2. a. Outpatient Hospital Services

(1) Reimbursement is based on a fee for service and may not exceed the amount established for any qualified provider for the same service. Laboratory and x-ray services may not exceed the amount established by Medicare for the procedures.

(2) Other services specific to hospitals; i.e., emergency room, outpatient surgery, cast room, may not exceed the established Medicare upper limits based on reasonable cost.

b. 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 outpatient acute care hospital;
(b) Must be enrolled as a West Virginia Medicaid provider;
(c) 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 public hospital is determined by:

(a) Calculating for each hospital the reasonable estimate of the amount that would be paid for outpatient 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 outpatient 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 outpatient Medicare payment to charge ratio is then multiplied by each hospitals Medicaid's outpatient 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 class of hospitals as defined in 42 CFR 447.321 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 §447.321 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, 2014, 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 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.
(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 2015 estimate the SFY 2015 costs. The outpatient Medicaid portion of the cost of the .62% 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, 2014, 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 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.
(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 2015 to estimate SFY 2015 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).

1. a. **Federally Qualified Health Center and Rural Health Clinic Services**

All Federally Qualified Health Centers and Rural Health Clinics (hereinafter collectively referred to as "clinic/center") shall be reimbursed on a prospective payment system ("PPS") beginning October 1, 2012,

RATE DETERMINATION PROCESS

1. INITIAL RATES
   a. For facilities with an effective date prior to Fiscal Year ("FY") 1999, payment rates will be set prospectively using the total clinic/centers reasonable cost of furnishing core and other ambulatory services for FYs 1999 and 2000, adjusted for any change in scope, divided by the number of encounters for the two year period to arrive at a cost per visit. For each calendar year thereafter, each clinic/center will be paid the per visit amount paid in the previous year, adjusted by the Medicare Economic Index ("MEI") as reported on January 1 and adjusted to take into account any increase (or decrease) in the scope of services furnished during the FY.

   b. For facilities with an effective date on or after FY 2000, payment rates will be set prospectively using the total clinic/centers reasonable cost of furnishing core and covered non-core services divided by the number of encounter for the first full fiscal year of operations. The first full year of operations is defined as a final settled Medicare cost report, as adjusted for Medicaid services, that reflects twelve months of continuous service.

      1. The calculation of the initial PPS rates and any subsequent adjustment to such rate shall be determined on the basis of reasonable costs of the center/clinic as provided under 42 CFR Part 413. Administrative costs will be limited to 30 percent of total costs in determining reasonable costs. Reasonable costs do not include unallowable costs.

      2. Unallowable costs are expenses incurred by a clinic/center that are not directly or indirectly related to the provision of covered services, according to applicable laws, rules and standards.

2. NEW FACILITIES
   A "new" clinic/center is a facility that meets all applicable licensing or enrollment requirements on or after October 1, 2012. Sites of an existing clinic/center that are newly recognized by HRSA are treated, for purposes of this State Plan, as a change in scope of services.

a. A new clinic/center must file a projected cost report to establish an interim initial base rate. The cost report must contain the clinic/center's reasonable costs anticipated to be incurred in the initial FY. The initial rate will be set at the lesser of eighty-percent (80%) of the pro forma allowable cost(s) as established by the interim cost report or the statewide average PPS rate of all existing providers within the same peer group, excluding the lowest and highest rate obtained from the current period.

b. A peer group is divided into three rate groupings; (1) FQHCs; (2) free-standing RHCs and (3) hospital based RHC facilities

c. Each new clinic/center must submit an as-filed Medicare cost report after the end of the clinic/center's FY. An updated interim rate will be determined based on one hundred-percent (100%) of reasonable costs as adjusted for Medicaid services contained in the as-filed cost report. Interim rates will be adjusted prospectively until the final settled Medicare cost report is processed.

d. Each new clinic/center must submit a final settled Medicare cost report, reflecting twelve months of continuous service. The rate established shall become the final base rate for the center/clinic. The State will reconcile payments back to the beginning of the interim period applying the final base rate. If the final base rate is greater than the interim rate, the Bureau for Medical Services ("BMS") will compute and pay the clinic/center a settlement payment that represents the difference in rates for services provided during the interim period. If the final base rate is less than the interim rates, BMS will compute and recoup from the center/clinic any overpayment resulting from the differences in rates for the services provided in the interim period.

3. SERVICES CONSIDERED AN ENCOUNTER

The following services qualify as clinic/center encounters:

a. Covered Core Services are those services provided by:
   1. Physician services specified in 42 CFR 405.2412;
   2. Nurse practitioner or physician assistant services specified in 42 CFR 405.2414;
   3. Clinical psychologist and clinical social worker services specified in 42 CFR 405.2450
   4. Visiting nurse services specified in 42 CFR 405.2416;
   5. Nurse-midwife services specified in 42 CFR 405.2401;
   6. Preventive primary services specified in 42 CFR 405.2448;
   7. Diabetes Self-Management Therapy specified in 42 CFR 405.2463;

8. Medical Nutrition Therapy specified in 42 CFR 405.2463; and
9. Advanced Practice Registered Nurse specified in 42 CFR 440.166

b. Covered Non-Core Services
All other ambulatory services, except for radiology, pharmacy, and laboratory services, as defined and furnished in accordance with the approved State Plan.

c. Services and supplies incidental to the professional services of encounter-level practitioners are included in the encounter rate paid for the professional services when the services and supplies are:

1. Furnished as an incidental, although integral, part of the practitioner's professional services;
2. Of a type commonly furnished either without charge or included in the center/clinic bill;
3. Of a type commonly furnished in a provider's office (e.g. tongue depressors, bandages, etc.);
4. Provided by center employees under the direct, personal supervision of encounter-level practitioners; and
5. Furnished by a member of the center's staff who is an employee of the center (e.g. nurse, therapist, technician or other aide).

d. A billable encounter is defined as a face-to-face visit between an eligible practitioner and a patient where the practitioner is exercising independent professional judgment consistent within the scope of their license.

e. Only one medical encounter, one behavioral health and one dental encounter per day per member may be billed except in cases in which the member suffers illness or injury requiring additional diagnosis or treatment.

4. CHANGE IN SCOPE OF SERVICES

a. A change in scope of services is defined as a change in the type, intensity, duration and/or amount of services (a "qualifying event") provided by the clinic/center. A change in scope of service applies only to Medicaid covered services.

