Inpatient Hospital Services

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

For services rendered on or after July 1, 2011, 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 (Senate Bill 492).

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 2012 and SFY 2013, the Hospital fiscal year end 2009 Medicare cost reports 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 market basket rates for 2.5 years to estimate both SFY 2012 and SFY 2013 costs. All hospital specific Medicaid inpatient payments and estimated costs will be trended for 2.5 years using a factor based on utilization growth in the Medicaid program to estimate both SFY 2012 and 2013 Medicaid data. The inpatient Medicaid portion of the cost of the .88% 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") 2009 total inpatient Medicaid paid claim amounts to the total inpatient Medicaid paid claim amounts for all private PPS hospitals in CY 2009; 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, 2011, 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 2012 and SFY 2013, the Hospital fiscal year end 2009 Medicare cost reports will be utilized.

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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 market basket rates for 2.5 years to estimate both SFY 2012 and SFY 2013 costs. All hospital specific Medicaid inpatient payments and estimated costs will be trended for 2.5 years using a factor based on utilization growth in the Medicaid program to estimate both SFY 2012 and 2013 Medicaid data. The inpatient Medicaid portion of the cost of the .88% tax will also be added to the hospital specific inpatient Medicaid 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).

5. 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).