DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Title of Regulations: **12 VAC 30-70-10 et seq. Methods and Standards for Establishing Payment Rates; Inpatient Hospital Care (12 VAC 30-70-200 through 12 VAC 30-70-490).**

CHAPTER 70.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES; IN-PATIENT HOSPITAL CARE.

PART V.

INPATIENT HOSPITAL PAYMENT SYSTEM.

Article 1.

Application of Payment Methodologies.

12 VAC 30-70-200. Application of payment methodologies.

~~The state agency will pay for inpatient hospital services under the methodologies and during the time periods specified in this part. During state fiscal years (SFY) 1997 and 1998, the state agency's methodology for inpatient hospital services in general acute care hospitals will transition from a per diem methodology to a DRG-based methodology. Article 2 (12 VAC 30-70-210) describes the special rules that apply during the transition period. Article 3 (12 VAC 30-70-220 et seq.) describes the DRG methodology that will apply (at a specified transition percentage) during the transition period and that will remain after the transition is over. Article 4 (12 VAC 30-70-400 et seq.) describes the revised per diem methodology that will apply in part during the transition, but that will cease to apply after the transition is over.~~

~~For inpatient hospital services in general acute care hospitals and rehabilitation hospitals occurring before July 1, 1996, reimbursement shall be based on the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130), which language, until July 1, 1996, was Attachment 4.19-A of the State Plan for Medical Assistance Services. The provisions contained in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130) shall not be effective after June 30, 1996, except as otherwise provided in this part.~~

~~For inpatient hospital services that are psychiatric or rehabilitation services and that are provided in general acute care hospitals, distinct part units of general acute care hospitals, freestanding psychiatric facilities licensed as hospitals, or rehabilitation hospitals on and after July 1, 1996, reimbursement shall be based on a methodology described in Articles 2, 3 and 4 of this part. This methodology implements a transition from revised per diem rates taken from the previous methodology (12VAC 30-70-10 through 12 VAC 30-70-130) to different per diem rates that will be used in the context of the DRG methodology. These services shall not be reimbursed by means of DRG per case rates. For freestanding psychiatric facilities licensed as hospitals there shall be no transition period, but the new per diem rates are to be implemented effective July 1, 1996. Also effective for those services rendered on or after July 1, 1996, the professional component for the care rendered in such freestanding psychiatric facilities licensed as hospitals may be billed separately by the attending professional who is enrolled in Medicaid. Inpatient hospital services that are provided in long stay hospitals and state-owned rehabilitation hospitals shall be subject to the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, which until July 1, 1996, was Attachment 4.19-A of the State Plan for Medical Assistance Services.~~ 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 (12 VAC 30-70-220 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12 VAC 30-70-400 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 (12 VAC 30-70-10 through 12 VAC 30-70-130). Until claims can be processed and paid by the DRG payment methodology, interim payments to hospitals will continue to be made by the per diem payment methodology described at Article 3 (12 VAC 30-70-400) and cost settled at the DRG amount when the hospitals' cost reports are settled at year end. The limit of coverage for adults of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply in the processing of claims (interim payments).

C. Transplant services shall not be subject to the provisions of this part. ~~They~~ These services ~~shall~~ continue to be subject to 12 VAC 30-50-100 ~~through~~ 12 VAC 30-50-310 and 12 VAC 30-50-540.

12 VAC 30-70-201. Prior notice of onset of claims processing system. DMAS shall provide prior notice to the onset of the DRG claims process system by direct notices to all affected hospitals.

Article 2.

~~Transition Period~~. Prospective (DRG-based) Payment Methodology

12 VAC 30-70-210. ~~Transition period reimbursement rules~~. Reserved.

12 VAC 30-70-220. General.

A. ~~Effective July 1, 1996, the state agency's reimbursement methodology for inpatient hospital services shall begin a transition from a prospective per diem to a prospective diagnosis related groupings (DRG) methodology. During the transition period, reimbursement of operating costs shall be a blend of a prospective DRG methodology (described in Article 3 of this part) and a revised prospective per diem methodology (described in Article 4 of this part). The transition period shall be SFY1997 and 1998, after which a DRG methodology~~

~~alone shall be used.~~ . Effective July 1, 1999, 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. ~~Tentative payment during the transition period. During the transition period claims will be tentatively paid on the basis of the revised per diem methodology only. Payment of claims based on DRG rates shall begin July 1, 1998~~. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12 VAC 30-70-230, 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 12 VAC 30-70-240, 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 12 VAC 30-70-250, 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 12 VAC 30-70-260, 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 12 VAC 30-70-270, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12 VAC 30-70-280, payments for direct medical education costs shall be made on an allowable cost basis.