A change in scope of service may be recognized if any of the following qualifying events occur:

1. Addition of a new clinic/center service(s) that is not present in the existing PPS rate;

2. Deletion of an existing service;
3. A change in service resulting from opening or relocating a center or clinic site;
4. A change in service resulting from federal or state regulatory requirements; **OR**
5. A change in sites or scope of services approved by the Health Resource and Services Administration ("HRSA").

b. All of the following criteria must be met to qualify for a change in scope adjustment:

1. The qualifying event must have been implemented continuously for six (6) consecutive months;
2. The cost attributable to the qualifying event, on a cost per visit basis, must account for an increase or decrease to the existing PPS rate of five-percent (5%) or greater. To determine whether the threshold is met, the cost per visit of the year immediately preceding the cost reporting year in which the qualified even occurs will be compared to the PPS rate in effect for the year in which the change in scope has been implemented for six (6) consecutive months; and
3. The cost related to the qualifying event shall comply with Medicare reasonable cost principles. Reasonable costs, as used in rate setting is defined as those costs that are allowable under Medicaid cost principles, as required in 45 CFR 92.22(b) and the applicable OMB circular, with no productivity screens or per visit payment limit applied to the rate. Reasonable costs do not include unallowable costs.

c. Each clinic/center will be responsible for notifying BMS of a qualifying event by the last day of the third month after the qualifying event has been implemented for six (6) consecutive months or a maximum of nine (9) months from the date of the qualifying event implementation.

d. Each clinic/center will be responsible for providing sufficient documentation, including any and all documentation requested by BMS, to support the review and request for a determination of change in scope.

e. Providing that all notification timeframes in 4(c) and (d) above are met and a qualifying event is established, the adjusted PPS rate will be retroactively applied back to the date the change in scope was implemented.

f. Failure to meet all the notification timeframes in 4(c) and (d) above shall result in the effective date of the approved rate to be the first day following

g. the fiscal year end that the clinic/center submitted the documentation for the change in scope.

h. A clinic/center may apply only once during any fiscal year for an adjustment due to a change in scope of service.

5. ADMINISTRATION OF MANAGED CARE CONTRACTS

Where a center/clinic furnishes services pursuant to a contract with a managed care organization, BMS will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

(iii) Reimbursement to those providers dually licensed as Behavioral Health and Residential Child Care Facilities will be prospective based on allowable provider specific cost for treatment within each peer group level. Reimbursement will be capped for individual providers within each peer group level based on allowable provider specific cost.

Allowable Provider Specific Cost

Reimbursement for Behavioral Health Residential Child Care Facilities is limited to those costs required to deliver allowable medically necessary behavioral health treatment services by an efficient and economically operated provider. Costs determined to be reasonable and allowable by the Department will be reimbursed up to the level of the peer group ceiling derived from the weighted average cost of providers by peer group. These costs specifically exclude costs for room, board and the minimum supervision required by Social Services licensing regulations.

Peer Group Ceiling

The peer group ceiling will be derived from the weighted average per patient day treatment costs of all providers, at an assigned occupancy of 90% in the peer group. Patient day is defined as eight (8) continuous hours in residence in the facility in a twenty-four hour period during which the patient receives medical services.

Efficiency Allowance

When a provider's actual allowable per diem costs are below the peer group ceiling an incentive of 50% of the difference between the provider's allowable cost and the peer group ceiling within each level of care (if lower than the peer group ceiling) will be paid, up to a maximum of four dollars ($4) per resident day.

Inflation Factor

A factor will be assigned to cost as a projection of inflation for subsequent rate setting cycles. Changes in industry wage rate and supply costs compared with CPI are observed and the lesser amount of charge is expressed as a percentage and applied to the allowable reimbursable costs for the six-month reporting period.

This inflation factor represents the maximum rate of inflation recognized by the Department for the rate period.

Cost Reporting Periods

Cost reports must be filed with the State agency. Cost reports must be postmarked within sixty (60) days following the end of each six month cost reporting period: January 1-June 30 and July 1-December 31. Rates will be calculated and effective for six month periods starting three months after their reporting period. Rates will be frozen at the current level (January to June 2001) and will remain at that level for no longer than two rate periods.

3. Other Laboratory and X-ray Services

Laboratory Services:

Payment shall be the lesser of 90% of the Medicare established fee or the provider's usual and customary fee. All fees are published on the web at: www.wvdhhr.org then medical services.

Reimbursement shall be the same for governmental and private providers.

X-Ray Services:

The following will apply to the technical component for radiology services:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public. The agency's fees were set as of January 1, 2008 and are effective for services on or after that date. All fees are published on the web at: www. wvdhhr.org then medical services. Except as otherwise noted in the plan, state developed fees are the same for both governmental and private providers.

4. b. **Early Periodic Screening, Diagnostic and Treatment Services**

Screening services are reimbursed on an encounter rate based on the cost of providing the components of the screening examination, and referral where indicated, for qualified providers.

(iii) Reimbursement to those providers dually licensed as Behavioral Health and Residential Child Care Facilities will be prospective based on allowable provider specific cost for treatment within each peer group level. Reimbursement will be capped for individual providers within each peer group level based on allowable provider specific cost.

Allowable Provider Specific Cost
Reimbursement for Behavioral Health Residential Child Care Facilities is limited to those costs required to deliver allowable medically necessary behavioral health treatment services by an efficient and economically operated provider. Costs determined to be reasonable and allowable by the Department will be reimbursed up to the level of the peer group ceiling derived from the weighted average cost of providers by peer group. These costs specifically exclude costs for room, board and the minimum supervision required by Social Services licensing regulations.

Peer Group Ceiling
The peer group ceiling will be derived from the weighted average per patient day treatment costs of all providers, at an assigned occupancy of 90% in the peer group. Patient day is defined as eight (8) continuous hours in residence in the facility in a twenty-four hour period during which the patient receives medical services.

Efficiency Allowance
When a provider's actual allowable per diem costs are below the peer group ceiling an incentive of 50% of the difference between the provider's allowable cost and the per group ceiling within each level of care (if lower than the peer group ceiling) will be paid, up to a maximum of four dollars ($4) per resident day.

Inflation Factor
A factor will be assigned to cost as a projection of inflation for subsequent rate setting cycles. Changes in industry wage rate and supply costs compared with CPI are observed and the lesser amount of charge is expressed as a percentage and applied to the allowable reimbursable costs for the six-month reporting period. This inflation factor represents the maximum rate of inflation recognized by the Department for the rate period.

Cost Reporting Periods
Cost reports must be filed with the State agency. Cost reports must be postmarked within sixty (60) days following the end of each six month cost reporting period: January 1 - June 30 and July 1 - December 31. Rates will be calculated and effective for six month periods starting three months after their reporting period. Rates will be frozen at the current level (January to June 2001) and will remain at that level for no longer than two rate periods.

