State: Territory of the Virgin Islands

AMOUNT, DURATION AND SCOPE OF ASSISTANCE

OFFICIAL

Limitations

1. Inpatient Services

Limited to care in Virgin Islands hospitals operating under the authority of the Hospital and Health Facilities Corporation, except that when medically necessary and with prior authorization by the Medicaid Agency, the recipient may be referred or transferred to a hospital outside the Virgin Islands. Hospitals must have a provider agreement signed with the Medicaid Agency.

2. Outpatient Services

a. Hospitals
Limited to services provided by Virgin Islands hospitals operating under the authority of the Hospital and Health Facilities Corporation, except that when medically necessary and with prior authorization by the Medicaid Agency, the recipient may be referred to a hospital outside the Virgin Islands for outpatient hospital services. Hospitals must have a provider agreement signed with the Medicaid Agency.

b. Rural Health Clinics
There are no rural health clinics in the Virgin Islands.

c. Federally Qualified Health Care Centers
Limited to services provided by the Federally Qualified Health Care Centers (as designated by HRSA) located in the Territory of the Virgin Islands. With prior authorization from the Medicaid Agency, recipients may receive services from Federally Qualified Health Care Centers (as designated by HRSA) located in Puerto Rico or the contiguous United States.

3. Other Laboratory and X-ray Services

Limited to medically necessary services provided by Department of Health or Hospital and Health Facilities Corporation facilities and personnel. Other Virgin Islands providers may provide laboratory and X-ray services with prior authorization from the Medicaid Agency so long as the providers have signed provider agreements with the Medicaid Agency and they are certified to meet the requirements of Section 42CFR 493, in accordance with the Clinical Laboratory Act of 1988 (CLIA).

With prior authorization from the Medicaid Agency, recipients may receive medically necessary services from qualified laboratory or X-ray service providers outside the Virgin Islands, when test services are not available in Virgin Island facilities. Qualified laboratory or X-ray service providers are those that are enrolled in the State's Medicaid program and are certified to meet the requirements of Section 42CFR 493, in accordance with the Clinical Laboratory Act of 1988 (CLIA).

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AMOUNT, DURATION AND SCOPE OF ASSISTANCE
MEDICALLY NEEDY GROUP(S): _____

Limitations

1. Inpatient Services

   Limited to care in Virgin Islands hospitals operating under the authority of the Hospital and Health Facilities Corporation, except that when medically necessary and with prior authorization by the Medicaid Agency, the recipient may be referred or transferred to a hospital outside the Virgin Islands. Hospitals must have a provider agreement signed with the Medicaid Agency.

2. Outpatient Services

   a. Hospital

      Limited to services provided by Virgin Islands hospitals operating under the authority of the Hospital and Health Facilities Corporation, except that when medically necessary and with prior authorization by the Medicaid Agency, the recipient may be referred to a hospital outside the Virgin Islands for outpatient hospital services. Hospitals must have a provider agreement signed with the Medicaid Agency.

   b. Rural Health Clinics

      There are no rural health clinics in the Virgin Islands.

   c. Federally Qualified Health Care Centers

      Limited to services provided by the Federally Qualified Health Care Centers (as designated by HRSA) located in the Territory of the Virgin Islands. With prior authorization from the Medicaid Agency, recipients may receive services from Federally Qualified Health Care Centers (as designated by HRSA) located in Puerto Rico or the contiguous United States.

Methods and Standards for Establishing Payment Rates – Other Types of Care (cont'd)

1. Outpatient Services

a. Hospitals

For government hospitals, as certified by the Territory government, payment amounts and expenditures will be determined in accordance with the protocol described on Attachment 4.19B pages 1a.1 through 1a.5.

All facilities must have a signed provider agreement with the Medicaid Agency.

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Certification of Public Expenditures (CPE) Protocol and Interim Payment System - Outpatient Hospital Services

Cost and Calculation of Interim Payment Basis

For the hospitals that the MAP determines are eligible to certify public expenditures/costs, and actually certify expenditures/costs in accordance with 42 CFR 433.51(b), the expenditures claimable for Federal Financial Participation (FFP) will be the hospital's allowable costs incurred in serving Medicaid outpatients as determined in accordance with Medicare cost principles. This cost assignment exercise will be performed on an annual basis.

For the *payment year* ancillary cost-to-charge ratios for the applicable cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare fiscal intermediary (the year for which the cost report is filed is thereafter referred to in this document as the *base year*). The cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs are identified from Worksheet B Part I Column 27. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2.

The cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's Medicaid outpatient costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine ancillary cost center costs for the payment year, the hospital's allowable outpatient Medicaid fee-for-service charges, as obtained from validated fee-for-service claim data submitted to MAP for the period covered by the as-filed cost report will be used. These charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the allowable Medicaid outpatient costs for each cost center (Note: for the computation of the cost-to-charge ratio for cost center #62/Observation Beds, the cost amount is reported on worksheet C, Part I, column 1, instead of worksheet B. Allowable Medicaid hospital outpatient charges for observation beds are then applied to this cost-to-charge ratio to compute the Medicaid outpatient observation bed costs). The allowable Medicaid fee-for-service charges used pertain only to outpatient hospital services, and must exclude charges pertaining to inpatient hospital services, any professional services, or non-hospital component services.

Step 5

For purposes of calculating payments, *net costs* must be derived and used. To arrive at net costs, costs which are eligible for certification are equal to the Medicaid allowable costs described in Step 4 less Medicaid payments for hospital outpatient services made independent of the payment system described herein.

Step 6

Net costs are trended forward to payment year based on data in the most recent Global Insight Healthcare Cost Review[1].

