

WEST VIRGINIA LEGISLATURE

2023 REGULAR SESSION

Introduced

Senate Bill 694

By Senators Takubo and Woelfel

[Introduced February 20, 2023; referred
to the Committee on Health and Human Resources;
and then to the Committee on Finance]

1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section,
 2 designated §9-5-30, relating to providing a Supplemental Medicaid Reimbursement for
 3 Academic Medical Center Acute Care Providers.

Be it enacted by the Legislature of West Virginia:

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-30. Supplemental Medicaid Reimbursement for Academic Medical Center Acute Care Providers.

1 (a) Definitions. — As used in this section, the following terms have the following meanings:

2 (1) "Academic Medical Center" means an accredited medical school, one or more faculty
 3 practice plans affiliated with the medical school or one or more affiliated hospitals which meet the
 4 requirements set forth in 42 C.F.R 411.355(e).

5 (2) "Department" means the West Virginia Medicaid program as administered by the West
 6 Virginia Department of Health and Human Resources.

7 (3) "Upper payment limit" or "UPL" means the methodology permitted by federal regulation
 8 to achieve the maximum allowable amount on aggregate hospital Medicaid payments to nonstate
 9 government-owned hospitals and private hospitals under 42 C.F.R. sec. 447.272.

10 (4) "UPL gap" means the difference between the UPL and claim amount paid to qualifying
 11 hospitals.

12 (5) "Qualifying hospital" means a Medicaid-participating, in-state Academic Medical
 13 Center and any owned or operated acute care facilities.

14 (b) An Academic Medical Center acute hospital services provider that provides services to
 15 Medicaid beneficiaries is eligible for supplemental reimbursement.

16 (c) An eligible provider's supplemental reimbursement shall be calculated and paid as
 17 follows:

18 (1) To the extent allowable under federal law, the department shall develop the following
 19 program to increase Medicaid reimbursement for inpatient hospital services provided by a

20 qualified hospital to Medicaid recipients:

21 (A) A program to increase inpatient reimbursement to qualifying hospitals within the
22 Medicaid fee-for-service program in an aggregate amount equivalent to the UPL gap; and

23 (B) A program to increase inpatient reimbursement to qualifying hospitals within the
24 Medicaid managed care program in an aggregate amount equivalent to the managed care gap.

25 (2) On an annual basis prior to the start of each program year, the departments shall
26 determine:

27 (A) The maximum allowable UPL for inpatient services provided in West Virginia for
28 Medicaid fee-for-service program on qualifying hospitals.

29 (B) The fee-for-service UPL gap;

30 (C) A per discharge uniform add-on amount to be applied to Medicaid fee-for-service
31 discharges at qualifying hospitals for that program year, determined by dividing the UPL gap for
32 the applicable ownership group by total fee-for-service hospital inpatient discharges at qualifying
33 hospitals in the data used to calculate the UPL gap;

34 (D) The maximum managed care gap for inpatient services; and

35 (E) A per discharge uniform add-on amount to be applied to Medicaid managed care
36 discharges at qualifying hospitals for that program year in an amount that is calculated by dividing
37 the managed care gap by total managed care in-state qualifying hospital inpatient discharges in
38 the data used to calculate the managed care gap.

39 (3) At least 30 days prior to the beginning of each program year, the department shall
40 provide each qualifying hospital the opportunity to verify the base data to be utilized in both the
41 fee-for-service and managed care gap calculations, with data sources and methodologies
42 identified.

