, Nicholas, Webster Pocahontas, Upshur, Barbour, Taylor	11.33	0.76728

	Gilmer, Calhoun, Wirt, Ritchie, Doddridge, Tyler, Wetzel, Pleasants, Braxton		
5.	Randolph, Pendleton, Tucker, Hardy Grant, Preston, Mineral, Hampshire, Morgan, Berkeley, Jefferson	13.80	0.93463
6.	Lewis, Harrison, Marion, Monongalia Marshall, Ohio, Brooke, Hancock	14.86	1.00595
	Overall	14.77	1.00000

(d) The wage adjustment applies to only the labor-related portion of operating costs. The Bureau uses Medicare's determination that 71% of operating costs are labor-related and 29% of operating costs are nonlabor-related costs.

(i) The formula for calculating the market area geographic wage adjustments, which represents the weighting for labor and nonlabor related portions of operating costs, is as follows:

Geographic wage adjustment factor = (0.71 * wage index) + 0.29

(ii) The six index values are as follows:

Area	Counties	Geographic Wage Adjustment Factor
1.	McDowell, Logan, Mingo Boone, Wayne Lincoln, Wyoming	0.970
2.	Cabell, Putnam Kanawha, Fayette, Raleigh Summers, Mercer, Monroe, Greenbrier	1.034
3.	Wood, Mason	0.974
4.	Jackson, Roane, Clay, Nicholas Webster, Pocahontas, Upshur Barbour, Taylor, Gilmer Calhoun, Wirt, Ritchie, Doddridge Tyler, Wetzel, Pleasants, Braxton	0.835
5.	Randolph, Pendleton, Tucker, Hardy	0.954

	Grant, Preston, Mineral, Hampshire Morgan, Berkeley, Jefferson	
6.	Lewis, Harrison, Marion, Monongalia Marshall, Ohio, Brooke, Hancock	1.004

(e) The Bureau will evaluate the need to update the geographic wage adjustment factor on an annual basis using the most recent wage data as reported by HCFA in its Wage Index Computer File and as published in the Federal Register.

2. **Indirect Medical Education Adjustment:** An adjustment is made to the operating portion of the standardized payment amount to teaching hospitals to cover the indirect costs associated with training physicians.

(a) The IME teaching add-on is applied to the sum of the basic DRG payment and outlier payment amounts for the case.

(b) The IME adjustment was obtained from a regression equation which explains how allowable costs per case vary by teaching intensity, measured as the log of [1 + residents/(average daily census)], among other factors. Teaching intensity was found to have a significant, positive influence on allowable costs per case compared to nonteaching hospitals.

(c) The exponential coefficient on the teaching intensity variable (0.319) is applied to one plus the ratio of interns and residents to average daily census to yield the multiplicative IME payment adjustment. For each teaching hospital, its own 1994 FTE intern-resident to average daily census ratio is the basis for the IME adjustment factor. The IME adjustment is based upon the following formula:

$$[1 + \text{interns and residents}/(\text{average daily census})]^{0.319}$$

(d) **Establishment of Maximum Allowable Number of Specialist Residents:** The Bureau established a maximum allowable number of residency positions for specialists in each teaching hospital.

(i) The Bureau established that only three-quarters of the nonprimary care residents in teaching institutions would be eligible for coverage.

(ii) Each teaching hospital's number of FTEs in specialty training programs was capped at 75% and the number of interns residents per teaching hospital recalculated to reflect the cap.

(iii) All primary care residents are eligible for full payment coverage.

(e) **Establishment of Minimum Occupancy Rate:** The Bureau established a minimum hospital occupancy rate that would be reflected in each teaching hospital's average daily census.

(i) The Bureau established that each hospital must meet a minimum 75% occupancy rate.

(ii) Each teaching hospital that had a occupancy rate of less than 75% had its average daily census set equal to a value that would achieve the occupancy rate minimum of 75%.

(f) **Rate Year 1996 Indirect Medical Education Adjustments Factors:** The Bureau has established the following IME adjustment factors for rate year 1996:

Hospital	IME Factor
West Virginia University Hospital	1.198
Greenbrier Valley	1.008
United Hospital Center	1.023
St. Mary's Hospital	1.017
Charleston Area Medical Center	1.052
Monongalia General	1.003
Ohio Valley Medical Center	1.054
Logan General	1.015
Wheeling Hospital	1.022
Cabell Huntington	1.047

(g) The Bureau will evaluate the need to update the indirect medical education adjustment factor on an annual basis using the most currently available data from the Medicare cost reports.

F. **METHODS USED FOR PAYMENT FOR HIGH COST CASES:** The Bureau will make an additional payment to the DRG payment rate in certain instances where cases are found to be extremely resource intensive.