Example of Calculations:

Peer group of three (3) providers A, B, and C with the following data:

Provider	Beds	Patient Days	Occupancy Percentage	Allowable Treatment Cost	Cost PPD Actual
A	9	1,296	80%	$ 77,760	60.00
B	7	1,134	90%	$ 73,710	65.00
C	18	3,078	95%	$153,900	50.00

For this example only, assume 180 days in six month reporting period, actual days will be utilized during actual calculations, and an increase in the inflation factor of 1%:

Peer Group Ceiling Calculation

Provider	Beds	Possible Days	Patient Days	Allowable Costs	Costs PPD @ 100% Occp	Cost Adjusted to 90% Occp	Allowable Cap Calculation
A	9	1,620	1,296	$ 77,760	48.00	53.33	$ 69,120
B	7	1,260	1,134	$ 73,710	58.50	65.00	$ 73,710
C	18	3,240	3,078	$153,900	47.50	52.78	$162,450
Total		6,120	5,508	$305,370			$ 305,280

Weighted average per patient day allowed treatment cost ($305,280/5,508 days) of $55.42.

Provider	PPD Cost	Reimbursement Cap	Lower of PPD Or Cap	Efficiency Incentive	1% Inflation	Specific Rate
A	60	55.42	55.42	0	0.55	55.97
B	65	55.42	55.42	0	0.55	55.97
C	50	55.42	50.00	0	0.50	50.50

(iv) Payment for Early Intervention services will be through an agreement with the state Title V agency. Payments shall be based on total cost of service provision. The Title V agency must maintain, in auditable form, all records of cost of services for which claims for reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected costs may be used as necessary with a settlement to cost at the end of the fiscal year.

(v) Private duty nursing is reimbursed on a fee-for-service based on units of time. Fees will not exceed the provider's usual and customary charge .

c. Family Planning Services and Supplies

1. Family planning clinic services are reimbursed on a cost basis for the clinic including staffing and cost of supplies dispensed to the recipients.

2. Family planning supplies as ordered by a physician and dispensed by a retail pharmacy are reimbursed as a pharmacy service.

5. a. Physicians' Services

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the providers's customary charge for the service to the general public.

Physician Services

Special Payments to Essential State-owned or operated Physicians and Dentists

I. Specific criteria for essential state-owned or operated physicians and dentists who are members of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority.

A. Must be a West Virginia licensed physician or dentist;
B. Must be enrolled as a West Virginia Medicaid provider;
C. Must be a member of a state-owned or operated physician or dental group practice organized by or under the control of a state academic health system or an academic health system that operates under a state authority, as determined by the Department of Health and Human Resources, Bureau for Medical Services.

II. Payment Methodology:

A. A supplemental payment will be made for services provided by qualifying essential state-owned physicians or dentists who are members of a group practice organized by or under the control of a state academic health system or an academic health system that operates under a state authority based on the following methodology. The supplemental payment to each qualifying physician or dentist will equal the difference between the Medicaid payments otherwise made to these qualifying providers for physician and dental services and the average amount that would have been paid by commercial insurers for the same services. The average amount that private commercial insurers would have paid for Medicaid services will become the maximum Medicaid reimbursable amount for total Medicaid reimbursement, i.e., regular Medicaid payments and the supplemental payments made under this plan amendment. To determine this maximum Medicaid reimbursable amount, the Medicaid Agency will determine what all private commercial insurance companies paid for at least 80% of the commercial claims from the public physician providers affected by this plan amendment and divide that amount by the respective charges for those same claims. (The claims payments and charges will be obtained from the year preceding the reimbursement year.) The resulting ratio of payments to charges will be multiplied by the actual charges for the Medicaid services provided by the public physician providers, and the product will be the maximum Medicaid reimbursable amount. The actual non-supplemental Medicaid payments to the public physician providers will be subtracted from the maximum Medicaid reimbursable amount to yield the supplemental payment amount.

B. The supplemental payment for services provided will be implemented through a quarterly supplemental payment to providers, based on specific claim data.

4.19 Payments for Medical and Remedial Care and Services

6. a. Podiatrists' Services

Payment will not exceed the upper limit established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the services to the general public.

The agency's fees were updated January 1, 2010 and are effective for services on or after that date.
Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.wvdhhr.org/bms.

b. Optometrists' Services

Payment will not exceed the upper limit established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the services to the general public.

The agency's fees were updated January 1, 2010 and are effective for services on or after that date.
Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.wvdhhr.org/bms

c. Chiropractors' Services

Payment will not exceed the upper limit established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

The agency's fees were updated January 1, 2010 and are effective for services on or after that date.
Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.wvdhhr.org/bms.

d. Other Practitioners' Services

Psychologists' Services

The agency's rates were set as of January 1, 2010 and are effective for services on or after that date. All rates are published on the agency's website at www.wvdhhr.org/bms. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers

Payment will not exceed a fee schedule established from .....

4.19 Payments for Medical and Remedial Care and Services

usual and customary charge information supplied by the provider community which was analyzed using accepted mathematical principles to establish the mean dollar value for the service, or the provider's customary charge, whichever is less.

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public. The agency's fees were updated January 1, 2010 and are effective for services on or after that date.

6. d.2 Gerontological Nurse Practitioner Services
Adult Nurse Practitioner Services
Women's Health Nurse Practitioner Services
Psychiatric Nurse Practitioner Services

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. The conversion factors are published annually in the "Resource Based Relative Value (RBRVS) Policy and Procedure Manual".

Payment may not exceed the amount paid to physicians for the service the provider is authorized by State Law to perform or the provider's customary charge, whichever is less. All private and governmental providers are reimbursed according to the same published fee schedule that may be accessed at: ww.wvdhhr.org then medical services, then manuals.

d.3 Other Licensed Practitioners

Pharmacy reimbursement for vaccines will be based on the appropriate NDC code at the current pharmacy reimbursement rate for covered drugs and may include an administration fee. If the vaccine is free, only an administration fee will be reimbursed. Reimbursement will be through the MMIS point-of-sale system.

