4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1

Inpatient Hospital Services - Disproportionate Share Hospitals

Methodology to adjust payments for inpatient services furnished by disproportionate share hospital.

A. Definitions: A disproportionate share hospital is a hospital licensed by the State of West Virginia Department of Health and Human Resources and which meets one of the following criteria:

1. The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals in the State which is the ratio of Medicaid inpatient days in a cost reporting period to the total number of the hospital's inpatient days in that period. Inpatient days include each day in which an individual (including a newborn) is an inpatient in the hospital, whether in a specialized ward or awaiting placement elsewhere.

2. The hospital's low-income utilization rate exceeds 25 percent. The hospital's low-income utilization rate is the sum of:

   a. The fraction (expressed as a percentage)-

      (1) The numerator of which is the sum (for a period) of (a) the total revenues paid the hospital for patient services under the Medicaid State Plan and (b) the amount of the cash subsidies for patient services received directly from State and local governments, and

      (2) The denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

   b. A fraction (expressed as a percentage) -

      (1) The numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in the period, less the portion of any cash

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subsidies described in a. (1) above in the period reasonably attributable to inpatient hospital services, and

(2) The denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under (b)(1) above shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the approved Medicaid State Plan).

3. Hospitals with high Medicaid inpatient utilization defined as meeting the following criteria:

a. During the hospital's cost reporting period the hospital provided in excess of 3,000 Medicaid inpatient days of service, or

b. For the same hospital cost reporting period, the sum of the following factors equalled or exceeded eight percent:

(1) Total Medicaid inpatient days divided by total inpatient days, and

(2) The ratio of Medicare Part A days attributable to SSI recipients or the SSI inpatient days divided by the total Medicare covered days. This information can be obtained from the Medicare intermediary or, since the SSI/Medicare percentages are determined by HCFA on a federal fiscal year basis, hospitals have the option of determining the SSI/Medicare percentage based upon data from their own cost reporting periods (which must be reconciled to the most recent

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Federal fiscal years); and

(3) Total days of care provided to eligible Medicaid inpatients in excess of "covered days" divided by total Medicaid inpatient days.

4. The hospital is an acute care or psychiatric hospital owned by the State of West Virginia and operated by the Department of Health and Human Resources or a rehabilitation hospital owned by the State of West Virginia and operated by the Department of Education; or Hospitals designated as CRITICAL ACCESS HOSPITALS, (also known as ESSENTIAL ACCESS COMMUNITY HOSPITALS as defined in Section 4.19-A.3.a. of the State Plan), by the West Virginia Department of Health and Human Resources, Bureau of Public Health. New hospitals or hospitals offering expanded services may submit eligibility data for their most recently completed quarter.

5. In addition to the above criteria, all hospitals must meet the following:

a. All hospitals offering non-emergency obstetrical services as of 12/22/87 must have two obstetricians with staff privileges. These physicians must agree to provide obstetrical services to Medicaid recipients. In the case of hospitals located in a rural area, "obstetrician" may include any physician with staff privileges who performs non- emergency obstetrical services at the hospital.

b. All hospitals must have a one percent or greater Medicaid Utilization Rate (MUR).

B. Payment Adjustment: Hospitals qualifying As disproportionate share hospitals (DSH) under this plan (as noted in A above) will receive a payment adjustment in addition to others made for services. The Commissioner of the Single State Agency shall allocate funds for disproportionate share hospital payments. The hospitals will be notified sixty (60) days prior to the end of each quarter as to the total quarterly allotment. The allotment of funds will be paid as follows:

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1. MINIMUM DISPROPORTIONATE SHARE HOSPITAL (DSH) OR CRITICAL ACCESS HOSPITAL PAYMENT POOL - The Commissioner of the Single State Agency will allocate an additional payment amount to hospitals qualifying under a. or b. below:

   a. Hospitals qualifying under A.1. or A.2. and A.5. above may receive a minimum DSH payment adjustment equal to the lesser of:

      (1) The hospital's quarterly approved claims times the percentage by which the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals qualified under this Section, or

      (2) One fourth of the hospital's annual cost limit as defined in Section B.4.

   b. Hospitals designated as CRITICAL ACCESS HOSPITALS, (also known as ESSENTIAL ACCESS COMMUNITY HOSPITALS as defined in Section 419-A.3.a. of the State Plan), by the West Virginia Department of Health and Human Resources, Bureau of Public Health, and qualifying under A.1. through A.3. and A.5. above, may receive a quarterly payment adjustment equal to one fourth of the hospital's annual cost limit as defined in Section B.4.