1. **Definition of High Cost Case:** A discharge qualifies as a cost outlier and the hospital will receive additional payment if the adjusted operating cost for a case exceeds the DRG payment rate plus a fixed dollar amount, or deductible. The sum of the DRG payment and the fixed dollar deductible is called the outlier threshold.

   (a) No additional outlier payments will be made for high cost capital cases.
   (b) No additional outlier payments will be made for cases that have long lengths of stay unless they meet the criteria as specified in Section F5.

2. **Establishment of Level of Risk Sharing:** The Bureau has determined the following:

   (a) The outlier payments will be self-financing through a uniform reduction in the standardized operating amounts for each peer group and through a DRG-specific reduction in the DRG weights. The outlier payment for high cost cases is 4% for the 1996 rate year. This 4% (as in the Medicare program) is a target dollar amount, rather than a limiting amount. No pre-set dollar limits are applied and, during any rate year, total outlier payments may exceed the target outlier payment.

   (b) The Bureau has established the outlier pool at 4% for rate year 1996.

   (c) The Bureau has established the outlier payment portion as 80 percent of estimated operating costs above the fixed loss threshold.

3. **Establishment of the Fixed Dollar Deductible:** The high cost outlier fixed loss deductible is determined by the size of the outlier pool. For rate year 1996, the Bureau has established an outlier pool of 4 percent of total hospital

payments and will pay 80% of estimated costs above the threshold to hospitals.

(a) The high cost outlier threshold was determined using the following iterative process:

(i) establishing a preliminary threshold;
(ii) calculating total outlier payments;
(iii) estimating the size of the outlier pool as a percentage of total PPS payments;
(iv) adjusting the DRG weights and standardized operating payment amounts to maintain budget neutrality within PPS; and
(v) adjusting the thresholds until a 4% outlier pool was obtained.

(b) Calculation of the high cost outlier payments were determined by comparing the standardized estimated costs of a case to the outlier threshold and multiplying the differential by 80 percent.

(c) The cost of a case was determined by multiplying submitted charges on each 1992 HCCRA Medicaid hospital bill by the appropriate operating cost-to-charge ratio, adjusted for indirect medical education costs. The IME adjustment is made because no IME add-on is applied to DRG payments for purposes of calculating the size of outlier payments.

(d) The DRG-specific adjustment to the DRG weights used the following methodology:

(i) Each DRG weight is reduced by the proportion of outlier to total PPS payments expected to be made to patients in the DRG.

(ii) All debited weights are normalized by a new average case-mix index value calculated using the methodology specified in Section C3 and the debited weights calculated in Section F3.

(e) The standardized operating amounts were reduced by 4%.

(f) For rate year 1996, the fixed dollar deductible has been set at $11,040.

4. **Establishment of High Cost Outlier Threshold:** The high cost outlier threshold is the determined for each DRG and each hospital as follows:

(a) For hospitals that are not Medicare designated Sole Community Hospitals, the hospital's peer group standardized operating payment is multiplied by the appropriate geographic wage adjustment factor to yield a wage-adjusted standardized operating amount.

(b) For hospitals that are Medicare designated Sole Community Hospitals, a wage-adjusted standardized operating amount is calculated using the following three steps:

(i) The hospital's peer group standardized operating payment is multiplied by the appropriate geographic wage adjustment factor and by 0.50.

(ii) The hospital's own standardized operating costs is multiplied by the appropriate geographic wage adjustment factor and by 0.50.

(iii) The two products are summed.

(c) The wage-adjusted standardized operating amounts are multiplied by the DRG weights to yield a wage-adjusted DRG operating payment amount.

(d) Hospital-specific deductibles are calculated by multiplying the fixed dollar threshold by each hospital's geographic wage adjustment factor.

(e) The DRG-specific outlier thresholds are determined for each hospital by adding the wage-adjusted DRG operating payment amount to the hospital-specific fixed dollar deductible.

5. **Identification of High Cost Cases:** Cases with extraordinary costs are determined by comparing estimated costs to a fixed-dollar outlier threshold for the DRG to which the case has been assigned using the following methodology:

(a) All charges for non-covered services as well as charges for all services that should be billed separately on a HCFA-1500 are subtracted from the submitted charges.

(b) The adjusted charge is multiplied by the hospital's operating cost-to-charge ratio, adjusted by the geographic wage adjustment factor, to obtain an estimated operating cost.

(c) The estimated operating cost for the case is compared with the outlier threshold for the DRG to which the case has been assigned.

(d) If the estimated cost exceeds the outlier threshold value, then the case qualifies for high cost outlier payments.

