



COMMONWEALTH of VIRGINIA
Office of the Attorney General

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MEMORANDUM

TO: EMILY MCCLELLAN
Department of Medical Assistance Services

FROM: ABRAR AZAMUDDIN 
Assistant Attorney General

DATE: February 29, 2016

**SUBJECT: Fast Track Regulations regarding Hospital Reimbursement System, General,
and Payment to Disproportionate Share Hospitals; 12 VAC 30-70-50, 12
VAC 30-70-221, 12 VAC 30-70-301**

I have reviewed the attached proposed regulations, which will replace the current Disproportionate Share Hospital payment methodologies for hospitals providing care to Medicaid members. Based on that review, it is my view that the Director, acting on behalf of the Board pursuant to Virginia Code § 32.1-324 and with the authority provided for by Virginia Code § 32.1-325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Please be aware that this review is based solely upon whether DMAS has the legal authority to promulgate these regulations, not the appropriateness of whether it should be promulgated pursuant to the fast track process. Pursuant to Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either House of the General Assembly or of the Joint Commission on Administrative Rules, the Department of Medical Assistance Services shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the fast-track regulations serving as the Notice of Intended Regulatory Action.

If you have any questions or need any additional information, please feel free to call me at (804) 786-6004.

cc: Kim F. Piner, Senior Assistant Attorney General



Logged in as

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Proposed Text

Action: Hospital DSH Changes**Stage:** Fast-Track

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12VAC30-70-50. Hospital reimbursement system.

The reimbursement system for hospitals includes the following components:

A. Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural - 0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban - 0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) Centers for Medicare and Medicaid Services (CMS) in determining routine cost limitations.

B. Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982, were subject to the new reimbursement ceilings.

1. The calculation of the initial group ceilings as of July 1, 1982, was based on available, allowable cost data for hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

2. Effective July 1, 1986, and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

3. The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

4. The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

5. Effective on and after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the moving average of the Data Resources,

Incorporated Health Care Cost HCFA-Type Hospital Market Basket determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals shall be adjusted to reflect this change.

6. Effective on or after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the Virginia moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia, as developed by Data Resources, Incorporated, values as compiled and published by Global Insight (or its successor) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals shall be adjusted to reflect this change.

7. Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described above, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points, (200 basis points) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992, the conversion to the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992, and their next fiscal year ending on or before May 31, 1993.

Effective July 1, 2009, the escalation factor shall be equal to the allowance for inflation.

Effective July 1, 2010, through June 30, 2012, the escalation factor shall be zero. In addition, ceilings shall remain at the same level as the ceilings for long stay hospitals with fiscal year's end of June 30, 2010.

~~Effective July 1, 2009, the escalation factor shall be equal to the allowance for inflation.~~

Effective July 1, 2012, through June 30, 2013, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 2.6%.

Effective July 1, 2013, through June 30, ~~2014~~ 2016, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 0.0%.

8. The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

C. Subsequent to June 30, 1992, the group ceilings shall not be recalculated on allowable costs, but shall be updated by the escalator factor.

D. Prospective rates for each hospital shall be based upon the hospital's allowable costs plus the escalator factor, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment shall be made to prospective rates.

Capital and education costs approved pursuant to PRM-15 (§ 400), shall be considered as pass throughs and not part of the calculation. Capital cost is reimbursed the percentage of allowable cost specified in 12VAC30-70-271.

E. An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 10.5% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report. Effective for dates of service July 1, 2010, through September 30, 2010, the incentive plan shall be eliminated.

F. Disproportionate share hospitals defined.

Prior to July 1, 2014, The the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment pay. Effective July 1, 2014, the payment methodology for DSH is defined in 12VAC30-70-301.

1. Criteria.

a. A Medicaid inpatient utilization rate in excess of 10.5% for hospitals receiving Medicaid payments in the Commonwealth, 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

b. 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.

c. Subdivision 1 b of this subsection does not apply to a hospital:

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

2. Payment adjustment.

a. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the number of utilization Medicaid inpatient days by the total number of inpatient days. Each hospital with a Medicaid utilization of over 10.5% shall receive a disproportionate share payment adjustment.

b. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 10.5% times 11, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 10.5% times (ii) the lower of the prospective operating cost rate or ceiling.

c. No payments made under subdivision 1 or 2 of this subsection shall exceed any applicable limitations upon such payments established by federal law or regulations.

