Virginia Regulatory Town Hall

Final Regulation
Agency Background Document

Agency Name:	Dept. of Medical Assistance Services (12 VAC 30)
VAC Chapter Number:	Chapter 70
Regulation Title:	Methods and Standards for Establishing Payment Rates-Inpatient Hospital Care
Action Title:	Diagnosis Related Groups
Date:	05/03/00

Please refer to the Administrative Process Act (§ 9-6.14:9.1 *et seq.* of the *Code of Virginia*), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99) , and the *Virginia Register Form,Style and Procedure Manual* for more information and other materials required to be submitted in the final regulatory action package.

Summary

Please provide a brief summary of the new regulation, amendments to an existing regulation, or the regulation being repealed. There is no need to state each provision or amendment; instead give a summary of the regulatory action. If applicable, generally describe the existing regulation. Do not restate the regulation or the purpose and intent of the regulation in the summary. Rather, alert the reader to all substantive matters or changes contained in the proposed new regulation, amendments to an existing regulation, or the regulation being repealed. Please briefly and generally summarize any substantive changes made since the proposed action was published.

These permanent final regulations are DMAS' last changes to the Diagnosis Related Groups inpatient hospital payment methodology. These final regulations do vary from the previous emergency regulations.

These regulations contain the following changes: reference to the onset of the automated claims processing system has been deleted; the operating cost-to-charge ratio has been modified; the source of charges for psychiatric care has been modified; long range design of capital cost payments has been deleted; the method of calculating direct medical education has been revised;

the disproportionate share adjustment formula has been modified; the formula for calculating operating costs has been modified; DRG method of reimbursing noncost-reporting general acute care hospitals has been modified; the lump sum payment provided by the 2000 General Assembly which was mandated in the 2000 Appropriations Act has been added.

Changes Made Since the Proposed Stage

Please detail any changes, other than strictly editorial changes, made to the text of the proposed regulation since its publication. Please provide citations of the sections of the proposed regulation that have been altered since the proposed stage and a statement of the purpose of each change.

These regulations contain the following changes: reference to the onset of the automated claims processing system has been deleted; the operating cost-to-charge ratio has been modified; the source of charges for psychiatric care has been modified; long range design of capital cost payments has been deleted; the method of calculating direct medical education has been revised; the disproportionate share adjustment formula has been modified; the formula for calculating operating costs has been modified; DRG method of reimbursing noncost-reporting general acute care hospitals has been modified; the lump sum payment provided by the 2000 General Assembly which was mandated in the 2000 Appropriations Act has been added.

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency: including the date the action was taken, the name of the agency taking the action, and the title of the regulation.

The Director of the Department of Medical Assistance Services adopted these final regulations on May 2, 2000.

Basis

Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority, shall be provided. If the final text differs from that of the proposed, please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the final regulation and that it comports with applicable state and/or federal law.

The Code of Virginia (1950) as amended, §32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, §32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Director approved, on November 10, 2000, the initiation of a public comment period for the proposed regulations. The Code, in §9-6.14:7.1 et seq., requires

agencies to adopt and amend regulations subject to public notice and comment when the action being taken does not meet one of the statutory exemptions.

Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on July 1, 1998, and was extended by 1999 General Assembly action to July 1, 1999.

The 2000 General Assembly, in the 2000 Appropriations Act, directed DMAS to provide for a lump sum payment to hospitals for the purpose of mitigating the estimated impact of re-basing DRG rates. This additional provision, added at 12 VAC 30-70-345, permits the agency no discretion and is therefore exempt from the public notice and comment requirements of the Administrative Process Act pursuant to § 9-6.14:4.1(C)(4)(a).

Title 42 of the Code of Federal Regulations Part 447 regulates the reimbursement of all Medicaid-covered services.

Purpose

Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the final regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.

The purpose of this proposal is to amend the existing inpatient hospital payment methodology regulations to remove transition period rules and to fully implement the new Diagnosis Related Groups methodology which began to be phased in on July 1, 1996. This regulation is not expected to affect the public's health, safety, or welfare.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement of the regulatory action's detail.

The section of the State Plan affected by this action is Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services (Attachment 4.19-A (12 VAC 30-70-200 through 12 VAC 30-70-490).