7. As stipulated in 12 VAC 30-70-290, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12 VAC 30-70-300, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. ~~Final operating reimbursement during the transition period. During the transition period settlement of each hospital fiscal year will be carried out as provided in 12 VAC 30-70-460. Each hospital's final reimbursement for services that accrue to each state fiscal year of the transition shall be based on a blend of the prospective DRG methodology and the revised per diem methodology. For services to patients admitted and discharged in SFY1997 the blend shall be 1/3 DRG and 2/3 revised per~~ diem. ~~For services to patients admitted after June 30, 1996, and~~

~~discharged during SFY1998 the blend shall be 2/3 DRG and 1/3 revised per diem. Settlements shall be completed according to hospital fiscal years, but after June 30, 1996, changes in rates and in the percentage of reimbursement that is based on DRGs vs. per diem rates, shall be according to state fiscal year. Services in freestanding psychiatric facilities licensed as hospitals shall not be subject to the transition period phase-in of new rates, or to settlement at year-end; the new system rates for these providers shall be fully effective on July 1, 1996. In hospital fiscal years that straddle the implementation date (years starting before and ending after July 1, 1996) operating costs must be settled partly under the old and partly under the new methodology:~~ The terms used in this article shall be defined as follows~~:~~

~~1. Days related to discharges occurring before July 1, 1996, shall be settled under the previous reimbursement methodology (see 12 VAC 30-70-10 through 12 VAC 30-70-130).~~

~~2. Stays with admission date before July 1, 1996, and discharge date after June 30, 1996, shall be settled in two parts, with days before July 1, 1996, settled on the basis of the previous reimbursement methodology (see 12 VAC 30-70-10 through 12 VAC 30-70-130), and days after June 30, 1996, settled at 100% of the hospital's revised per diem rate as described in Article 4 (12 VAC 30-70-400 et seq.) of this part. The DRG reimbursement methodology shall not be used in the settlement of any days related to a stay with an admission date before July 1, 1996.~~

~~3. Stays with admission dates on and after July 1, 1996, shall be settled under the transition methodology. All cases admitted from July 1, 1996, onward shall be settled based on the rates and transition rules in effect in the state fiscal year in which the discharge falls. The only exception shall be claims for rehabilitation cases with length of stay sufficient that one or more interim claims are submitted. Such claims for rehabilitation cases shall be settled based on rates and rules in effect at the time of the end date ("through" date) of the claim, whether or not it is the final or discharge claim.~~

1. The "base year" is 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 rebasing, the Commonwealth shall notify affected providers of the base year to be used in this calculation. For State Fiscal Year 1999, the base year shall be State Fiscal Year 1997. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

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

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

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

5. "Per diem cases" are 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 are 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 the Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A&B (12 VAC 30-50-95 through 12 VAC 30-50-310). 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.

6. "Transfer cases" are 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.

7. "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.

8. "Outlier cases" are 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.

9. The "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. In the base year, this ratio shall be calculated for each hospital by (i) calculating the average of the ratio over the most recent five years for which data are available and (ii) trending the hospital specific average forward from the mid-point of the five year period with a statewide trend factor. The statewide trend factor shall be the average of the four annual statewide aggregate factors of change that occurred in the five year period. This trend factor shall be compounded from the mid point of the five year period to the base year. The separate treatment of DRG costs and charges provided in this section shall begin when those data become available through the cost report. Until then, a single all-inclusive ratio shall be used for each hospital.

10. The "psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital is 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 subdivision 9 of this subsection, using data from psychiatric DPUs.

11. The "rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital is the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in subdivision 9 of this subsection, using data from rehabilitation units or hospitals.

12. The "statewide average labor portion of operating costs" is 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.

13. The "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.

14. The "outlier operating fixed loss threshold" is 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 percent of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

15. The "outlier adjustment factor" is 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.

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

17. The "hospital case-mix index" is the weighted average DRG relative weight for all cases occurring at that hospital.

18. The "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 and geography from the claims data and places all hospitals on a comparable basis.