G. Outlier adjustments.

1. DMAS shall pay to all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under one year of age.

2. DMAS shall pay to disproportionate share hospitals (as defined in subsection F of this section) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

3. The outlier adjustment calculation.

a. Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in subdivision 1 or 2 of this subsection. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

b. Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in subdivision 1 or 2 of this subsection.

c. Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in subdivision 3 a (ii) of this subsection.

d. DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.

4. Pursuant to 12VAC30-50-100, there is no limit on length of time for medically necessary stays for individuals under six years of age. This section provides that consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

Article 2

Prospective (DRG-Based) Payment Methodology

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. For Type Two hospitals, 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. Effective April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs.

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.

"Base year standardized costs per case" means 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" means 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 inpatient utilization rate in excess of 14%, 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" or "Medicaid inpatient utilization rate" 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 or Medicaid inpatient utilization rate 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 (~~from DMAS MR reports for fee-for-service days and managed care organization or hospital reports for HMO days~~) and nonpaid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). 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. Effective July 1, 2014, the definition for Medicaid utilization percentage or Medicaid inpatient utilization rate is defined in 12VAC30-70-301(C).

"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 distinct part unit (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 includes (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, as defined in 12VAC30-95-5. 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" means 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 new cases. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"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 diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

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

"Type Two hospitals" means all other hospitals.

"Uncompensated care costs" or "UCC" means unreimbursed costs incurred by hospitals from serving self-pay, charity, or Medicaid patients without regard to disproportionate share adjustment payments.

"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
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file

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

12VAC30-70-301. Payment to disproportionate share hospitals.

A. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis, ~~shall be final, and shall not be subject to settlement except when necessary due to the limit in subsection D of this section.~~ and shall be final subject to provisions in subsections E, K, and L of this section.

B. Effective July 1, 2014, in order to qualify for DSH payments, DSH eligible hospitals shall have a total Medicaid inpatient utilization rate equal to 14 percent or higher in the base year using Medicaid days eligible for Medicare DSH defined in 42 USC § 1396r-4(b)(2) or a Low Income utilization rate defined in 42 USC § 1396r-4(b)(3) in excess of 25 percent. Eligibility for out of state cost reporting hospitals shall be based on total Medicaid utilization or on total Medicaid neonatal intensive care unit (NICU) utilization equal to 14 percent or higher.

C. Effective July 1, 2014, the DSH reimbursement methodology for all hospitals except Type One hospitals is the following:

1. Each hospitals DSH payment shall be equal to the DSH per diem multiplied by each hospitals eligible DSH days in a base year. Days reported in provider fiscal years in state FY 2011 (available from the Medicaid cost report through the Hospital Cost Report Information System (HCRIS) as of July 30, 2013) will be the base year for FY 2015 prospective DSH payments. DSH shall be recalculated annually with an updated base year. Future base year data shall be extracted from Medicare cost report summary statistics available through HCRIS as of October 1 prior to next years effective date.

2. Eligible DSH days are the sum of all Medicaid inpatient acute, psychiatric and rehabilitation days above 14 percent for each DSH hospital subject to special rules for out-of-state cost reporting hospitals. Eligible DSH days for out-of-state cost reporting hospitals shall be the higher of the number of eligible days based on the calculation in the first sentence times Virginia Medicaid utilization (Virginia Medicaid days as a percent of total Medicaid days) or the Medicaid NICU days above 14 percent times Virginia NICU Medicaid utilization (Virginia NICU Medicaid days as a percent of total NICU Medicaid days). Eligible DSH days for out-of-state cost reporting hospitals who qualify for DSH but who have less than 12 percent Virginia Medicaid utilization shall be 50 percent of the days that would have otherwise been eligible DSH days.

3. Additional eligible DSH days are days that exceed 28 percent Medicaid utilization for Virginia Type Two hospitals, excluding Childrens Hospital of the Kings Daughters (CHKD).