Step 7

Interim per-encounter outpatient payment rates specific to each hospital are derived by dividing hospital net costs as calculated in Step 6 by the sum of Medicaid outpatient encounters in the base year as derived from validated fee-for-service claim data submitted to MAP.

[1] Table 6.3 Hospital Market Basket.

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Method of Payment – Interim Per-Encounter Payments

MAP will make monthly payments to each hospital based on the interim per-encounter outpatient payment rates computed in Step 7 times the number of Medicaid outpatient encounters reported to MAP by the hospital for the service month during the payment year; a summary spreadsheet of Medicaid outpatient encounters by hospital attached to paper-based or electronically submitted CMS-1500 claim forms for each Medicaid hospital will be used to report Medicaid outpatient encounters to MAP. An outpatient encounter is defined as all outpatient services rendered to an eligible MAP beneficiary at the servicing/billing hospital during a particular date of service, i.e. a single payment is made irrespective of the number or mix of services rendered in that service date. Payments to the hospitals will be made in accordance with federal and local prompt payment standards.

First Interim Payment Reconciliation

Interim per-encounter payments made through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If at the end of the interim reconciliation process it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Conversely, if an underpayment is determined the MAP will submit the applicable claim to the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3
Costs and charges from the as-filed CMS 2552 cost report for the payment year are used.

Step 4
Actual Medicaid charges from validated fee-for-service claim data submitted to MAP for hospital outpatient services rendered during the payment year are used.

Step 5
Medicaid payments that are made independent of the Medicaid outpatient hospital payment system for Medicaid outpatient services, for which costs are already included in the Medicaid outpatient hospital cost computation described above, must be included in the total Medicaid payments under this interim reconciliation process. Additionally, the MAP will take steps to ensure that payments associated with pending claims for Medicaid costs included in the current spending year cost report are properly accounted for in this reconciliation.

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Final Cost Report Reconciliation

Once the CMS 2552 cost report for the payment year has been finalized by the Medicare FI with the issuance of a Notice of Program Reimbursement, a reconciliation of the finalized amounts will be carried out. Subsequent reconciliations and adjustments to the CPE claims are also performed for any cost report appeal resolution (including PRRB appeals and intermediary hearings) or cost report reopening that impacts the CPE computation as prescribed in this protocol. The same method as described for the interim reconciliation will be used except that the updated Medicaid program and payment data and finalized CMS 2552 amounts will be substituted as appropriate.
In the final reconciliation, Medicaid cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid outpatient hospital charges for each ancillary cost center. Use of Worksheet D series also includes the application of all Medicare cost report adjustments unless expressly exempt for Medicaid.

If at the end of the final reconciliation process it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. If it is determined that a hospital received an underpayment, MAP will submit the applicable claim to the federal government.

For hospitals whose cost report year is different from the Territory's fiscal year, MAP will proportionally allocate the costs of two cost report periods encompassing the payment year. To do so, MAP will obtain actual Medicaid fee-for-service encounters and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid fee-for-service cost for the reporting periods; this Medicaid fee-for-service cost will then be proportionally allocated. All allocations will be made based upon number of months. For example, for a hospital reporting period ending 12/31/09, the Medicaid fee-for-service cost and encounters/charges from that period encompass three-fourths of the Territory fiscal year ending 9/30/2009, and one-fourth of the Territory fiscal year ending 9/30/2010. To fulfill reconciliation requirements for Territory fiscal year 2009, the hospital would match three-fourths of the Medicaid fee-for-service costs from its reporting period ending 12/31/2009, and one-fourth of the Medicaid fee-for-service costs from its reporting period ending 12/31/2008, to the Territory fiscal year. MAP will ensure that the total costs claimed in a Territory fiscal year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

Fee-for-Service Claim Data Validation Procedures

MAP has claims management processes in place to verify MAP eligibility and service coverage as part of the adjudication of claims for all services. Additionally, MAP will systematically review the records associated with fee-for-service outpatient hospital claims submitted to MAP to

ensure the validity of the claims data being submitted and used in the calculations described in this Protocol. Moreover, MAP has utilization management procedures and controls which are employed to prior-authorize many outpatient services including all surgical procedures.

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Methods and Standards for Establishing Payment Rates – Other Types of Care (cont'd)

a. Rural Health Clinics

There are no rural health clinics in the Virgin Islands.

b. Federally Qualified Health Care Centers

These will be reimbursed under an Alternative Payment Methodology. The Federally Qualified Health Centers (FQHCs) will receive interim payments per service provided according to the Medicaid Agency developed fee schedule. At the end of the federal fiscal year, these payments will be subject to a reconciliation to Medicaid costs based on an encounter rate calculated in accordance with the Prospective Payment System (PPS) as required by the Benefits Improvement and Protection Act of 2000.

1. Other Laboratory and X-Ray Services

Facilities in the Virgin Islands will be reimbursed 100 percent of the Medicare fee schedule.

Off-island facilities located in Puerto Rico or the contiguous United States will be reimbursed for these services based on the Medicaid rate of the locality in which the service is being provided.

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Methods and Standards for Establishing Payment Rates – Other Types of Care

10. Physical Therapy and Related Services

The Medicaid Agency will reimburse for these services at 100 percent of the Medicare fee schedule.

11. Prosthetic Services and Dentures

The Medicaid Agency will reimburse for prosthetic services at 100 percent of the Medicare fee schedule.

The Medicaid Agency will reimburse for dentures according to a fee schedule developed by the Department of Health based on prevailing charges in the community. The state-developed fee schedule rates are the same for both governmental and non-governmental providers of dentures. The Department's fee schedule was set as of January 1, 2010 and is effective for services provided on or after that date. All rates are published in the provider manual for dental services and are available on the Department's website.