19. The "base year standardized costs per day" reflect 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 and geography 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 number 5 of this subsection.

20. A "disproportionate share hospital" is a hospital that meets the following criteria:

a. A Medicaid utilization rate in excess of 15 percent, or a low-income patient utilization rate exceeding 25 percent (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. Number 20b 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.

21. The "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.

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

23. "Cost" means allowable cost as defined in Supplement 3 and by Medicare principles of reimbursement.

D. ~~Capital cost reimbursement. During the transition period capital cost shall be reimbursed as a pass through as described in 12 VAC 30 70 10 through 12 VAC 30 70 130, except that paid days and charges used to determine Medicaid allowable cost in a fiscal period for purposes of capital cost reimbursement shall be the same as those accrued to the fiscal period for operating cost reimbursement. Effective July 1, 1998, capital cost shall be reimbursed as described in Article 4 (12 VAC 30 70 400 et seq.) of this part. Until capital costs are fully included in prospective rates the provisions of 12 VAC 30 70 70 regarding recapture of depreciation shall remain in effect. Reimbursement of capital cost for freestanding psychiatric facilities licensed as hospitals shall be included in their per diem rates as provided in Article 4 (12 VAC 30 70 400 et seq.) of this part, and shall not be treated as a pass through during the transition period or afterward.~~ The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. As of the effective date of these regulations, and 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. ~~Disproportionate Share Hospital (DSH) payments during the transition. Effective July 1, 1996, DSH payments shall be fully prospective amounts determined in advance of the state fiscal year to which they apply, and shall not be subject to settlement or revision based on changes in utilization during the year to which they apply. Payments prospectively determined for each state fiscal year shall be considered payment for that year, and not for the year from which data used in the calculation was taken. Payment of DSH amounts determined under this methodology shall be made on a quarterly basis.~~

~~For patient days occurring before July 1, 1996, DSH reimbursement shall be determined under the previous methodology and settled accordingly (12 VAC 30-70-10 through 12 VAC 30-70-130). Effective for days occurring July 1, 1996, and after, DSH reimbursement made through prospective lump sum amounts as described in this section shall be final and not subject to settlement except when necessary due to the limit in subdivision 2 e of this subsection. After July 1, 1998, DSH reimbursement shall be as provided in Article 4 (12 VAC 30-70-400 et seq.) of this part.~~

~~1. Definition. A disproportionate share hospital shall be a hospital that meets the following criteria:~~

~~a. 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~~

~~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. A disproportionate share hospital's additional payment shall be based on the type of hospital and on the hospital's Medicaid utilization percentage. There shall be two types of hospitals: (i) Type One, consisting of hospitals that were state owned teaching hospitals on January 1, 1996, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization percentage is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days. Each eligible hospital with a Medicaid utilization percentage above 15% shall receive a disproportionate share payment.

b. For Type One hospitals, the disproportionate share payment shall be equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 15%, times 11, times the hospital's Medicaid operating reimbursement, times 1.3186 in SFY1997, and 1.3782 in SFY1998 and (ii) the hospital's Medicaid utilization percentage in excess of 30%, times 11, times the hospital's Medicaid operating reimbursement, times 1.3186 in SFY1997, and 1.3782 in SFY1998.

c. For Type Two hospitals, the disproportionate share payment shall be equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 15%, times the hospital's Medicaid operating reimbursement, times 1.0964 in SFY1997, and 1.1476 in SFY1998 and (ii) the hospital's Medicaid utilization percentage in excess of 30%, times the hospital's Medicaid operating reimbursement, times 1.0964 in SFY1997, and 1.1476 in SFY1998.

d. For hospitals which do not qualify under the 15% inpatient Medicaid utilization rate, but do qualify under the low-income patient utilization rate, exceeding 25% in subdivision 1 a of this subsection, the disproportionate share payment amount for Type One hospitals shall be equal to the product of the hospital's low-income utilization in excess of 25%, times 11, times the hospital's Medicaid operating reimbursement. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

e. OBRA 1993 § 13621 Disproportionate Share Adjustment Limit.

