12VAC30-70-201. Application of payment methodologies.

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals and state-owned rehabilitation hospitals shall be subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

D. Reduction of Payments Methodology.

1. For state fiscal years (FYEs) 2003 and 2004 , the DMAS shall reduce payments to hospitals participating in the Virginia Medicaid Program by $8,935,825 total funds, and $9,227,815 total funds respectively. For purposes of distribution, each hospital's share of the of the total reduction amount shall be determined as follows:

2. Determine base for revenue forecast:

a. The Department of Medical Assistance Services (DMAS) shall use, as a base for determining the payment reduction distribution for hospitals Type I and Type II, net Medicaid inpatient operating reimbursement and outpatient reimbursed cost, as recorded by the DMAS for state fiscal year 1999 from each individual hospital settled cost reports. This figure is further reduced by 18.73%, which represents the estimated state-wide HMO average percent of Medicaid business for those hospitals engaged in HMO contracts, to arrive at net baseline proportion of non-HMO hospital Medicaid business.

b. For freestanding psychiatric hospitals, the DMAS shall use estimated Medicaid revenues for the 6 month period (1-1-01 through 6-30-01), times two, and adjusted for inflation by 4.3% for state fiscal ’02, 3.1% for state fiscal ’03, and 3.7% for state fiscal ’04 as reported by DRI-WEFA, Inc.’s hospital input price level percentage moving average.

3. Determine forecast revenue:

a. Each Type I hospital’s individual state fiscal ’03 & ’04 forecast reimbursement is based on the proportion of non-HMO business (see 2. a. above) with respect to DMAS forecast of SFY ’03 & ‘04 inpatient and outpatient operating revenue for Type I hospitals.

b. Each Type II, including freestanding psychiatric, hospital's individual state fiscal '03 & '04 forecast reimbursement is based on the proportion of non-HMO business (see 2. a. and 2. b above) with respect to the DMAS forecast of SFY '03 & '04 inpatient and outpatient operating revenue for Type II hospitals.

4. Each hospital's total yearly reduction amount is equal to their respective state fiscal '03 and '04 forecast reimbursement as described above in 3.a. and 3.b., times 3.235857 percent for state fiscal '03, and 3.235857 percent, subject to revision by DMAS annual budget forecast, for state fiscal '04, not to be reduced by more than $500,000 per year.

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in 4. above. Payment reduction offsets not covered by claims remittance by May 15, 2003, and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30, 2003, or 2004, as applicable.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

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Date Patrick W. Finnerty, Director

Dept. of Medical Assistance Services