HISTORY

On July 1, 1996, the Department of Medical Assistance Services (DMAS) implemented a new prospective payment methodology for hospital services based largely on Diagnosis Related

Groups (DRGs). From that date through June 30, 1998, was a transition period, with Medicaid payment transitioning by thirds each year from per diem payment to DRG payment. This allowed hospitals time to adjust to the new methodology. Emergency regulations were adopted prior to July 1, 1996, to govern rate setting during the transition period, and were adopted as final regulations through the Administrative Process Act (APA) during state fiscal year 1997.

The regulations that authorized the new methodology stated that rates must be "rebased" every two years, with the first rebasing scheduled for an effective date of July 1, 1998. Also on July 1, 1998, the DRG methodology was to be fully implemented, and the transition period to be brought to an end. However, the regulations adopted to govern the transition period did not provide the methodology for rebasing, and as a result DMAS sought and obtained legislative authorization (in the 1998 Appropriations Act) to adopt emergency regulations effective July 1, 1998, that would include the rebasing methodology. Emergency regulations were adopted effective July 1, 1998, and the 1999 General Assembly authorized the continuation for one more year of these emergency regulations. These emergency regulations will expire June 30, 2000.

PRESENT

The purpose of the present regulatory proposal is to adopt as a final regulation the methodology that has been in place since July 1, 1998, by the authority of emergency regulations. This regulatory package is presented as an amendment to the existing permanent regulation, which is the regulation for the transition period.

The regulatory package appears to have many changes (many crossed-out and underlined words). However, this is because this final regulation must be done as an amendment to the previous permanent regulation, which was effective during 1997 and 1998, not as an amendment to the emergency regulation that is currently in effect. The actual language of this suggested final permanent regulation is in reality nearly identical to the emergency regulation that is currently in effect, and contains only one substantive change from the emergency regulation. The substantive change, the addition of 12 VAC 30-70-435, has resulted from action of the 2000 General Assembly and is discussed in detail below.

The reimbursement system prior to the emergency regulation was a one-third per diem methodology and two-thirds DRG methodology system for inpatient hospital services. The transitioning from the per diem methodology over to the DRG methodology by one-third each year was prescribed by the Joint Task Force formed by DMAS and the Virginia Hospital and Healthcare Association. The Task Force and enrolled provider hospitals expected a complete (full DRG without any per diem method) DRG system to be effective July 1, 1998, which was implemented by the emergency regulation.

Additional features of this DRG payment system include disproportionate share adjustment payments, medical education costs, capital costs, the handling of psychiatric and rehabilitation inpatient hospital cases, and state teaching hospital costs. These elements are being addressed as follows. Additional payments to hospitals with a “disproportionate share” of Medicaid patients will continue under these regulations but will be targeted to a smaller group of hospitals that have a very high proportion of Medicaid and low income patients. Medical education and capital

costs continue to be paid as they have been in the past -- that is, based on reasonable cost incurred. Psychiatric and rehabilitation inpatient hospital cases will continue to be paid on a per diem basis into the foreseeable future and the current payment methodologies remain unchanged in this package. State teaching hospitals will continue to be treated as a separate peer group in this methodology. In addition, DMAS proposes to define the significant terms that have been used in this suggested permanent regulation.

At the same time that DMAS has been undergoing considerable regulatory activity in this area of DRGs, the agency's computer system has been undergoing modification as well. At the present time, the fiscal agent has completed the necessary changes and the claims processing system for DRGs became operative on January 1, 2000.

This regulation is essential to protect the health and welfare of the Commonwealth's citizens because it prescribes the methodology by which DMAS reimburses for the critical, mandatory service of inpatient hospital services. HCFA requires that this methodology be spelled out in the State Plan for Medical Assistance, thereby making it subject to the Commonwealth's promulgation requirements of the Administrative Process Act.

This regulation's impact on families will be transparent in that DMAS will continue to cover inpatient hospital services.

The most significant difference between these final regulations and those that were proposed for public comment is the addition of 12 VAC 30-70-435. The issue expressed by this VAC section concerns the additional lump sum payment of $12.2 million to eligible Virginia hospitals. The purpose of the additional payments will be to mitigate the estimated effect of the re-based Diagnosis Related Groupings rates which became effective July 1, 1998, through December 31, 1999. The General Assembly's mandatory language afforded DMAS with no discretion in carrying out this directive, therefore the issue conforms to the exemption (9-6.14:4.1(C)(4)(a)). Other changes are: deletion of reference to onset of claims processing system; modifications to the operating cost-to-charge ratio; long range design of capital cost payments has been deleted; method of calculating direct medical education was revised; disproportionate share adjustment payment formula has been revised; formulas for the adjustment factor and calculating operating costs was revised; and the reimbursement of noncost-reporting hospitals was revised.