7. **Home Health Services**

a. & b. Medicaid reimbursement of Medicare certified home health services shall be based on ninety percent (90%) of the Medicare established low-utilization payment adjustment (LUPA) per visit rate by discipline or the provider's charge whichever is less. The calculated LUPA rates will include an applicable Core-Based Statistical Area (CBSA) wage index adjustment for the county in which the provider has its initially assigned physical location. If services are rendered to beneficiaries outside that initially assigned county, payments will be limited to the provider's LUPA rates with no payment recognition for any difference between county wage indexes. The LUPA rate will be adjusted in accordance with Medicare's scheduled adjustments. LUPA per visit payment amounts are considered payment-in-full. All private and governmental providers are reimbursed according to the same published fee schedule that may be accessed at www.wvdhhr.org.org.

c. Medical Equipment
Reimbursement for medical equipment (ME), medical supplies, esthetics and prosthetics is the lesser of 80% of the Medicare fee schedule or the provider's charge to the public. Reimbursement for unlisted/unpriced codes is based on cost invoice and reimbursed per WV Medicaid's established fee schedule. The Agency's fees were updated January 1, 2010 and are effective for services on or after that date. All private and governmental providers are reimbursed according to the same published fee schedule that may be accessed at www.wvdhhr.org or the Agency's Provider Manuals

Diabetic supplies are reimbursed at 90% of the Medicare fee schedule.

Certain medical equipment may be subject to a leasing arrangement with repairs the responsibility of the ME Provider.

4.19 Payments for Remedial Care and Services

Inpatient Hospital Services

8. Private Duty Nursing Services
Payment is based on an hourly rate by skill level; i.e., R.N., LPN, Aide, considering customary charges and rate paid for these services by private insurance, or other state agencies.

9. Clinic Services
Payment for services provided by established clinics may be an encounter rate based on all inclusive costs, or on a fee for the services provided in the clinic. Payment not to exceed that allowed for the services when provided by other qualified providers. Payment for free standing ambulatory surgery center services shall be the lesser of 90% of the Medicare established fee or the provider billed charge.

10. Dental; Services

10. **Dental, Orthodontic and Oral and Maxillofacial Services**

Dental practitioners who provide covered dental services shall be reimbursed, by procedure, utilizing the American Dental Association Survey of Dental Fees for the Southern Atlantic Region Norms. The 25 percentile of the Southern Atlantic Regional Survey constitutes the Medicaid cap.

Physicians who provide covered oral and maxillofacial services shall be reimbursed by the upper limit utilizing a Resource-Based Relative Value (RBVU) for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment shall not exceed the provider's usual customary charge to the public. The agency's rates were set July 1, 2009 and are effective for services on or after that date. All rates are published on the agency's website at www.wvdhhr.org/bms. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

Administration of anesthesia services shall be reimbursed by Current Dental Terminology (CDT) codes based on an average American Society of Anesthesiologist base units (for Head Procedures) plus time units multiplied by the anesthesia conversion factor. Payment shall not exceed the provider's usual customary charge to the public.

4.19 Payments for Medical and Remedial Care and Services

11. a. **Physical Therapy**

Payment will not exceed the upper limit established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

The agency's fees were updated January 1, 2010 and are effective for services on or after that date.
Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners, and the fee schedule and any annual/periodic adjustments to the fee schedule are published at wwwvdhhr.org/bms.

b. **Occupational Therapy**

Payment will not exceed the upper limit established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

The agency's fees were updated January 1, 2010 and are effective for services on or after that date.
Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.wvdhhr.org/bms.

4.19 Payment for Medical and Remedial Care and Services

c. Services for Individuals with Speech, Hearing and Language Disorders

An upper limit is established using the relative value for the procedure published in the Health Care Consultants, Inc., Physicians Fee Guide for 1991 times a conversion factor of 7.5. Payment will not exceed the provider's customary charge for the service to the general public.

For services provided on and after 11-01-94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider's customary charge for the service to the general public.

Augmentative/Alternative Communication Devices: reimbursement is based on 80% payment of invoice cost for purchase, and 90% payment of invoice cost on repairs.

d. Speech Therapy

An upper limit is established by procedure using a survey of Medicaid coverage conducted by the American Speech, Language, Hearing Association; Medicare upper limits published in the Federal Register 3/21/91; and data compiled from state providers by geographical regions.

12. a. Prescribed Drugs

Reimbursement for prescription drugs shall be the lower of the cost of the drug as defined in paragraphs A and B, plus a reasonable dispensing fee of $2.50 for brand name drugs and $5.30 for generic drugs, or the usual and customary charges to the general public, including any sale price which may be in effect on the date of the service.

Reimbursement for program drugs is based on the following methodology:

A. Multiple Source Drugs: The upper limit for reimbursement for all multiple source drugs listed in the Federal regulation at 42 CFR 447.332 will be the lower of the established specific upper limit per unit or the provider's usual and customary charges to the general public.

The use of generic drugs is mandated if therapeutically equivalent products are available. A physician may order a brand name drug by writing in his/her

own handwriting, "Brand Medically Necessary" or state such to the pharmacist for an oral prescription order. If the brand name drug is so ordered, the pharmacist may indicate this by using the appropriate "Dispensed as Written" (DAW) code, and reimbursement will be made at the brand drug rate.

All such certified prescriptions must be maintained in the pharmacy files and made available for inspection by the United States Department of Health and Human Services or the State agency.

B. Reimbursement for drugs shall not exceed the lowest of the following:

a. The Estimated Acquisition Cost (EAC), AWP minus 15% for brand name drugs and AWP minus 30% for generic drugs, plus a dispensing fee, or
b. The Federal Upper Limit (FUL), Maximum Allowable Cost (MAC) of the drug, in the case of a multi-source (generic), plus a dispensing fee, or
c. State Maximum Allowable Cost (SMAC), plus a dispensing fee, or
d. The provider's usual and customary charge of the drug to the general public.
e. Reimbursement will be at the Medicare price or Bureau for Medical Services assigned fee for any drug that has a HCFA Common Procedure System (HCPCS) code.
f. For drugs described in section 340B of Public Law 102-585, the Veteran's Health Act of 1992 the actual acquisition cost plus a dispensing fee of $8.25.

Exception: the FUL, MAC or SMAC shall not apply in the case where a physician certifies in his/her handwriting the "Brand Necessary" is required and medically necessary.

Methodology for SMAC including Legend Drugs and selected Over the Counter Preparation (OTCs).

