Virginia Regulatory Town Hall

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# Proposed Regulation
# Agency Background Document

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| **Agency name** | DEPT OF MEDICAL ASSISTANCE SERVICES |
| **VAC citation** | 12 VAC 30 -70 |
| **Regulation title** | Methods and Standards for Establishing Payment Rates—Inpatient Hospital Services |
| **Action title** | NICU/DSH and Indirect Medical Education; Freeze Freestanding Psychiatric Hospital Rates |
| **Document preparation date** | ; NEED GOV APPROVAL BY |

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 21 (2002) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

## Brief summary

*In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.*

This proposed action affects the Methods and Standards for Establishing Payment Rates—Inpatient Hospital Services in two areas: reimbursement for Neonatal Intensive Care Units (NICU), Disproportionate Share (DSH) payments, and Indirect Medical Education (IME) as well as the reimbursement for free-standing psychiatric hospitals. This action proposes to eliminate a separate DSH payment calculation for Medicaid-recognized NICU programs and to modify indirect medical education payments. This action also proposes to exclude freestanding psychiatric hospitals from the standard re-basing action conducted for other types of hospitals' reimbursement. These two issues will be discussed in this order throughout this background document.

## Legal basis

*Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.*

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 DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

NICU/DSH

Chapter 4 of the *2004 Acts of Assembly*, Item 326(OO) directed DMAS to eliminate a separate Disproportionate Share Hospital (DSH) payment calculation for hospitals with state-recognized Neonatal Intensive Care Unit (NICU) programs and to increase Indirect Medical Education (IME) payments, in total, to offset any net reduction in net payments as a result of this action. This regulatory action eliminates the language directing a separate DSH payment for recognized NICU providers, and amends the current multiplier used in the calculation of IME payments to private hospitals to generate additional IME payments for private hospitals to compensate for the net reduction to private hospital DSH payments caused by the elimination of NICU DSH.

Freestanding Psychiatric Hospitals

Chapter 4 of the *2004 Acts of Assembly*, Item 326(NN) directed DMAS not to rebase per diem rates of freestanding psychiatric facilities licensed as hospitals but to continue reimbursement based on SFY 2004 rates for these providers.

## Purpose

*Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal and the problems the proposal is intended to solve.*

None of these three changes will have any direct affect on the health, safety, or welfare of the citizens of the Commonwealth nor on Medicaid recipients.

NICU/DSH and IME

This regulatory action proposes to eliminate the Disproportionate Share Hospital (DSH) payment for Medicaid-recognized Neonatal Intensive Care Unit (NICU) programs and to modify indirect medical education payments.

Freestanding Psychiatric Hospitals

The purpose of this action is to exclude freestanding psychiatric hospitals from the standard re-basing action that has been conducted for the reimbursement methodology for other types of hospitals.

## Substance

*Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (More detail about these changes is requested in the "Detail of changes" section.)*

The sections of the State Plan for Medical Assistance that are affected by these changes are the Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services (12 VAC 30-70-206, 70-291, 70-301, and 70-391).

NICU/DSH and IME

The budget language calls for the elimination of Neonatal Intensive Care Unit Disproportionate Share Hospital (NICU DSH) payments but makes this change budget neutral through an enhancement in Indirect Medical Education (IME) payments.

The reimbursement methodology for inpatient hospital services recognizes two separate groups of hospitals: Type One hospitals (the public hospitals, MCV/VCU and UVA) and Type Two hospitals (all other private hospitals). Currently, the Commonwealth provides Medicaid DSH funding separately based on medical/surgery hospital utilization (including psychiatric hospital utilization), NICU utilization (for certain recognized programs), and rehabilitation hospital utilization. Under the current methodology, Virginia's Medicaid program recognizes NICU programs in six Type Two hospitals (including two out-of-state hospitals) and both Type One hospitals (MCV/VCU and UVA).

Under current regulations, Medicaid pays DSH monies specifically based on Medicaid NICU utilization percentages at these eight hospitals. The same methodology for calculation of Medicaid DSH payments is followed for NICU DSH as is followed for medical/surgery care DSH and rehabilitation DSH in terms of the thresholds for qualification and the basic formula to calculate payment. There are significant differences, however, in the methods used between the Type Two hospitals and the Type One hospitals.

For both types of hospitals (Type One and Type Two), however, this calculation is dependent on an estimation of Medicaid operating payments specific to these NICU programs based on a percentage of total Medicaid operating payments derived from 1997 allowable costs data. DMAS has not been able to collect more current data comparable to the 1997 data since the shift to the Diagnosis Related Groups (DRG) payment system. DMAS has had concerns that the 1997 data has become obsolete, which was the impetus for the elimination of the NICU DSH payment methodology.

With the elimination of NICU DSH for these providers, the Medicaid NICU days and the estimate of Medicaid NICU operating payments are rolled back into the total, which is used in the calculation of medical/surgery disproportionate share. This serves to increase overall Medicaid utilization at these hospitals, and serves to increase their estimated operating payments – both of these variables drive the calculation of the medical/surgery disproportionate share amount. This results in an increase in medical/surgery disproportionate share payment at those NICU DSH hospitals that also qualify for the medical/surgery disproportionate share payment.