Issues

Please provide a statement identifying the issues associated with the final regulatory action. The term "issues" means: 1) the advantages and disadvantages to the public of implementing the new provisions; 2) the advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please include a sentence to that effect.

The agency projects no negative issues involved in implementing this proposed change. The primary advantage to the public of this regulation is the completion of the agency's conversion to

the full DRG payment methodology. The complete conversion, supported by the computer claims processing system, will restore automated claims processing by reducing the need for manual intervention, thereby saving those costs.

Public Comment

Please summarize all public comment received during the public comment period and provide the agency response. If no public comment was received, please include a statement indicating that fact.

DMAS' proposed regulations (concerning the Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care (Diagnosis Related Groups)) were published at 16 VR 9:1122 (Jan. 17, 2000)). The public comment period was from January 17 through March 17, 2000. The only comment that was received was from the Virginia Hospital and Healthcare Association (VHHA). A summary of the VHHA comments received follows.

Also, in conformance to federal law, DMAS' proposed rates were published. One comment from VCU-MCV Hospital was received.

VHHA General Comments

The Department does not agree with all of the VHHA general comments and characterizations of certain occurrences. For the most part, these general comments do not address themselves to specific recommended changes to the regulations. Therefore, DMAS has not addressed them point by point. In instances where the general comments recommend a specific change to the regulation, DMAS provided a response.

1. Prior Review of Regulations

Comment: The VHHA disagrees with the statement in the introduction to the proposed regulations, that says: "DMAS has worked closely with the regulated industry to design this regulation." The VHHA agrees that it participated in the development of the previous regulations that governed rates during SFY1997 and 1998. However, it states that it did not participate in the development of the emergency regulations that took effect July 1998, and that are largely the same as the current proposed permanent regulations. The VHHA stated that DMAS had unilaterally adopted the current emergency regulations without the benefit of discussion with the affected industry. The VHHA stated that there were several critical policy provisions in the regulations with which it took exception. The VHHA reiterated its support for a prospective DRG payment system because of its demonstrated efficiency incentives and improved distributional equity. The VHHA disagreed with parts of the proposed regulations that the VHHA felt violated the basic goals of fairness, stability and simplicity.

2. Fairness

Comment: The VHHA disagrees with the use of the "adjustment factor", stating that it perpetuates payment system discounts taken by Medicaid. The VHHA believes there is no sound basis for Medicaid paying 25% less than cost and recommends that the adjustment factor be eliminated. The VHHA stated that the "adjustment factor" amounts to a collective tax on Medicaid hospital providers that is unilaterally calculated by DMAS in a discriminatory manner. The VHHA recommends that in place of the "adjustment factor" a payment system be designed that is sufficient to provide hospitals a reasonable opportunity to recover their costs. It also recommends that rate methodologies and rates should be reviewed in advance by the Medicaid Hospital Payment Policy Advisory Council.

Response: Refer to the VHHA specific comment number 5 Adjustment Factor for the Department's response.

3. Stability

Comment: The VHHA reiterated its support of the prospective DRG system and, furthermore, defined 'prospective' as meaning "knowing in advance of the date for which services are delivered what payments for such inpatient stays will be." The VHHA objects to the delays that have occurred in calculating and finalizing rates. It recommends that rates should be analyzed, discussed and finalized prior to their effective date, and if they are delayed beyond the effective date, providers should be settled to the higher of the new rates or the prior ones in effect adjusted for inflation.

Response: DMAS agrees with the VHHA regarding having a prospective DRG payment system and believes that these final regulations will promote such a system. DMAS does not agree with the specific regulatory change proposed by the VHHA. While it is acknowledged that the 1999 rates were issued later than intended, this was due to issues related to the start-up period for DRG rate setting and is not expected to be the norm. It is not necessary or appropriate to adopt the suggested change to address a problem that the Commonwealth does not intend to see repeated. In addition, in most rebasing processes some hospitals gain and some lose relative to the previous rates. If the suggested change were made, the language would have to provide that either 1) each hospital would be paid whichever rates were higher for it or 2) all hospitals would be paid under the rates that were the highest across all hospitals. The first approach would not be fiscally responsible for the Commonwealth because the total expenditures if each hospital were given the greater of two sets of rates would exceed those under either set of rates alone. The second approach would possibly be unfair to hospitals whose individual rebasing results were different from the majority.