State Maximum Allowable Cost (SMAC) will be determined using 130% of the lowest WAC (Wholesale Acquisition Cost) as provided by national drug information suppliers for three (3) manufacturers or; State Maximum Allowable Cost (SMAC) based upon a mean average of pharmacy provider costs obtained through a survey of a percentage of pharmacy providers that are representative of the overall geographical distribution, service volume, and business structures of all pharmacies serving the West Virginia Medicaid Program. This methodology will be used to adjust the pricing methodology described above in accordance with drug market competition, and to establish SMAC pricing in those instances where less than three (3) manufacturers are supplying products in the market. The following steps outline this process:

State West Virginia

4.19 Payment for Medical and Remedial Care and Services

a. A survey of pharmacy providers will be conducted for the determination of the SMAC price through a voluntary advisory process in which pharmacy providers are requested or advised to provide their inventory pricing. The survey will be sent to a statistically valid set of pharmacies, including pharmacies in rural and urban settings with both chain and independent pharmacy representation, for this survey.

b. The provided drug purchase information will be entered into a database and reviewed to identify all potential errors, such as incomplete or incorrect national drug codes (NDCs) and missing pricing information. A per unit price for each line of information will be computed.

c. All brand and generic drug products meeting the criteria for therapeutic equivalency ("A" rated) product availability and utilization will be grouped based on similar chemical composition, package size, dose and form. Each common class of brand and generic drugs will be considered to be a "drug group" and assigned a drug group number.

d. All unit costs computed for each brand and generic drug in each drug group will be sorted from high to low, and the number of pharmacies reporting purchases at the same unit cost will be recorded. Each computed unit cost will then be multiplied by the number of pharmacies reporting purchasing the drug at that price.

e. The total number of pharmacies reporting unit cost information for each drug in the drug group will be summed. The State will determine weighted prices based on the individual drug price multiplied by the number of pharmacies purchasing drugs at each reported price. The sum of the weighted prices will then be divided by the sum of the number of pharmacies reporting purchasing information. This calculation will produce the "average acquisition cost".

f. The resulting "average acquisition cost" will then be multiplied by a factor to produce a State MAC rate. The factor, referenced as the "State MAC multiplier" reflects the percentage variance in pharmaceutical prices that may be accommodated by the State MAC rate. The current state MAC multiplier of 2.1 means that a particular state MAC rate should accommodate the pharmacies' drug acquisition costs up to 210% above the average acquisition price for drugs in a particular drug group.

State West Virginia

4.19 Payment for Medical and Remedial Care and Services

g. The State MAC rate will be applied to all brand and generic drug products in each drug group. Non-"AB" rated drugs recognized by national drug information suppliers as comparable to a particular brand drug will be subjected to the same State MAC rate applicable to the brand and "AB" rated generic drugs of the same chemical composition, package size, dose, and for (drug group).

h. The determination of which drugs will be part of a SMAC list will be designated by the Bureau. Drugs no longer available at the State MAC price will be removed. New drugs will be added to the SMAC as they are identified. The Bureau will continually monitor pharmacies and industry information and make changes to the SMAC to reflect current pharmaceutical market conditions. The Bureau reserves the right to revise the individual SMAC prices from time to time based on factors such as, but not limited to, supply and variability within market and market access.

C. Compounded Prescriptions: Payment will be based upon the estimated acquisition cost (EAC) from the current price in effect on the date of service for each ingredient, one of which must be a legend item. A fee of $1.00 will be added to the reasonable dispensing fee for the extra compounding time required by the pharmacist.

D. Compounded prescriptions for parenterally administered drugs: Payment will be based upon the estimated acquisition cost (EAC) of the drug plus a compounding fee determined by the agency to cover the cost of specially prepared admixtures and case management services for drugs requiring parenteral administration.

E. Dispensing fee limitations: Providers of pharmacy services to recipients residing in nursing facilities will be limited to one dispensing fee per drug entity dispensed within the same given month.

4.19 Payment for Medical and Remedial Care and Services

6. Assurances: Payment for multiple source drugs will not exceed, in the aggregate, payment levels determined by applying for each drug entity a reasonable dispensing fee plus an amount established by HCFA that is equal to 150% of the published price for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules or, in the case of liquids, the commonly listed size, as required in 42 CFR 447.332 (a) & (b).

7. Manufacturer Restriction: Reimbursement for prescribed drugs will be limited to those drugs supplied from manufacturers that have signed a national agreement in accordance with Section 1927 of the Social Security Act (The Act), (as amended by Section 4401 of P.L. 101-508).

12. b. Dentures

Payment for dentures is included in item 10.

3. Prosthetic Devices

Payment is based on the upper limit established for the service by Medicare.

4. Eyeglasses

Payment will not exceed an upper limit established considering cost information from national sources; i.e., Optometry Today and Review of Optometry; a survey of practitioners in the State; and the upper limits established by Medicare adjusted to reflect complexity of material.

An upper limit is established for each lens code. The upper limit for frame is wholesale cost up to $40.00 multiplied by a factor 2.5. Payment for low vision aids may not exceed invoice cost plus 30 percent.

Reimbursement may not exceed the provider's customary charge for the service to the general public.

13. c. Preventive Services

Disease State Management

1. The state developed fee schedule rates are the same for both public and private providers of these 1905(a) services. The fee schedule and any annual/period adjustments to the fee schedule are published.

13. d. Rehabilitative Services

Behavioral Health Services

1. Reimbursement to those agencies licensed as behavioral

4.19 Payments for Medical and Remedial Care and Services

health agencies only is based on payment rates for each service by units of time with limitations established for occurrences. The payment upper limit is established by arraying charges of providers for the services to establish a reasonable customary and prevailing charge.

Reimbursement for Assertive Community Treatment (ACT) is based on an assessment of the fees of those services codes included in the ACT array of services together with a review of the staff level and hours of the professionals included in the ACT team. A per diem or a monthly rate will be based on the historical data of the frequency of those service codes included in ACT and the number of staff and average wages of the professional team.

State West Virginia

4.19 Payments for Medical and Remedial Care and Services

18. a. Hospice Reimbursement - General

Payment for hospice care is made at one of four predetermined Medicare rates for each day in which an individual is under the care of the hospice. These rates are established by Medicare for the hospice, and will apply to payment for Medicaid recipients who are not eligible for Medicare. The Medicare rates are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Medicaid pays the Medicare coinsurance for dually eligible individuals.

b. Nursing Facility Residents

When hospice care is furnished to a Medicaid recipient residing in a nursing facility the hospice is paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. This additional amount paid to the hospice must equal 95 percent of the per diem rate that would have been paid by Medicaid for that individual. The amount of reimbursement will be a "daily rate" that is 95 percent of the facility per diem rate together with the Medicaid adjustment for the acuity of the Medicaid recipient.

The hospice is responsible for "room and board" which includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medications, maintaining cleanliness of the resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

c. Limitations on Payment for Inpatient Care

Limitation on payment for inpatient care will be calculated according to the number of days of inpatient care furnished to Medicaid patients. During the 12 month period, beginning November 1 of each year and ending October 31, the aggregate number of inpatient (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period.

