

12VAC30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12VAC30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12VAC30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12VAC30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12VAC30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12VAC30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12VAC30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. Payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full time equivalent (FTE) interns and residents as reported on the cost report.

7. As stipulated in 12VAC30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12VAC30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated. ~~In subsequent~~

~~rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.~~ In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" reflects the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid utilization rate in excess of 15%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subdivision 2 of this definition does not apply to a hospital:

- a. At which the inpatients are predominantly individuals under 18 years of age; or
- b. Which does not offer nonemergency obstetric services as of December 21, 1987.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days and non-paid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits. The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and include (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment

3.1 A & B (12VAC30-50-95 through 12VAC30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" occur when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. "Type Two" hospitals means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Until notification of a change is given, Version 14.0 of this grouper shall be used. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to

develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology

Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file

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Total number of rehabilitation days for each acute care Claims history file
and freestanding rehabilitation hospital

Operating cost-to-charge ratio for each hospital Cost report file

Operating cost-to-charge ratio for each freestanding Medicare cost
psychiatric facility licensed as a hospital reports

Psychiatric operating cost-to-charge ratio for the Cost report file
psychiatric DPU of each general acute care hospital

Rehabilitation cost-to-charge ratio for each Cost report file
rehabilitation unit or hospital

Statewide average labor portion of operating costs VHI

Medicare wage index for each hospital Federal Register

Medicare geographic adjustment factor for each hospital Federal Register

Outlier operating fixed loss threshold Claims history file

Outlier adjustment factor Federal Register

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

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