4. Simplicity

Comment: The VHHA objects to the "unnecessarily complex and error-laden" cost trending methodology used in the regulations to forecast cost in the base year. The VHHA recommends using actual cost data rather than trended forecasts since "virtually every other public or private payer utilizing a DRG system conducts rebasing in such a fashion, linking the claims and costs to the same time period. This approach also provides an increased opportunity to ensure that the underlying information is complete and accurate…."

Response: The Department does not agree that the cost trending methodology is unnecessarily complex and error-laden. However, the Department does not object to using the methodology recommended by the VHHA. The Department will use actual cost data and claims from the same base year used to rebase hospital rates.

VHHA Specific Comments

1. Groupable Cases Definition

Comment: The VHHA believes the Commonwealth needs to ensure that cases are assigned to DRG following the "technical specifications of the version 14 DRG grouper software selected for use by the State". The concern is that, due to system limitations the number of diagnosis codes and procedure codes accepted by the system has been limited to five and three respectively. The VHHA feels that a consequence of this limitation "may be assignment errors in a substantial number of cases."

Response: Effective January 1, 2000, this problem has been corrected. No further regulatory change is required for this issue.

2. Standards for Data Accuracy and Quality Control

Comment: The VHHA refers to the fact that developing an accurate and complete database is a difficult and iterative process requiring input from providers. The VHHA recommends as a solution to this issue that procedures for ensuring data accuracy, quality control, and external review be provided in regulations. These would specify the quality control procedures, release of data and external review of data and calculations.

Response: To the extent permitted by federal law, DMAS has already shared data and calculations with the VHHA. DMAS has provided individual hospitals with their detail claims information for review. This process has served to identify and correct errors in rate calculations and omissions from databases. However, the VHHA has requested that individual hospital patient-specific data be provided directly to them. It is DMAS' understanding that such information cannot be provided to third parties without violating federal patient confidentiality laws. DMAS has informed the VHHA of this limitation and is unwilling to propose regulations that would require it to release prohibited data. Each hospital can also request detail reports on a monthly and quarterly basis that identify all DRG claims processed for their own reviews. If there are substantial errors in rate calculations hospitals already have the right to appeal their rates. To further codify the process of conducting rate setting activities is therefore unnecessary.

DMAS would like to emphasize that it has taken considerable steps to validate the data used for rebasing against other available data sources.

3. Payment for Capital Costs

Comment: The VHHA recommends removal from regulations a description of a prospective capital payment methodology that is not presently scheduled for implementation.

Response: Although DMAS still hopes to apply a prospective methodology to capital costs at some point, this language has been removed until there is opportunity to discuss and develop a final plan.

4. Payment for Direct Medical Education

Comment: The VHHA identifies language that it believes gives the impression there may be a change in reimbursement for medical education costs at some point. It recommends removal of this language, since "a change in payment approach [for direct medical education costs] requires promulgation of new regulations, not simple notice."

Response: DMAS agrees with this comment and has changed the regulations accordingly.

Comment: A second comment related to this issue raises concerns about quality of data representing services to recipients in managed care programs. It is suggested that regulations address this issue and perhaps provide that incorrect data in one year be corrected in a later year's settlement.

Response: DMAS does not believe a regulation change is necessary. DMAS receives information quarterly from each managed care organization by hospital that is used to calculate disproportionate share hospital and graduate medical education payments to hospitals. This information is routinely shared with hospitals on request and any errors found are corrected by DMAS.

5. Adjustment Factor

Comment: The VHHA repeats here the points already discussed in second "General Comments" item above. The VHHA objects to the use of the adjustment factor and sees it as "a means by which past underpayments to some hospitals become a mechanism to automatically guarantee future underpayments," adding that "…the adjustment factor constitutes a collective tax on Medicaid-related hospital costs that is unilaterally computed, and then discriminatorily applied by the Department." The VHHA further commented that "tax policy and the setting of the adjustment factor tax rate are not properly administrative functions, and therefore should not be established by regulation." The VHHA suggests that by paying less than actual cost, DMAS is improperly making tax policy. This is supported by the assertion that paying less than full cost (and thereby forcing other payers to pay the difference), DMAS is raising a tax on Medicaid-related hospital costs.