4.19 Payments for Medical and Remedial Care and Services

D. Cap on Overall Hospice Reimbursement

The overall aggregate payments made to a hospice during a cap period from November 1 each year though October 31 of the next year will be limited based on services rendered during the cap year on behalf of all Medicaid recipients receiving services during the cap year. Any payments in excess of the cap must be refunded by the hospice.

19. Case Management

Reimbursement for case management services provided under the plan will be based on actual cost; i.e., established hourly rates for units of service provided. Payment for case management services will not duplicate payment made to public agencies or private entities under other program authorized for the same purpose. Medicaid will be the payor of last resort.

Payment for Birth to Three Early Intervention Services will be through an agreement with the state Title V agency. Payments shall be based on total cost of service provision. The Title V agency must maintain, in auditable form, all records of cost of services for which claims of reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year.

20. c. Expanded Prenatal Services

Reimbursement for expanded prenatal care services, as defined in Supplement 2 to ATTACHMENT 3.1-A and 3.1-B, 20.c., will be based on units of services. Each defined activity will be weighted and assigned a time value which will convert to dollars for reimbursement purposes.

Payment for expanded prenatal services will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid will be the payor of last resort.

(v) Respirator Care Services

Payment is made for ventilator equipment and supplies, the respiratory therapist, or other professional trained in respiratory therapy, at the lowest customary charge from qualified providers serving the geographical area of the recipient's residence.

4.19 Payments for Medical and Remedial Care and Services

23. Pediatric or Family Nurse Practitioner Services

Payment may not exceed the amount paid to physicians for the service the provider is authorized by State Law to perform, or the provider's customary charge, whichever is less.

For services provided on and after 11.01.94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversation factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lessor of the upper limit or the provider's customary charge for the service to the general public.

1. a. Transportation

Payment is made for transportation and related expenses necessary for recipient access to covered medical services via common carrier or other appropriate means; cost of meals and lodging, and attendant services where medically necessary.

Reimbursement Upper Limits:

(i) Common Carriers (bus, taxi, train or airplane) – the rates established by any applicable regulatory authority, or the provider's customary charge to the general public.

(ii) Automobile – Reimbursement is computed at the prevailing state employee travel rate per mile.

(iii) Ambulance – Reimbursement is the lesser of the Medicare geographic prevailing fee of EMS provider charge to the general public as reported on the State Agency survey.

(iv) Meals - $5.00 per meal during travel time for patient, attendant, and transportation provider.

(v) Lodging – At cost, as documented by receipt, at the most economical resource available as recommended by the medical facility at destination.

PERSONAL CARE

4.19 Payments for Medical and Remedial Care and Services
Methods and Standards for Estahlishine Payment Rates

26. Personal Care Services

Personal Care services will be reimbursed using a statewide fee-for-service rate schedule based on units of services authorized in the approved plan of care. Payment for Personal Care services under the State Plan will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Medicaid will be the payer of last resort. Unless specifically noted otherwise in the plan, the state-developed fee schedule rate is the same for both governmental and private providers. Providers will be reimbursed at the lesser of the provider's usual and customary billed charge or the Bureau for Medical Services (Bureau) fee schedule.

Personal care services are limited **on a per unit, per month basis (15 minutes per unit) with all services subject to prior authorization. Individuals can receive up to a maximum of 840 units (210) hours) each month.**

Rate Methodology:
Rates for Personal Care services arc developed using a market-factor rate-setting model. The model reflects individual service definition, operational service delivery, administrative, capital and technology considerations. The following factors arc used in determining the rates:

- Wage - Wage data is obtained from the Bureau for Labor Statistics (BLS). The wage is based on two elements consisting of occupation/wage categories reported by BLS and identified by Medicaid staff as comparable to services delivered under the personal care program as well as results of a formal provider survey
- Inflation - The base wage is adjusted by an inflationary factor determined by the percent change in Consumer Price Index (CPI-U. U.S. City: All Items 1982-84 = 100) from base period 2009 to current rate period.
- Payroll Taxes - The payroll taxes factor represents the percentage of the employer's contribution to Medicare, Social Security, workers' compensation and unemployment insurance.
- Employee Benefits - The employee benefits factor represents the percentage of employer's contribution to employee health insurance and retirement benefits. The employee benefit factor varies by employee type. This factor is discounted to reflect the Medicaid agency's share of cost based on the Medicaid payer mix.
- Allowance for Administrative Costs - The allowance for administrative costs factor represents the percentage of service costs that results from non-billable administrative activities performed by direct care staff and services provided by employer administrative support and executive start This factor is discounted to the Medicaid payer mix as determined by provider survey conducted in 2010 and 2011.
- Allowance for Transportation Costs - The allowance for transportation costs factor represents an allowance for average travel time by the provider as indicated by the provider survey.
- Allowance for Capital and Technology - The allowance for capital and technology factor represents weighting of various income and balance sheet account information and provider survey data to calculate a capital and technology cost per dollar of employee wages. This factor is discounted to reflect the Medicaid agency's share of cost based on the Medicaid payer mix.
- Room and Board - Room and Board shall not **be a component used in developing the rate methodology.**

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: West Virginia

PERSONAL CARE

The following steps are used to determine the rates:

1. The State will use West Virginia specific hourly wages from BLS that are adjusted to provider participation mix rates and average wage level percentiles as indicated by the provider survey.
2. The base hourly wage rate will be adjusted for annual inflation by calculating the percent change in CPI between the base year (2009) and that of the current rate review period.
3. All rate factors, excluding mileage, will use the inflation adjusted base wage rate as determined in Step 2 above in calculating the additional rate components.
4. The percentage of payroll, applicable employee benefits, administrative allowances, capital and technology factors are each multiplied by the inflation adjusted wage rate to determine the rate components.
5. The mileage rate component is determined by multiplying the State employee mileage rate by the average miles traveled as indicated by the provider survey.
6. The sum of all rate components described in Steps 2 -5 will equal the allowable service rate.

The Bureau's rates were set as of October 1, 2011 and are effective for services on or after. Rates will be published on the Bureau's website at: www.dhhr.wv.gov/bms.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR FREESTANDING BIRTH CENTER SERVICES

Medicaid providers of freestanding birth center services are reimbursed as follows:

The payment for services provided by a freestanding birth center is limited to the lower of the encounter rate base or on a fee for the services provided in the clinic. The agency's fee schedule for freestanding birth center services was established on April 1, 2012, and is effective for services provided on or after that date. All government and private providers are paid according to the same methodology. The fee schedule will be published on the Medicaid website at: http://www.dhhr.wv.gov/bms/Pages/default.aspx

Physicians, midwives, and other licensed practitioners as defined per Attachment 3.1-A, Page 11 are paid a separate fee for services performed in the freestanding birth center based on procedure code and as specified in Attachment 4.19-B, physicians' services (page 3a) and Women's Health Nurse Practitioner Services (page 5). All government and private providers are paid according to the same methodology. The fee schedule will be published on the Medicaid website at: http://www.dhhr.wv.gov/bms/Pages/default.aspx

REIMBURSEMENT TO SCHOOL-BASED SERVICE PROVIDERS:

A. Reimbursement Methodology for School-Based Service Providers

Reimbursement to Local Education Agencies (LEAs) for School-Based Service Providers is based on a cost based methodology.

