WEST VIRGINIA CODE: §9-5-14

§9-5-14. Medicaid program; health care facilities financed by bonds; rules regarding reimbursement of capital costs.

(a) The Legislature finds and declares that a number of health care facilities have been financed by public bonded indebtedness, and as a result of policies, rules and standards which may be in conflict, the facilities and the health and welfare of those citizens served by such facilities are in jeopardy. The provisions of subsection (b) are enacted for the purpose of addressing this as a short-term solution. The provisions of subsection (d) are enacted for the purpose of further addressing such conflicting policies, rules and standards.

(b) As to any health care facility licensed under article five-c, chapter sixteen of this code, constructed after April 1, 1981, and affected on or after that date by the reimbursement methodology implemented by the department regarding standard appraised value, beginning on April 1, 1988, and for a two-year period only, ending on March 31, 1990, all in compliance with federal rules and regulations, the department shall reimburse such health care facilities no less than any actual annual capital costs, including, but not limited to, debt service, lease payments or costs of comparable financing arrangements incurred in connection with any capital expenditure approved pursuant to article two-d, chapter sixteen of this code or any rule promulgated thereunder or in conjunction with the financing of such capital expenditure pursuant to article two-c, chapter thirteen of this code, whichever is greater; and in no event, for the purpose of reimbursement of such capital costs, may the value of any health care facility licensed pursuant to article five-c, chapter sixteen of this code be deemed to be less than the greater of the aggregate principal amount of any public bond issue undertaken pursuant to the provisions of article two-c, chapter thirteen of this code or the maximum capital expenditure approved pursuant to article two-d, chapter sixteen of this code or any rule promulgated thereunder, and any appraisal made by the department in connection therewith shall include costs related to the financing of the bond issue or the maximum capital expenditure approved pursuant to article two-d, chapter sixteen of this code, as applicable: Provided, That said values may be reduced by (A) any functional obsolescence which is determined and identified annually pursuant to any rule promulgated hereunder and (B) the pro rata share of such value which is attributable to capital expenditures incurred with respect to facilities which provide services which are not eligible for reimbursement under Title XIX of the social security act: Provided, however, That the department may not exceed the Medicare upper payment limit for Medicaid in making any reimbursement pursuant to this section.

As to any health care facility constructed after April 1, 1981, and affected on or after that date by the reimbursement methodology implemented by the department regarding standard appraised value, with respect to reimbursement to the state by such health care facility arising from adjustment of projected rates, the department shall provide for the adjustment of projected rates based upon values which are consistent with the provisions of

this section and based upon the actual occupancy experience of the health care facility during the projected rate period, all in compliance with federal rules and regulations.

(c) The Medicaid payments that a long-term care facility would otherwise receive may not be reduced in any manner as a result of the operation of this section.

(d) For the rate setting cycle beginning on April 1, 1990, and for a period ending on July 1, 1992, the department shall reimburse health care facilities described in subsection (b), with sixty or more licensed beds, for actual annual capital costs in the manner prescribed in subsection (b): Provided, That the capital costs reimbursement attributable to subsection (b) of this section may not exceed the Medicare upper payment limit based upon presumed occupancy of ninety percent or actual occupancy of the facility, whichever is greater: Provided, however, That any capital cost reimbursement attributable to the computation made pursuant to the provisions of this subsection (d) shall not exceed the per patient day cost of capital as computed under the rules of the department, without reference to this section, plus $6 per patient day. Requests for information from the department regarding reimbursement pursuant to this subsection (d) shall be completed and submitted to the department not later than sixty days subsequent to the receipt of the department's request by the facility.

The department shall provide for the adjustment of projected rates for health care facilities described in subsection (b), with sixty or more licensed beds, in the manner prescribed in subsection (b).