2. NON-STATE OWNED HOSPITAL PAYMENT POOL - The Commissioner of the Single State Agency may allocate an additional payment amount to hospitals qualifying under A.1. through A.3. and A.5. above. The allocation will not exceed the Federal Allotment of Funds less Section B.1., B.3. and B.5. payments.

   a. The Commissioner will establish the following Non-State Owned Hospital Groups for the payment of funds allotted under this Section.

      (1) Small Hospital Group - Hospitals qualifying under Sections A.1. through A.3. and A.5. above with less than one hundred licensed acute care beds (does not include distinct part nursing facility beds) shall be paid ten percent (10%) of the total funds allocated in this Section.

      (2) Large Hospital Group - Hospitals qualifying under Sections A.1. through A.3. and A.5 above with one hundred or more licensed acute care beds (does

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not include distinct part nursing facility beds) shall be paid fifteen percent (15%) of the total funds allocated in this Section.

(3) Eligibility Group - Hospitals qualifying under Sections A.1. through A.3. and A.5. above shall be paid seventy-five percent (75%) of the total funds allocated in this Section.

b. The payment factors for the Small Hospital Group, Large Hospital Group and Eligibility Group will be computed at the beginning of each State Fiscal Year. The factors will be based on each hospital's financial statements, cost reports and related data for its fiscal year ended during the calendar year preceding the start of the State Fiscal Year. New hospitals or hospitals with significant organizational changes, may submit survey data for their most recent quarter. The financial statements must be prepared in accordance with Generally Accepted Accounting Principles (GAAP). The payment factors will be computed as follows:

(1) The Small Hospital Payment Factor will be calculated for each qualifying hospital in Section B.2.a.(1). The factor will be the sum of the following:

(a) Inpatient Factor. The payment factor shall be the sum of the following:

(i) Five percent.

(ii) Two percent for every one percent or fraction thereof that the Medicaid inpatient days as a percent of total inpatient days for the

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hospital exceeds five percent.

(b) Obstetrical Services (OB) Factor. For qualifying hospitals providing non-emergency obstetrical care where the hospital's ratio of total Medicaid deliveries of newborn babies to total deliveries is in excess of thirty-nine percent, the adjustment factor will be the sum of the following:

(i) Five percent.

(ii) One-half of one percent for every one percent or fraction thereof that the ratio of Medicaid deliveries to total deliveries exceeds thirty-nine percent.

(c) Uncovered Day Factor. One percent for every percent or fraction thereof that the ratio of total Medicaid days to total "covered" Medicaid days exceeds one hundred percent.

(2) The Large Hospital Payment Factor will be calculated for each qualifying hospital under Section B.2.a.(2). The factor will be the sum of the following:

(a) Inpatient Factor. The payment factor shall be the sum of the following:

(i) Five percent.

(ii) Two percent for every one percent or fraction thereof that the Medicaid inpatient days as a percent of total

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inpatient days for the hospital exceeds five percent.

(b) Obstetrical Services (OB) Factor. For qualifying hospitals providing non-emergency obstetrical care where the hospital's ratio of total Medicaid deliveries of newborn babies to total deliveries is in excess of thirty-nine percent, the adjustment factor will be the sum of the following:

(i) Five percent.

(ii) One-quarter of one percent for every one percent or fraction thereof that the ratio of Medicaid deliveries to total deliveries exceeds thirty-nine percent.

(c) Uncovered Day Factor. One percent for every percent or fraction thereof that the ratio of total Medicaid days to total "covered" Medicaid days exceeds one hundred percent.

(3) Eligibility Payment Factor. The eligibility payment factor is calculated by dividing each hospital's total operating expenses by the total operating expenses for all qualifying hospitals under Section B.2.a.(3).

c. The quarterly payment adjustment for hospitals qualifying under this Section is calculated as follows:

(1) The small hospital adjustment factor will be multiplied by the hospitals quarterly Medicaid approved claims and prorated for all eligible hospitals against the total dollars allocated to the small hospital group.

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(2) The large hospital adjustment factor will be multiplied by the hospital's quarterly Medicaid approved claims and prorated for all eligible hospitals against the total dollars allocated to the large hospital group.