Medicaid Services provided by School-Based Service Providers are services that are medically necessary and provided to Medicaid recipients by LEAs in accordance with an Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA):

1. Audiology and Speech-Language Pathology Services
2. Occupational Therapy Services
3. Physical Therapy Services
4. Psychological Services
5. Nursing Services
6. Personal Care Services
7. Targeted Case Management Services
8. Specialized Transportation

Providers will be paid interim rates based on historical cost data for school-based direct medical services. For the initial periods covered by this SPA the interim rate will be based on the current rates for school based health services until sufficient cost data has been collected through the annual cost report process to establish revised interim rates. Annually, provider specific cost reconciliation and cost settlement processes will occur to identify and resolve all over and under payments.

B. Direct Medical, Personal Care Services, and Targeted Case Management Payment Methodology

Effective for dates of service on or after July 1, 2013, the Bureau for Medical Services (BMS) will institute a cost based payment system for all School-Based Service Providers. As a cost based methodology, this system will incorporate standard cost based components: payment of interim rates; a CMS approved Random Moment Time Study (RMTS) approach for determining the allocation of direct service time; a CMS approved Annual Cost Report based on the State Fiscal Year (June 30 end); reconciliation of actual incurred costs attributable to Medicaid with interim payments; and a cost settlement of the difference between actual incurred costs and interim payments.

To determine the allowable direct and indirect costs of providing medical services to Medicaid-eligible clients in the LEA, the following steps are performed on those costs pertaining to each of

the three cost pools; direct services, personal care services, and targeted case management services:

1) Direct costs for medical services include unallocated payroll costs and other unallocated costs that can be directly charged to medical services. Direct payroll costs include the total compensation (i.e. salaries and benefits) to the service personnel identified for the provision of health services listed in the description of covered Medicaid services delivered by LEAs.

   Other direct costs include costs related to the approved service personnel for the delivery of medical services, such as materials, supplies and equipment and capital costs such as depreciation and interest. Only those materials, supplies, and equipment that have been identified and included in the approved BMS Medicaid cost reporting instructions are allowable costs and can be included on the Medicaid cost report.

   Total direct costs for medical services are reduced on the cost report by any credits, adjustments or revenue from other funding sources resulting in direct costs net of federal funds.

2) The net direct costs for each service category are calculated by applying the direct medical services percentage from the approved time study to the direct costs from Item 1 above.

   The RMTS incorporates a CMS approved methodology to determine the percentage of time medical service personnel spend on IEP related medical services, and general and administrative time. This time study will assure that there is no duplicative claiming of administrative costs.

3) Costs incurred through the provision of direct services by contracted staff are allowable costs net of credits, adjustments or revenue from other funding sources. This total is then added to the net direct costs identified in Item 2 above.

4) Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate to its net direct costs identified in Item 3 above. West Virginia LEAs use predetermined fixed rates for indirect costs. The West Virginia Department of Education is the cognizant agency for LEAs, and approves unrestricted indirect cost rates for LEAs for the United States Department of Education. Only allowable costs are certified by LEAs.

5) Net direct costs, from Items 2 and 3 above, and indirect costs from Item 4 above are combined.

6) Medicaid's portion of total net costs is calculated by multiplying the results from Item 5 above by the cost pool specific IEP ratio. West Virginia LEA's use a different IEP ratio for each of three service type cost pools, including direct services, personal care services, and targeted case management services. For direct services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a direct medical service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a direct medical service outlined in their IEP. For personal care services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a personal care service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a personal care service outlined in their IEP. For targeted case management services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a targeted case management service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a targeted case management service outlined in their IEP.

C. Specialized Transportation Payment Methodology

Effective for dates of services on or after July 1, 2014, providers will be paid on a cost basis. Providers will be paid interim rates based on historical cost data for specialized transportation services. For the initial periods covered by this SPA the interim rate will be based on the current rates for school based health services until sufficient cost data has been collected through the annual cost report process to establish revised interim rates. Annually, provider specific cost reconciliation and cost settlement processes will occur to identify and resolve all over and under payments.

Specialized transportation is allowed to or from a Medicaid covered direct IEP service which may be provided at school or other location as specified in the IEP. Transportation may be claimed as a Medicaid service when the following conditions are met:

1. Specialized transportation is specifically listed in the IEP as a required service;
2. The child required specialized transportation in a vehicle that has been modified as documented in the IEP; and
3. The service billed only represents a one-way trip; and
4. A Medicaid IEP medical service (other than transportation) is provided on the day that special transportation is billed

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with specialized transportation reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Personnel Costs – Personnel costs include the salary and benefit costs for transportation providers employed by the school district. The definitions for allowable salary and benefit costs for transportation services are the same as for direct medical service providers. The personnel costs may be reported for the following staff:
   a. Bus Drivers
   b. Attendants
   c. Mechanics
   d. Substitute Drivers
2. Transportation Other Costs – Transportation other costs include the non-personnel costs incurred in providing the transportation service. These costs include
   a. Lease/Rental costs
   b. Insurance costs
   c. Maintenance and Repair costs
   d. Fuel and Oil cost
   e. Contracted – Transportation Services and Transportation Equipment cost
3. Transportation Equipment Depreciation Costs – Transportation equipment depreciation costs are allowable for transportation equipment purchased for more than $5,000.

The source of these costs will be audited general ledger data kept at the LEA level.

LEAs may report their transportation costs as specialized transportation only costs when the costs can be discretely identified as pertaining only to specialized transportation or as general transportation costs when the costs cannot be discretely identified as pertaining only to specialized transportation.

All specialized transportation costs reported on the annual cost report as general transportation costs will be apportioned through two transportation ratios; the Specialized Transportation Ratio and the Medicaid One Way Trip Ratio. All specialized transportation costs reported on the annual cost report as specialized transportation only will only be subject to the Medicaid One Way Trip Ratio.

a. **Specialized Transportation Ratio** – The Specialized Transportation Ratio is used to discount the transportation costs reported as general transportation costs by the percentage of Medicaid eligible IEP students receiving specialized transportation services. This ratio ensures that only the portion of transportation expenditures related to the specialized transportation services for Medicaid eligible students are included in the calculation of Medicaid allowable transportation costs.