Response: In the DRG system development process of 1996, in which the VHHA acknowledges its participation, it was agreed by all affected parties that the DRG rates would be set at a level designed to pay 75% of cost. When the present proposed regulations were under development, the adjustment factor approach was devised so that the percent of cost covered would not be permanently held to 75%, but could increase if cost efficiencies by hospitals (between rebasing

years) resulted in rates paying a higher percentage of costs. In fact, it is estimated that the rebased rates for the 1998-2000 biennium pay 79% of costs and DMAS anticipates this percentage will increase under the 2000-2002 rebased rates that result from these final regulations. The VHHA's assertion that the adjustment factor be eliminated in order to provide hospitals a "reasonable opportunity" to recover their costs represents a recent significant change of position by the VHHA. Of course, it is free to take this position, but it did not do so in 1996 when the DRG system was first developed or in 1997 when this regulatory language, including the adjustment factor, was first discussed with the Council. DMAS agrees this issue should be addressed in discussions of future rate development. However, since this is a significant policy change, DMAS cannot make such a change to these regulations without consideration by the Governor and General Assembly of the fiscal impact and appropriation of additional funds.

With respect to the question of the adjustment factor constituting a tax, DMAS does not agree with this claim. If use of the adjustment factor means DMAS is making tax policy, then every government procurement process that results in purchase of services or items at a cost below that paid by the general public is a process that improperly makes tax policy. This obviously cannot be the case.

6. Rebasing Policy

Comment: The VHHA believes that rebasing every two years is too great an administrative burden and involves too great a cost to the Commonwealth. In addition, it believes frequent rebasing introduces to much uncertainty for hospitals as well as the Commonwealth. The VHHA believes the regulations call for annual rebasing, "turning the re-basing of rates into something of an 'industry'. "Because the frequency of Virginia's rebasing is left in the regulations to the discretion of the Department with no stated criteria, we believe it generates unnecessary uncertainty." The VHHA suggests that rebasing should instead occur on a specific and more cost-effective schedule, approximately every four years, with the base rates being updated using DRI-Virginia or some other agreed-upon inflation measure. A fine-tuning of case weights in the interim should be possible. The VHHA believes that "the adoption of this more deliberate schedule will eliminate the need for the controversial practice of computing "trend factors" to predict costs… Instead, when the time comes for rebasing, the Department would employ the approach that, as we understand it, is universally used by other states – i.e., to match claims and costs to a common base period."

Response: The DMAS agrees that the rebasing policy should be revised and will change the regulations to require rebasing ever three year versus the current two years.

VCU-MCV Hospital Comment:

This comment stated that the "proposed rates and weights will lower the effective rate of reimbursement that MCV Hospitals receives. This, coupled with lower utilization efficiencies that will be achieved through the proposed DRG based system, will translate into a need to revise the calculation of disproportionate share" payment. This commenter recommended that DMAS revise the formula for calculating disproportionate share payments "to account for the lower rates and utilization efficiencies that the proposed DRG payment rates" are expected to introduce.

Response: DMAS agrees with this comment. Accordingly, it is revising the regulations to adjust the DSH calculation. The revised formula will not increase aggregate DSH expenditures but will avoid reducing DSH as a result of the efficiency and lower utilization that has occurred. In order to prevent potential disruption in DSH payments due to continued changes in utilization, the revision made in response to this comment will also ensure that DSH payments do not fluctuate dramatically between rebasing years.

Detail of Changes

Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or crosswalk - of changes implemented by the proposed regulatory action. Include citations to the specific sections of an existing regulation being amended and explain the consequences of the changes.

VAC Citation Federal Citation	Substance of the Suggested Change
12 VAC 30-70-205	Deletion of reference to prior onset of claims processing system as this has already occurred (1/1/2000).
12 VAC 30-70-221 Definitions	Modified operating cost-to-charge ratio to use same base year from hospitals FY as SFY used as base year.
Data Elements	Source of charges for psychiatric care changed.
12 VAC 30-70-271	Long range design of capital cost payments deleted as agency is not ready to implement this change.
12 VAC 30-70-281	Method of calculating payment of direct medical education revised.
12 VAC 30-70-301	Disproportionate share adjustment payment formula has been adjusted to account for reduced utilization and efficiency improvements.
12 VAC 30-70-331	Formula for adjustment factor changed.
12 VAC 30-70-381	Formula for calculating operating costs modified.

12 VAC 30-70-420	DRG methodology modified for purpose of reimbursing noncost-reporting general acute care hospitals.
12 VAC 30-70-435	Provision of a lump sum payment to providers as mandated by the 2000 General Assembly in the Appropriations Act

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the impact on the institution of the family and family stability including the extent to which the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

This regulatory action will not have any negative affects on the institution of the family or family stability. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, or the assumption of family responsibilities.