The increase in medical/surgery disproportionate share payments related to this methodology change, however, does not fully offset the loss in NICU DSH payments for the Type Two hospitals. Therefore, the net loss in DSH is offset by a concomitant increase in IME payments for private hospitals through a modification to the IME formula. In that formula, the payment is dependent upon a multiplier – this multiplier has been modified to provide additional funding across the IME program for private hospitals equal to the net loss in DSH funding due to the elimination of NICU DSH. Because the IME formula is not hospital specific, it is not possible for this methodology change to produce budget neutrality on the individual hospital level, but rather the methodology produces budget neutrality among the Type Two hospitals as a group.

Freestanding Psychiatric Hospitals

Provisions in 12 VAC 30-70-391 provide for re-basing of hospital rates at least every three years. In compliance with this, DMAS has calculated re-based hospital rates to be effective July 1, 2004. As directed by the Appropriations Act, the proposed amendment would add language providing that freestanding psychiatric hospitals' rates would not be re-based for SFY2005, but would continue to be based on the previous base year. The regulatory change provides language excluding freestanding psychiatric facilities licensed as hospitals from any rebasing until the next full inpatient hospital rebasing subsequent to SFY 2005.

## Issues

*Please identify the issues associated with the proposed regulatory action, including:*
*1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;*
*2) the primary 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 the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.*

NICU/DSH and IME

The primary advantage to the Commonwealth and to the agency is that an outdated source of information will no longer be used as an input in calculating one component of the Medicaid DSH program payments. While in the aggregate this is budget neutral, for many private hospitals the new methodology regarding increases in Indirect Medical Education payments is a net benefit; i.e. it results in more money paid to the hospitals. For some hospitals, however, there is no effect and for two hospitals, there is a negative effect.

Freestanding Psychiatric Hospitals

The primary advantage to the Commonwealth and to the agency is that this regulatory action will provide needed time to better understand the effects of rebasing on freestanding psychiatric hospitals before imposing the results of the rebasing on those providers. This is also an advantage to the providers themselves in terms of understanding payment policy and payment stability.

## Economic impact

*Please identify the anticipated economic impact of the proposed regulation.*

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| **Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures** | NICU/DSH and IME: There is no fiscal impact on the state<br>Freestanding Psychiatric Hospitals: There is no fiscal impact on the state |
| **Projected cost of the regulation on localities** | none |
| **Description of the individuals, businesses or other entities likely to be affected by the regulation** | Private Hospitals and Freestanding Psychiatric Hospitals |
| **Agency's best estimate of the number of such entities that will be affected** | NICU/DSH and IME: 31 Private hospitals<br>Freestanding Psychiatric Hospitals: 5 |
| **Projected cost of the regulation for affected individuals, businesses, or other entities** | $0 in the aggregate |

## Alternatives

*Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action.*

NICU/DSH and IME

Chapter 4 of the 2004 Acts of Assembly, Item 326(OO), directed this action. Item 326(OO) specifically directed that NICU DSH be eliminated and that the IME methodology be revised to increase total payments by an amount equal to the net reduction associated with the elimination of NICU DSH. This could be interpreted as an allowance for DMAS to completely re-design the IME methodology. However, there was no concern regarding the existing IME methodology behind this directive (the object was simply to eliminate NICU DSH in a budget neutral fashion). Therefore, DMAS believes that a complete re-design would be outside the scope of the Appropriations Act language and much more intrusive regarding providers' current understanding and expectation of the current IME methodology. Therefore DMAS decided to simply increase an existing component of the IME methodology to increase IME payments such that, in the aggregate, no net loss of payment occurred as a result of the elimination of NICU DSH.

Freestanding Psychiatric Hospitals

This action was specifically directed by Chapter 4 of the 2004 Acts of Assembly, Item 326(NN), therefore no alternatives were available.

## Public comment

*Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.*

No comments were received from the public or affected providers, during the NOIRA comment period, for either the NICU/DSH and IME change or the freestanding psychiatric hospital change.

## Family impact

*Please assess the impact of the proposed regulatory action on the institution of the family and family stability.*

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or 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. It does not strengthen or erode the marital commitment, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

## Detail of changes

*Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.*

*If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.*

| Current section number | Proposed new section number, if applicable | Current requirement | Proposed change and rationale |
|---|---|---|---|
| 12VAC30-70-301 | | Sets forth the formula for calculating the DSH payment, including NICU | Elimination of a NICU DSH calculation |
| 12VAC30-70-291 | | Sets forth formula for calculating the IME payments | Modification to IME formula for Type Two hospitals to offset net DSH loss from elimination of NICU DSH |
| 12VAC30-70-391 | | Sets forth the rebasing process for inpatient rates | Excludes freestanding psychiatric facilities licensed as hospitals from rebasing until the next full rebasing subsequent to SFY 2005 |