6. **Calculation of Outlier Payment:** The additional outlier payment is calculated as follows:

(a) The operating costs eligible for outlier payments are determined by subtracting the outlier threshold from the adjusted operating cost as specified in F5(b).

(b) The amount calculated in F6(a) is multiplied by the marginal cost factor of 0.80.

(c) The outlier payment is adjusted for indirect medical education by multiplying the amount determined in F6(b) by each hospital's respective indirect medical education adjustment factor.

(d) The total outlier payment amount determined in F6(c) is multiplied by 1.025 to adjust payment for the W. Virginia health care related provider tax.

7. **Updating the High Cost Outlier Threshold:** The Bureau will update the high cost outlier threshold annually to produce an expected 4% outlier payment pool. The Bureau will use the methodology as specified in Section F4 using the most available discharge data.

G. **METHODS USED TO ESTABLISH PROSPECTIVE CAPITAL PAYMENT RATES:** Capital costs will be reimbursed on

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a prospective per case basis which is determined by multiplying standardized capital payment amounts and the DRG weights. The 1996 standardized capital payment is a blend between a 1992 peer group amount and the hospital's own 1994 capital costs per discharge; all costs updated through the rate year 1996 using ProPAC's update methodology.

1. **Basis of the Standardized Capital Payment Amounts:** Capital represents a provider's stock of physical assets; the buildings, plant, land, and equipment.

   (a) Medicare principles were used to identify capital costs eligible for reimbursement. These costs include the following:

   (i) straight-line depreciation over the useful life of the asset;

   (ii) interest expenses related to patient care;

   (iii) leases and rental expenses;

   (iv) land and medical equipment that are allowable under Medicare cost reimbursement principles; and

   (v) other capital expenses, including but not limited to asset insurance, costs of minor equipment, taxes on land and depreciable assets, and capital costs of related organizations.

   (b) Fiscal year 1991 Medicare Cost Report and 1992 HCCRA hospital billing data for Medicaid discharges formed the basis for determining 1992 capital costs.

   (c) Fiscal year 1994 Medicare Cost Report and 1994 Medicaid hospital billing data formed the basis for determining 1994 capital costs.

   (d) A 1992 estimated capital cost for each Medicaid discharge was produced using 1992 Medicaid claims with their bed accommodation and ancillary department charges against per diems and cost-to-charge ratios calculated from the 1991 Medicare cost report. The following methodology was used:

   (i) Indirect capital costs were stepped down to bed accommodations and ancillary departments, where they were added to directly assigned capital costs.

   (ii) Capital cost per diems were calculated for the five nursing departments.

   (iii) Capital cost-to-charge ratios were calculated for the same 12 ancillary departments used to derive operating costs.

   (iv) To determine ancillary costs, ancillary charges on the 1992 billing data were multiplied by their respective capital cost-to-charge ratios.

   (v) To determine bed accommodation costs, bed accommodation lengths of stay were multiplied by their respective capital cost per diems.

(vi) The sum of F2(d)(iv) and F2(d)(v) produced a capital cost for each claim.

2. **Hospital-Specific Adjustments to Costs:** An adjustment was made to the estimated capital costs to remove the effect of case mix prior to calculation of the average standardized capital cost per discharge within each peer group.

(a) **Case Mix Adjustment:** The hospital's average capital cost per case is standardized to account for case mix by dividing the hospital's average capital cost per case by its case mix index as determined in Section C3.

(b) An overall average hospital capital cost per case was generated aggregating across all Medicaid patients.

3. **Establishing 1996 Capital Cost Peer Groups**

(a) An ordinary least squares regression was estimated on the average capital cost per case per hospital as derived in Section G2. The market geographic cost index, bed size, dummy variables for major vs. minor teaching status (defined as residents per average daily census greater than .2 or greater than 0) vs. Nonteaching (=0), disproportionate share percentage, and dummies for large vs. small urban cities were used as explanatory variables.

(b) Based on the regressions, it was concluded that capital costs per patient did not vary by hospital labor market wage differences, bed size or disproportionate share status, once costs were standardized for case mix, nor did they vary between rural and urban hospitals after adjusting for case mix. However, capital costs did vary by urban location and teaching status.

(c) Based on these findings, the Bureau decided to create three peer groups for capital costs:

(i) Major teaching peer group;
(ii) Large urban, nonmajor teaching peer group; and
(iii) All-other peer group.

4. **Establishing Maximum Capital Cost Thresholds:** The Bureau established maximum 1992 average capital costs per discharge thresholds for each peer group of hospitals and maximum 1994 average capital costs per discharge thresholds for each hospital's own costs using the following methodology:

(a) 1992 and 1994 average standardized capital costs per case were estimated for each hospital.