4. The DSH per diem shall be calculated in the following manner:

a. The DSH per diem for Type Two hospitals is calculated by dividing the total Type Two DSH allocation by the sum of eligible DSH days for all Type Two DSH hospitals. For purposes of DSH, Type Two hospitals do not include CHKD or any hospital whose reimbursement exceeds its federal uncompensated care cost limit.

The Type Two Hospital DSH allocation shall equal the amount of DSH paid to Type Two hospitals in state FY 2014 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act adjusted for the state fiscal year.

b. The DSH per diem for state inpatient psychiatric hospitals is calculated by dividing the total state inpatient psychiatric hospital DSH allocation by the sum of eligible DSH days. The State Inpatient Psychiatric Hospital DSH allocation shall equal the amount of DSH paid in state FY 2013 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act, adjusted for the state fiscal year.

c. The DSH per diem for CHKD shall be three times the DSH per diem for Type Two hospitals.

5. Each year, the department shall determine how much Type Two DSH has been reduced as a result of the Affordable Care Act and adjust the percent of cost reimbursed for outpatient hospital reimbursement.

D. Effective July 1, 2014, the DSH reimbursement methodology for Type One hospitals shall be to pay its uncompensated care costs up to the available allotment. Interim payments shall be made based on estimates of the uncompensated care costs and allotment. Payments shall be settled at cost report settlement and at the conclusion of the DSH audit.

~~B. Hospitals~~ E. Prior to July 1, 2014, hospitals qualifying under the 14% inpatient Medicaid utilization percentage shall receive a DSH payment based on the hospital's type and the hospital's Medicaid utilization percentage.

1. Type One hospitals shall receive a DSH payment equal to:

a. The sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433.

b. Multiplied by the Type One hospital DSH Factor. The Type One hospital DSH factor shall equal a percentage that when applied to the DSH payment calculation yields a DSH payment equal to the total calculated using the methodology outlined in subdivision 1 a of this subsection using an adjustment factor of one in the calculation of operating payments rather than the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times the hospital's Medicaid operating reimbursement, times 1.2074. Out-of-state cost reporting hospitals with Virginia utilization in the base year of less than 12% of total Medicaid days shall receive 50% of the payment described in this subsection.

~~G. F.~~ Hospitals qualifying under the 25% low-income patient utilization rate shall receive a DSH payment based on the hospital's type and the hospital's low-income utilization rate.

1. Type One hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times 17, times the hospital's Medicaid operating reimbursement.

2. Type Two hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

3. Calculation of a hospital's low-income patient utilization rate is defined in 42 USC § 1396r-4(b)(3).

~~D. No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and § 1923(g) of the Social Security Act.~~

~~E. G.~~ Each hospital's eligibility for DSH payment and the amount of the DSH payment shall be calculated at the time of each rebasing using the most recent reliable utilization data and projected operating reimbursement data available. The utilization data used to determine eligibility for DSH payment and the amount of the DSH payment shall include days for Medicaid recipients enrolled in capitated managed care programs. In years when DSH payments are not rebased in the way described above, the previous year's amounts shall be adjusted for inflation.

For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recently settled Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

~~F. H.~~ Effective July 1, 2010, and prior to July 1, 2013, DSH payments shall be rebased for all hospitals with the final calculation reduced by a uniform percentage such that the expenditures in FY 2011 do not exceed expenditures in FY 2010 separately for Type One and Type Two hospitals. The reduction shall be calculated after determination of eligibility. Payments determined in FY 2011 shall not be adjusted for inflation in FY 2012.

~~G. I.~~ Effective July 1, 2013, DSH payments shall not be rebased for all hospitals in FY 2014 and shall be frozen at the payment levels for FY 2013 eligible providers.

J. To be eligible for DSH, a hospital shall also meet the requirements in 42 USC § 1396r-4(d). No DSH payment shall exceed any applicable limitations upon such payment established by 42 USC § 1396r 4(g).

K. If making the DSH payments prescribed in these regulations would exceed the DSH allotment, DMAS shall adjust DSH payments to Type One hospitals. Any DSH payment not made as prescribed in the State Plan as a result of the DSH allotment shall be made upon determination that there is available allotment.