43 (4) On a quarterly basis in the program year, the department shall:

44 (A) Calculate a fee-for-service quarterly supplemental payment for each qualifying hospital
45 using fee-for-service claims for inpatient discharges paid in the quarter to the qualifying hospital

46 multiplied by the uniform add-on amount determined in paragraph (2)(C) of this subsection;

47 (B) Calculate a managed care quarterly supplemental payment for each qualifying hospital
48 to be paid by each managed care organization using managed care encounter claims for inpatient
49 discharges received in the quarter multiplied by the uniform add-on amount determined in
50 subsection (2)(E) of this section;

51 (C) Make the quarterly supplemental payment calculated under paragraph (A) of this
52 subsection;

53 (D) Provide each managed care organization with a listing of the supplemental payments
54 to be paid by each managed care organization to each qualifying hospital;

55 (E) Provide each managed care organization with a supplemental capitation payment to
56 cover the managed care organization's quarterly supplemental payments to be paid to qualifying
57 hospitals in the quarter;

58 (F) Determine the amount of state funds necessary to obtain federal matching funds that,
59 in the aggregate, equal the total quarterly supplemental payments to be paid to all qualifying
60 hospitals in both the fee-for-service and the Medicaid managed care programs;

61 (G) Determine a per discharge hospital assessment for the quarter for each qualifying
62 hospital, which shall be calculated by first applying towards the state share calculated under
63 paragraph (F) of this subsection and then dividing the remaining state share by the total
64 discharges reported by all in-state qualifying hospitals on the Medicare cost report filed by those
65 qualifying hospitals in the calendar year two years prior to the program year;

66 (H) Determine each qualifying hospital's quarterly assessment by multiplying the
67 assessment established in paragraph (G) of this subsection by the hospital's total discharges from
68 the qualifying hospital's Medicare cost report filed in the calendar year two years prior to the
69 program year; and

70 (I) Provide each qualifying hospital with a notice sent on the same day as the distribution to
71 managed care organizations of the supplemental capitation payments pursuant to paragraph (E)

72 of this subsection, of the qualifying hospital's quarterly assessment, that shall state the total
73 amount due from the assessment, the date payment is due, the total number of paid claims for
74 inpatient discharges used to calculate the qualifying hospital's quarterly supplemental payments,
75 and the amount of quarterly supplemental payments due to be received by the qualifying hospital
76 from the department and each Medicaid managed care organization.

77 (5) Each qualifying hospital shall receive four quarterly supplemental payments in the
78 program year, as determined under subsection (c) of this section.

79 (6) Medicaid managed care organizations shall pay the supplemental payments to
80 qualifying hospitals within five business days of receiving the supplemental capitation payment
81 from the department.

82 (7) A qualifying hospital shall pay its quarterly assessment no later than 15 days from the
83 date the qualifying hospital is notified of the assessment from the department. The department
84 may delay or withhold a portion of the supplemental payment if a hospital is delinquent in its
85 payment of a quarterly assessment.

86 (8) The department shall complete the actions required under subsection (c) of this section
87 expeditiously and within the same quarter as all required information is received.

88 (9) Qualifying hospitals may notify the department of errors in the data used to make a
89 quarterly supplemental payment by providing documentation within 30 days of receipt of a
90 quarterly supplemental payment from a Medicaid managed care organization. If the department
91 agrees that an error occurred in a qualifying hospital's quarterly supplemental payment, the
92 department shall reconcile the payment error through an adjustment in the qualifying hospital's
93 next quarterly supplemental payment.

94 (10) The programs in this section shall not be implemented if federal financial participation
95 is not available or if the provider tax waiver is not approved. A qualifying hospital shall have no
96 obligation to pay an assessment if any federal agency determines that federal financial
97 participation is not available for any assessment. Any assessments received by the department

98 that cannot be matched with federal funds shall be returned pro rata to the qualified hospitals that
99 paid the assessments.

100 (11) The department may implement the hospital rate improvement programs only if
101 Medicaid state plan amendments required for federal financial participation are approved by the
102 United States Centers for Medicare and Medicaid Services.

103 (12) The assessment authorized under this law shall be restricted for use to accomplish the
104 inpatient reimbursement increases established under this section. The state shall not maintain or
105 revert funds received under this law to the state general fund, except that the department may
106 receive \$250,000 in state funds each program year to administer the programs.

107 (13) The department shall promulgate administrative regulations to implement the
108 provisions of this law.

NOTE: The purpose of this bill is to provide for Supplemental Medicaid Reimbursement for Academic Medical Center Acute Care Providers.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.