(3) The eligibility payment adjustment is calculated by multiplying each hospital's eligibility factor by the total dollars allocated to the eligibility group.

(4) The quarterly payment adjustment for hospitals within the small, large and eligibility groups shall be the lessor of:

(a) The sum of each hospital's adjustments for (1) or (2) plus (3) above, or

(b) One fourth of the hospital's annual cost limit as defined in Section B.4 less the hospitals payment under Section B.1 above. If the payment amount calculated within this subsection is less than subsection (a) above, the difference between (a) and (b) will be reallocated to the remaining hospitals (in accordance within Section B.s above) where (b) is greater than (a).

3. STATE OWNED OR OPERATED HOSPITAL POOL

The Commissioner of the Single State Agency will allocate an additional payment amount to hospitals qualifying under Sections A:4 and A.5 above. The allocation will be equal to the cost limit for all hospitals qualifying

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under this Section less Section less Section B.1. payments. Qualifying hospitals will receive a payment adjustment which will not exceed the annual cost limit less Section B.1. payments.

4. ANNUAL COST LIMIT - The annual sum of each hospital's Section B.1, B.2. or B.3. payments will be limited as follows:

a. Each hospital's annual payment will be limited to the cost of services to Medicaid patients (Inpatients and Outpatients) less the amount paid by West Virginia Medicaid under the NON-DSH payment provisions plus the cost of services to uninsured patients (Inpatients and Outpatients) less any cash payments made by or for them. The uninsured (for the purposes of this plan) are those patients without third party coverage. The cost of services to uninsured patients may not include patients with third party coverage in whole or in part.

b. Institutions For Mental Disease (IMD) are subject to an additional annual payment limit based on Section 4721(b) of the Balanced Budget Act of 1997. The IMD annual DSH payment limit is the lesser of:

(1) The IMD's annual payment limit as computed in Section 4.a. above; or

(2) The IMD's portion of the State's total computable expenditures applicable to the 1995 DSH allotment as reported on the HCFA 64 as of January 1, 1997; or

(3) The IMD's portion of the amount equal to the product of the State's current year total computable DSH allotment (as calculated above) and the "applicable percentage".

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(4) The applicable percentage is defined as follows:

(a) For FYs 1998-2000, the ratio of 1995 total computable IMD DSH payments to the 1995 total computable share total DSH payments.
(b) For FYs 2001 and beyond, the lessor of the applicable percentage as computed above, or 50% for fiscal year 2001, 40% for fiscal year 2002, and 33% for each succeeding year.

c. An estimated cost limit will be computed at the beginning of each State Fiscal Year. The estimated cost limit will be based on each hospital's financial data for its fiscal year ended during the calendar year preceding the start of the State Fiscal Year. The estimated cost limit may be adjusted to reflect anticipated changes in cost and/or revenues. The estimated IMD limit is based on Section 4.b. above.

d. Tentative and final cost settlements will be made as necessary. A final settlement will be calculated from data contained within each hospital's best available data using tentative and/or final HCFA-2552 cost report and supplemental schedules as required as well as results of the DSH audit and final annual cost limit. The final DSH cost settlement will be made in addition to other cost settlements. The final IMD DSH limit is based on Section 4.b. above, and the State's annual IMD DSH limit as published in the Federal Register. Appeal rights are limited to errors in the DSH formula and errors that may result in material misstatement of DSH based on data submitted in the provider's DSH forms.

e. Final DSH cost settlement amounts shall be determined in accordance with the payment methodology set forth in sections of 4.19 A-1 above. Comparisons to final DSH cost limits indicating overpayments and underpayments shall be made and resulting amounts will be recouped and redistributed per 42 CFR Part 433.30 Subpart F. Overpayments will be redistributed. The redistribution shall be to all DSH hospitals which have not received the maximum for which they are eligible, meaning the following categories of hospitals: Critical Access, Minimum DSH, Non-State Owned, IMD, and State Owned or Operated. The redistribution shall be paid to the remaining hospitals proportionately based upon their audited Medicaid utilization rate. Aggregate DSH payments shall not exceed a hospital's specific DSH limit. Any existing overpayments remaining after complete redistribution shall result in return of federal share to CMS.

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5. The sum of section B.1., B.2. and B.3. payments will not exceed the total federal allotment of funds. Additionally, the sum of section B.1., B.2. and B.3. IMD hospital DSH payments will not exceed the federal IMD DSH limitations.

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Enclosure 3

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.