(b) Within each peer group, hospitals were arrayed from highest to lowest 1992 average standardized capital cost per case.

(c) The 80th percentile hospital's 1992 average standardized capital cost per case was used as the threshold for the two nonmajor teaching peer groups.

(i) The 1992 threshold for the large urban, nonmajor teaching peer group was established at $485.

(ii) The 1992 threshold for the all-other peer group was established at $277.

(iii) The 1992 threshold for the combined nonmajor teaching peer groups was established at $321.

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(d) For the major teaching peer group, which only contains four hospitals, the 80th percentile average capital cost per case was imputed.

(i) The 1992 threshold for the major teaching peer group was established at $438.

(e) The average cost of hospitals exceeding these thresholds were capped at the threshold and the three 1992 peer group averages calculated.

(f) To establish the 1994 thresholds within each peer group, hospitals were arrayed from highest to lowest 1994 average standardized capital cost per case.

(g) The 80th percentile hospital's 1994 average standardized capital cost per case was used as the threshold in each peer group.

(i) The 1994 threshold for the major teaching peer group was established at $360.

(ii) The 1994 threshold for the large urban, nonmajor teaching peer group was established at $325.

(iii) The 1994 threshold for the all-other peer group was established at $207.

(iv) Sole Community Hospitals' own 1994 capital costs were not subject to the 80th percentile threshold provision.

(v) 1994 thresholds were below 1992 thresholds due to declining average capital costs for the majority of hospitals.

(h) The average costs of hospitals exceeding these thresholds were capped at the threshold.

5. **Calculation of the 1992 Peer Group Average Standardized Capital Cost Per Case:**

(a) 1992 capital costs per discharge were calculated for three peer groups:

(i) The first peer group includes 4 major teaching hospitals, defined as those with intern -resident to average daily census ratio greater than 0.20.

(ii) The second peer group includes hospitals located in the three large urban counties of Kanawha, Putnam and Cabell, excluding major teaching hospitals.

(iii) The third peer group consists of all remaining hospitals.

(b) Within each peer group, an overall average standardized capital cost was determined by:

(i) multiplying each hospital's average standardized capital cost by its number of discharges;

(ii) summing across all hospitals within the peer group; and

(iii) dividing through by the total number of discharges across all hospitals within the peer group.

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6. **Establishment of Rate Year 1996 Standardized Capital Payment Amounts:** The 1992 and 1994 base year standardized average capital cost per case were trended to rate year 1996 to account for (a) inflation related to capital investment and (b) anticipated DRG coding changes from 1992 to 1996.

   (a) Each peer group's 1992 average capital cost was inflated to rate year 1996 using the Prospective Payment Assessment Commission's (ProPAC) capital update factors.

   (b) Each hospital's own 1994 average capital cost was inflated to rate year 1996 using the Prospective Payment Assessment Commission's (ProPAC) capital update factors.

   (c) 1996 updated capital payment amount were reduced by 8% to account for expected DRG coding improvements that are projected to occur during the 1992 through 1996 rate years and as specified in Section D5(b).

7. **Standardized Capital Payment Amounts for Rate Year 1996:** The Bureau has established three standardized capital payment amounts: one standardized amount for major teaching hospitals, a second for nonmajor teaching hospitals in large urban areas, and a third for all remaining hospitals.

   (a) For rate year 1996, the updated 1992 standardized amount for the major teaching peer group is $290.41

   (b) For rate year 1996, the updated 1992 standardized amount for the large urban peer group is $261.55

   (c) For rate year 1996, the updated 1992 standardized amount for the all-other peer group is $202.33

   (d) Capital payment will be a weighted average of each hospital's peer group and own-hospital amounts until 1999. Use of the hospital's own costs will be phased out over four years to its respective peer group amount.

   (e) The separate peer group amounts for nonmajor teaching hospitals will also be phased out over four years.

      (1) for rate year 1996, the updated 1992 all non-major teaching hospital peer group amount is $206.

   (f) The combined capital phase out schedule between own capital costs and peer group amounts is displayed in Attachment B.

   (g) Each hospital's capital payment is a strictly prospective amount with no retrospective adjustments.

   (h) There are no appeals and no adjustments for extraordinary capital expenditures, unless capital is spent by individual hospitals to meet federal or state regulatory requirements.

8. **Updating Beyond Rate Year 1996:** The peer group capital costs and each hospitals' own capital costs will be updated beyond rate year 1996 by the following methodology:

   (a) The methodology for updating beyond rate year 1996 will follow the methodology specified in Section G6.