   The Specialized Transportation Ratio will be calculated based on the number of Medicaid eligible students receiving specialized transportation services in the school district. The numerator for the ratio will be the total number of Medicaid eligible IEP students receiving

specialized transportation services. The denominator for this ratio will be the total number of all students receiving transportation services. The data for this ratio will be based on the same point in time as is used for the calculation of the IEP ratio.

The Specialized Transportation Ratio is defined by the following formula:

Numerator = Total number of Medicaid eligible students receiving Specialized Transportation services per their IEP
Denominator = Total number of all students receiving transportation services

An example of how the Specialized Transportation Ratio will be calculated is shown below:

Specialized Transportation Ratio	
Total Number of Medicaid Eligible Students Receiving Specialized Transportation Services per their IEP	100
Total Number of ALL Students Receiving Transportation Services (Specialized or Non-Specialized)	1,500
	7%

b. **Medicaid One Way Trip Ratio-** An LEA-specific Medicaid One Way Trip Ratio will be established for each participating LEA. When applied, this Medicaid One Way Trip ratio will discount the transportation costs by the percentage of Medicaid IEP one way trips. This ratio ensures that only Medicaid allowable transportation costs are included in the cost settlement calculation.

The Medicaid One Way Trip Ratio will be calculated based on the number of one way trips provided to students requiring specialized transportation services per their IEP. The numerator of the ratio will be based on the Medicaid paid one way trips for specialized transportation services as identified in the state's MMIS data. The denominator will be based on the school district transportation logs for the number of one-way trips provided to Medicaid eligible students with specialized transportation in the IEP. The denominator should be inclusive of all one way trips provided to students with specialized transportation in their IEP, regardless of whether the trip qualified as Medicaid specialized transportation or not. The data for this ratio will be based on the total number of trips for the entire period covered by the cost report, i.e. all one way trips provided between July 1 and June 30.

The Specialized Transportation Ratio is defined by the following formula:

Numerator = Total Medicaid paid one way trips for specialized transportation services per MMIS
Denominator = Total one way trips for Medicaid eligible students with specialized transportation in their IEP (from bus logs)

An example of how the Specialized Transportation Ratio will be calculated is shown below:

Medicaid One Way Trip Ratio	
Total Number of Paid Medicaid One Way Trips for Specialized Transportation Services (per MMIS)	250
Total Number of ALL One Way Trips for Medicaid Eligible Students with Specialized Transportation in their IEP (per bus logs)	600
	42%

D. Annual Cost Report Process

Each provider will complete an annual cost report for all school-based services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 31st of the same year of the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total allowable costs for delivering services by School-Based Service Providers, including direct costs and indirect costs, based on cost allocation methodology procedures; and

2. Reconcile interim payments to total allowable costs based on cost allocation methodology procedures.

All filed annual Cost Reports are subject to a desk review.

E. Certification of Funds Process

On an annual basis, each LEA will certify through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the nonfederal share.

F. The Cost Reconciliation Process

The total allowable costs based on cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school-based service providers during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation. West Virginia will complete the review of the cost settlement within a

reasonable time following the submission of the annual cost reports and the completion of all interim billing activities by the providers for the period covered by the cost report.

G. The Cost Settlement Process

For services delivered for a period covering July 1st through June 30th, the annual School Based Service Providers Cost Report is due on or before December 31st of the same year.

If a provider's interim payments exceed the actual, certified costs of the provider for school-based services to Medicaid clients, the provider will return an amount equal to the overpayment.

If the actual, certified costs of a provider for school-based services exceed the interim Medicaid payments, BMS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment.

BMS shall issue a notice of interim settlement that denotes the amount due to or from the provider. West Virginia will process the interim settlement within 6 to 12 months following the submission of the annual cost reports. BMS shall also issue a notice of final settlement that denotes the final amount due to or from the provider upon completion of the final cost reconciliation. The final settlement will be issued within 24 months following the final submission of the annual cost reports.

Payment for Medical and Remedial Care and Services

Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

___ The rates reflect all Medicare site-of-service and locality adjustments.

_X_ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

_X_ The rates reflect all Medicare geographic/locality adjustments.

___ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

_X_ The State utilizes the Deloitte fee schedule with the exception of the following vaccine administration codes.

_X_ The State utilizes the maximum regional cap to procedure codes 90471 and 90473.

_X_ The State will reimburse procedure code 90472 at the Medicare rate.

The following formula was used to determine the mean rate over all counties for each code: _____

Method of Payment

_X_ The state has adjusted its fee schedule to make payment at the higher rate for each Evaluation and Management (E&M) and vaccine administration code.

___ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Payment for Medical and Remedial Care and Services

Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Primary Care Services Affected by this Payment Methodology

___ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

_X_ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (SPECIFY CODES).
99288, 99315, 99316, 99318, 99339, 99340, 99358, 99359, 99360, 99363, 99364, 99366, 99367, 99368, 99374, 99377, 99379, 99380, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99485, 99486, 99487, 99488, 99789, 99495, 99496, 90460, 90461, 90474

_X_ The State will make payments under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (SPECIFY CODE AND DATE ADDED).
99224 – 01/01/11, 99225 – 01/01/11, 99226 – 01/01/11

_X_ The State will not adjust the fee schedule to account for any changes in Medicare rates throughout the year.

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate as implemented by the state in CYs 2013 and 2014

_X_ Medicare Physician Fee Schedule rate as implemented by the state and using the 2009 conversion factor.

_X_ State regional maximum administration fee set by the Vaccines for Children program

Payment for Medical and Remedial Care and Services

Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

___ The imputed rate in effect at 07/01/09 for code 90460 equals the rate in effect at 07/01/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 07/01/09 is:

_X_ A single rate was in effect on 07/01/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $12.00. The State did not cover 90460. The State elected to cover 90471-90473 for vaccine administration services; however, the single rate was only applied to procedure codes 90471 and 90472.

_X_ Alternative methodology to calculate the vaccine administration rate in effect 07/01/09:

Service code 90473 was added as a benefit 08/01/08 but was not priced using the single rate as other administration services. Service code 90473 is priced using the MPFS Relative Units times the State derived CF which will be used as the basis for determining the rate in effect 7/1/09.

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14, but not prior to December 31, 2014. All rates are published at dhhr.wv.gov/bms.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at dhhr.wv.gov/bms.