   (b) Peer group capital costs will be updated beyond rate year 1996 by ProPAC's capital cost factor using the ProPAC methodology. Beginning in 1998, capital cost shall be updated using HCFA's capital input price index (CIPI) as reported in the Federal Register. Beginning in 2000, peer group capital costs will be updated using the CIPI adjusted for the forecast correction in the Federal Register.

   (c) The Hospitals' own capital costs will be updated by using more current hospital-specific data.

(d) The Bureau will update the peer group capital costs no less frequently than every five years.

H. **DIRECT MEDICAL EDUCATION:** The Bureau has adopted a policy to pay teaching hospitals for their direct medical education (DME) costs which largely follows the current Medicare DME policy. Each teaching hospital will be paid a DME amount that is equal to the Bureau's share of total inpatient days multiplied by the total hospital reimbursable DME costs.

1. **DME Payments for Rate Year 1996:** DME payments will be made on a lump-sum basis, rather than a per case prospective basis, at the end of each calendar year quarter.

2. **Basis of the DME Payments:** Direct medical education costs under the prospective payment system are defined using Medicare's definition and include the following:

   (a) salaries and fringe benefits of interns and residents;

   (b) salaries attributable to the supervisory time of teaching physicians and other teacher salaries;

   (c) costs of nine related general overhead service cost centers appropriately allocated to the medical education cost centers;

   (d) appropriate costs from the employee benefits, administration and general, and cafeteria overhead service cost centers are allocated to resident salaries.

   (e) applicable costs from all nine general service cost centers allocated to the other teaching program cost categories: capital related costs--building & fixtures; capital related costs--movable equipment; employee benefits; administration and general; maintenance & repair; operation of plant; housekeeping; cafeteria; and maintenance of personnel.

3. **Definition of FTE Residents:** The number of FTE residents is determined according to where they are assigned, the length of time spent in a residency program, and their foreign medical graduate (FMG) status, and using the following rules:

   (a) Residents assigned to a PPS-excluded unit or facility are not counted toward a PPS hospital's FTE total.

   (b) If a resident spends time in more than one hospital, the resident's time is prorated to each PPS hospital to total no more than one FTE.

   (c) FTE resident status is based on the total time necessary to fill a residency slot. If a resident spends only 70 percent of the time necessary to fill a residency slot, that resident counts for at most 0.7 FTE.

      (i) For an "initial" residency period, defined as the number of years required to meet board eligibility in a specialty plus one year (up to a limit of five years), the weighting factor is 1.0.

      (ii) The weight falls to 0.5 for residents beyond the initial residency period.

      (iii) FMGs who fulfill the necessary requirements before their residency begins receive equal weight to

U.S. medical graduates, while those FMGs not meeting the appropriate criteria receive a weight of zero.

4. **Establishing Per-Resident Cost Amount:** The following methodology was used to establish per-resident cost amounts for each teaching hospital:

   (a) Medicare-allowable per-resident amounts were derived from Supplemental Worksheet E-3 in each hospital's 1994 Medicare cost report.

   (b) The per-resident amount is the weighted average of the OB/Gyn-primary care and non-primary care per-resident amounts used by Medicare.

   (c) The per-resident amounts established in H4(b) were updated through rate year 1996 by the most recent (1994) Urban Consumer Price Index (CPI-U). An annual growth rate of 2.56% was used compounded for two years.

5. **Establishing Share of Total Inpatient Days:** Total hospital DME costs for the 1996 rate year will be paid by the Bureau according to its own share of total inpatient days. Share of total inpatients days was determined using the following methodology:

   (a) Number of hospital days in total and by type of payer was obtained from the W. Virginia Health Care Cost Review Authority for 1994 .

   (b) For each teaching hospital, the total number of hospitalization days for Bureau for Medical Services patients was divided by total number of hospitalization days across all payers to yield the percentage of total days.

6. **Establishing Maximum DME Costs:** The Bureau has established a maximum number of FTE non-primary care interns and residents eligible for DME payments and a maximum per resident allowable amount.

   (a) The limits on the maximum number of residency positions for specialists, as specified in H3, was applied when counting the number of full-time residents.

   (b) The per resident amount in the base year, 1994, was capped at the rate of the fifth most costly hospital out of ten teaching hospitals in the state.

(f) Each of the five capped hospitals receive a two-year inflation update on the maximum allowable 1994 cost per resident, or $37,899 in 1996.

7. **Calculation of the Rate Year 1996 DME Payments:** Each teaching hospital will be paid a DME amount that is equal to the Bureau's share of total inpatient days multiplied by the total hospital reimbursable DME costs.

(a) Total DME costs for teaching hospitals for rate year 1996 are calculated as the product of the hospital's total FTE residents and the established per-resident amount.

(b) For each teaching hospital, the Bureau's share of DME costs is calculated by multiplying total DME costs by it's share of total hospital days as established in H5.

8. **Updating Beyond Rate Year 1996:** The Bureau will recalculate the Direct medical education adjustment factor on an annual basis using the most currently available data from the Medicare cost reports and the methodology specified in Sections H1 through H7.

I. **PAYMENT FOR TRANSFER CASES:** The Bureau makes a distinction in its prospective payment system between cases that are discharged after completing a full course of treatment and cases that are transferred between two acute care facilities.

1. **Definition of Transfer Cases:** Transfer cases are defined as those cases that are transferred between two acute care facilities for continuation of care.

2. **Basis of Payment for Transfer Cases:** Similar to Medicare's PPS, the Bureau pays transfer cases on a graduated per diem basis up to the full DRG payment amount.

(a) Transfer cases receive three times the DRG-specific per diem amount, capped at the full DRG payment amount for nontransfer cases.

(1) The Bureau determined that the unadjusted average cost per care on the first day prior to transfer is three times higher than the average cost of care on all subsequent days.

(b) Transfer cases are eligible for high cost outlier payments and indirect teaching adjustments in addition to their graduated per diem payments.

(c) All sending hospitals receive a graduated per diem amount based upon the DRG to which the case is assigned for the sending hospitals phase of the treatment.

(d) The final discharging hospital receives a full DRG payment amount based upon the DRG to which the case is assigned for the final discharging hospital's phase of the treatment.

(e) Each phase of the hospitalization is assigned a DRG based upon the principal diagnosis and surgical procedures performed during the respective phase.

(f) Cases assigned to the two DRGs specific to transfer cases, DRG 385, Neonates that died or were Transferred, and DRG 456, Burn Cases that are Transferred, receive the full DRG payment.

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Updating of Payment for Transfer Cases: The Bureau will evaluate the need to modify the level of payment for transfer cases on an annual basis using the methodology as described in Sections 11 and 12.

J. Special payments to prospective payment system (PPS) Hospitals

Providing a Special Payment plan to enhance payments statewide to all hospitals participating in the West Virginia-PPS.

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 participant in the WV Medicaid's PPS; and,
4. Must be designated as a Rural PPS or Urban PPS hospital by the Bureau. Designation will be pursuant to the Core Based Statistical Area (CBSA) classification as an Urban PPS hospital. The Bureau will designate a hospital as a Urban PPS hospital based on the CBSA's Metropolitan Core Based Statistical Area (MCBSA) classification. Hospitals outside the MCBSA classification will be designated rural hospitals. The State's MCBSAs will be updated at the beginning of the State Fiscal Year (SFY) following the U.S. Census Bureau's reconfiguration approval date.

B. Payment Methodology:

1. Payment will be calculated based on each provider's percentage of its Medicaid paid DRG days to its assigned groups. Medicaid paid DRG days times the distribution amount designated to that particular group.

2. Using the payment calculation J.B.1. above, interim payments will be determined and issued to each provider on an interim basis. Interim payments will be calculated using the historic Medicaid paid DRG days and exclude Medicare/Medicaid crossover days, for each providers' paid days count and each pools' total paid days count. Subsequent years interim payments will likewise use the most recently completed data from the preceding plan's settlement data to establish the interim payment amounts for each following year.

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3. An annual final settlement for each year of the plan will be determined by the Bureau. The final settlement adjustment amounts will be the calculated utilizing the difference between the providers' interim payments and the providers' final settlement amount. The final settlement amounts for each SFY will be determined using the Bureau's annual claims processed data for the specific year's settlement in the formula described in Section J.B.1.

4. Collection or disbursement of final settlement payment amounts will be conducted annually. Final settlement adjustment amounts, that is, overpayments and under payments, may be collected or disbursed in accordance with Bureau's current overpayment recovery policy and settlement procedures. However, when practical, collections and disbursement may be offset or added to subsequent interim payments.

C. Distribution amounts per State Fiscal Year 2013 (SFY) for these PPS hospitals is $16,135,179 for urban and $8,312,062 for rural.

K. Special Payment to Safety Net Hospitals

Provides special payments to qualified Tertiary Safety Net and Rural Safety Net hospitals. The special payments will be made as described below:

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 participant in the WV Medicaid's PPS;
4. Must be designated as a Rural PPS or Urban PPS hospital by the Bureau. Designation will be pursuant to the Core Based Statistical Area (CBSA) classification as an Urban PPS hospital. The Bureau will designate a hospital as an Urban PPS hospital based on the CBSA's Metropolitan Core Based Statistical Area (MCBSA) classification. Hospitals outside the MCBSA classification will be designated rural hospitals. The State's MCBSAs will be updated at the beginning of the State Fiscal Year (SFY) following the U.S. Census Bureau's reconfiguration approval date.

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B. Specific Criteria for Tertiary Safety Net Providers

In addition to the general criteria above, a Tertiary Safety Net provider must meet one of the following criteria:

1. Provides Level I or Level II Trauma Center services as designated by the WV Department of Health and Human Resources' Office of Emergency Medical Services; or,
2. Provides Neonatal Intensive Care Unit, Level III services (NICU) as defined by the WV State Health Plan; or,
3. Provides Pediatric Intensive Care Unit services (PICU) as defined by the WV State Health Plan; or,
4. Hospital must have at least fifty (50) interns and residence in an approved teaching program.

C. Specific Criteria for Payment for Rural Safety Net Services:

In addition to the general criteria above, Rural Safety Net providers must meet all of the following criteria:

1. Hospital must be classified as a Rural PPS hospital as defined in Section K.A.4;

2. Hospital must have less than one-hundred fifty (150) general acute care beds; count will exclude psychiatric, nursery, observation, swing, and distinct part unit beds.

D. In the event that a hospital's qualifying status changes during the period and it will no longer meet the criteria for safety net participation, it will be immediately removed from its safety net group. If the provider is removed as a participant, it will be entitled to a final settlement adjustment based on the actual days incurred prior to its disqualification. The group's distribution percentages will be recalculated for the following payments as appropriate. If a provider becomes eligible for participation in the Tertiary or Rural Safety Net group, entry into that group will begin on the first State Fiscal Year following certification/designation effective date.

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E. Payment Methodology for Qualified Tertiary and Rural Safety Net Hospitals:

1. Payment will be calculated based on each provider's percentage of its Medicaid paid DRG days to its assigned groups' Medicaid paid DRG days times the distribution amount designated to that particular group.

2. Payment will be made on an interim basis based on the state fiscal year and estimated due. Interim payments will be distributed based on the provider's percentage of the group's WV Medicaid paid DRG days (as defined above) times the groups' total funds to be distributed for the specified period.

3. Using the payment calculation K.E.1. above, interim payments will be determined and issued to each provider. The interim payments issued in year one of the plan will be calculated using the historic Medicaid paid DRG days and exclude Medicare/Medicaid crossover days, for each providers' paid days count and each pools' total paid days count. Subsequent years' interim payments will likewise use the most recently completed data from the preceding plan's settlement data to establish the interim payment amounts for each following year.

4. An annual final settlement for each year of the plan will be determined by the Bureau. The final settlement adjustment amounts will be the calculated using the difference between the providers' interim special payments and the providers' final settlement amount. The final settlement amounts for each SFY will be determined using the Bureau's annual claims processed data for the specific year's settlement in the formula described in Section K.E.1.

5. Collection or disbursement of final settlement special payment amounts will be conducted annually. Final settlement adjustment amounts, that is, overpayments and under payments, may be collected or disbursed in accordance with Bureau's current overpayment recovery policy and settlement procedures. However, when practical, collections and disbursement may be offset or added to subsequent interim payments.

F. Distribution Amounts for each State Fiscal Year 2013 (SFY) for these safety net hospitals will not exceed $22,850,980 for tertiary and $9,333,094 million for rural.

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L. Special Payment to Public Safety Net Hospitals

Provides enhanced payments to qualified Public Safety Net Hospitals beginning in SFY 2003. The enhanced payments will be made as described below:

1. Specific Criteria for Hospital Participation:

   a. Must be a West Virginia licensed inpatient acute care hospital;
   b. Must be enrolled as a West Virginia Medicaid provider;
   c. Must be a participant in the West Virginia Medicaid's PPS;
   d. Must be classified as a state-owned or operated hospital as determined by the Bureau for Medical Services.

2. The amount of the supplemental payment made to each state-owned or operated hospital is determined by:

   a. Calculating for each hospital the reasonable estimate of the amount that would be paid for inpatient services provided to Medicaid eligibles under the Medicare program and the amount otherwise actually paid for the services by the Medicaid program. The reasonable estimate of the amount that would be paid under Medicare payment principles is calculated using a hospital specific inpatient Medicare payment to charge ratio which is derived using the most recently settled Medicare cost report (2552) available for each hospital at the beginning of the state fiscal year for which calculations are made. The hospital specific inpatient Medicare payment to charge ratio is then multiplied by each hospitals Medicaid's inpatient charges to calculate each hospital's portion of the upper limit payment ceiling. The aggregate upper limit payment ceiling is then arrived at by summing up each specific hospital's calculated amount. For upper limit purposes, all hospitals are grouped in accordance with the state owned or operated public class of hospitals as defined in 42CFR 447.272 as amended.

   b. Dividing the difference determined in 2.a. above for the hospital by the aggregate difference for all such hospitals; and

   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 § 447.272 less all payments made to such hospitals other than under this section.

3. Supplemental payments made under this section will be made on a quarterly basis 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 § 447.271 or the limit specified at 42 U.S.C. § 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 L.2. above.

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

For services rendered on or after July 1, 2014, 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 total hospital inpatient cost to charge ratio is derived using the Medicare cost report (2552). For SFY 2015, 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 total hospital cost to charge ratios will be derived by dividing the sum of all hospital specific total hospital inpatient costs by the sum of all hospital specific inpatient charges.
   c. 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 2015 to estimate costs. The inpatient Medicaid portion of the cost of the .62% 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:

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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, 2014, 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 2015, 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 2015 to estimate SFY 2015 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).

4.19 Payments for Remedial Care and Services
ATTACHMENT 4.19-A Inpatient Hospital Services

Inpatient Hospitals Located Outside the State of West Virginia

A. OUT-OF-STATE FACILITIES EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM: The prospective payment system applies to most acute care hospitals located outside the state of West Virginia. Cases treated in excluded facilities are paid under their current payment methodologies. The qualifying provisions for exempt facilities and units that are of relevance are as follows:

1. **Psychiatric Hospitals:** Psychiatric hospitals must meet the Medicare regulatory definition of a psychiatric hospital and be primarily engaged in providing psychiatric treatment of mentally ill patients.

2. **Rehabilitation Hospitals:** Rehabilitation hospitals and distinct-part units may qualify as excluded facilities if they meet the Medicare regulatory definitions and are primarily engaged in furnishing intensive rehabilitation services. Payment for inpatient rehabilitation hospitals is a cost-based retrospective system determined by applying the standards, cost reporting periods, cost reimbursement principles, and method of cost apportionment used under Title XVIII of the Social Security Act, prior to the Social Security Amendment of 1983 (Section 601, Public Law 98-21). This is, payment is to be determined by the current Medicare Principles methodology of cost-based reimbursement.

3. **Rural Primary Care Hospitals (RPCH):** Payment for cases treated in RPCH hospitals is based on Medicare's per diem payment methodology.

B. **CASES EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM:** All criteria applying to excluded cases for inpatient hospitals located within the state of West Virginia shall apply to inpatient hospitals located outside the state of West Virginia.

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4.19 Payments for Remedial Care and Services

C. **METHODS USED TO ESTABLISH DRG PAYMENT WEIGHTS:** Out-of-state inpatient hospitals included in the prospective payment system shall be subject to the same methodology for the establishment of DRG Payment Weights as facilities located within the state of West Virginia, the most current Medicare GROUPER.

D. **METHODS USED TO ESTABLISH PROSPECTIVE OPERATING PAYMENT RATE:** One operating payment will be used for all out-of-state hospitals: the current Medicaid **instate** Statewide operating payment amount.
Out-of-state Sole Community Hospitals will be given no special payment consideration. There will be no blending of the PPS payment amount with their costs.

E. **HOSPITAL ADJUSTMENTS TO STANDARDIZED OPERATING RATE PAYMENTS:**

1. **Wage Difference Adjustment:** All out-of-state hospitals will be assigned to one of the West Virginia market areas based upon their respective county's average hourly wage rate as calculated from the 1993 HCFA Wage Index File.

2. **Indirect Medical Education Adjustment:** An indirect medical education adjustment will be made to the out-of-state hospital's standardized operating payment amount. HCFA's IME adjustment factors will be used with an adjustment made to reflect the specialty and occupational policies in the Medicaid program.

3. **Level III NICUs:** The Level III neonatal DRGPAY amounts (DRG 585-590) will be used to make inlier payments for neonatal DRG payment amounts.

F. **METHODS USED FOR PAYMENT FOR HIGH COST CASES:** The same methods will be applied to out-of-state hospitals as those located within West Virginia.

G. **METHODS USED TO ESTABLISH PROSPECTIVE CAPITAL PAYMENT RATES:** Two West Virginia capital peer group amounts will be used for out-of-state hospitals: major teaching and nonmajor teaching. Unlike instate hospitals, all out-of-state hospitals' capital payment amounts will be solely based upon the two West Virginia peer group amounts, i.e., there will be no blending of the peer group amount with their own capital costs. Capital peer group amounts are updated annually.

H. **DIRECT MEDICAL EDUCATION:** There are no direct medical education payments to out-of-state Hospitals.

I. **PAYMENT FOR TRANSFER CASES:** The West Virginia instate transfer payment policy will be the basis of payment for all out-of-state transfer cases.