(1) Limit on amount of payment. No payments made under subdivision E 2 of this section shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 § 13621. A payment adjustment during a fiscal year shall not exceed the sum of:

(a) Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year, and

(b) Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

(2) During state fiscal year 1995, the limit in this section shall apply only to hospitals which are owned or operated by a state or an instrumentality or unit of government within the state. During this year such a hospital, if it is one whose Medicaid inpatient utilization rate is at least one standard deviation above the mean inpatient utilization rate in the state or if it has the largest number of Medicaid days of any such hospital in the Commonwealth for the previous state fiscal year, shall be allowed a limit that is 200% of the limit described above which the Governor certifies to the Secretary of the U. S. Department of Health and

~~Human Services that such amount (the amount by which the hospital's payment exceeds the limit described above) shall be used for health services during the year.~~

~~3. Source data for calculation of eligibility and payment adjustment. Each hospital's eligibility for DSH payment, and the amount of the DSH payment in state fiscal year 1997, shall be based upon Medicaid utilization in hospital fiscal years ending in calendar year 1994, and on projected operating reimbursement in state fiscal year 1997, estimated on the basis of 1994 utilization. After state fiscal year 1997, each new year's DSH payments shall be calculated using the most recent reliable utilization and projection data available. For the purpose of calculating DSH payments, each hospital with a Medicaid-recognized Neonatal Intensive Care Unit (NICU) (a unit having had a unique NICU operating cost limit under subdivision 6 of 12 VAC 30-70-60), shall have its DSH payment calculated separately for the NICU and for the remainder of the hospital as if the two were separate and distinct providers.~~

~~For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recent filed Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.~~ 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	Claims history file
Total number of psychiatric days for each freestanding psychiatric hospital	Claims history file
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	VHI

Data Elements	***Source***
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*

~~F. Direct medical education (DMedEd). During the transition period (July 1996 through June 1998), DMedEd costs shall be reimbursed in the same way as under the previous methodology (12 VAC 30-70-10 through 12 VAC 30-70-130). This methodology does not and shall not include the DMedEd reimbursement limitation enacted for the Medicare program effective July 1, 1985. Reimbursement of DMedEd shall include an amount to reflect DMedEd associated with services to Medicaid patients provided in hospitals but reimbursed by capitated managed care providers. This amount shall be estimated based on the number of days of care provided by the hospital that are reimbursed by capitated managed care providers. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals. DMedEd will be paid in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end settlement.~~

~~G. Final payment adjustment fund (PAF) payment for certain hospitals. Hospitals receiving payments for Medicaid patients from managed care providers enrolled in Medallion II shall be paid a separate lump sum amount, based on the continuation of capitation rates during July 1, 1996, through December 31, 1996, that do not reflect adjustments made to hospital per diem and DRG payments on July 1, 1996. Each of these hospitals shall be paid a final PAF amount. It shall be equal to a hospital specific PAF per diem times the number of Medallion II days that occur in the hospital in July 1, 1996, through December 31, 1996. The PAF per diem shall be based on a revision of the PAF calculation that was carried out for the SFY1996 PAF payment that was made in August 1995. The revision shall be the hospital ceiling, DSH per diem, and cost report data used in the calculation from the cost reports that would be used under the PAF methodology if a SFY1997 PAF calculation were to be done. The "paid days" data used in this calculation shall be the same as that used in the SFY1996 calculation. Pending the calculation of the final PAF payment in the settlement of the relevant time period for the affected hospitals, an interim payment shall be made. The interim payment shall be equal to 1/2 the PAF payment made to the same hospitals for SFY1996.~~

~~H. Adjusting DRG rates for length of stay (LOS) reductions from 1995 Appropriations Act. If it is demonstrated that there are savings directly attributable to LOS reductions resulting from utilization initiatives directed by the 1995 Appropriations Act as agreed to and evaluated by the Medicaid Hospital Payment Policy Advisory Council, these savings, up to a maximum of $16.9 million in SFY1997, shall be applied as a reduction to SFY1997 and 1998 DRG rates used for settlement purposes.~~

~~I. Service limits during the transition period. The limit of coverage for adults of 21 days in a 60 day period for the same or similar diagnosis shall continue to apply in the processing of claims and in the per diem portion of settlement during the transition period. This limit shall not apply in the DRG portion of reimbursement, except for covered psychiatric cases. Psychiatric cases are 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 12 VAC 30-50-100 through 12 VAC 30-50-310.~~

12 VAC 30-70-230. Operating payment for DRG cases.

A. The operating payment for DRG cases that are not transfer cases shall be equal to the hospital specific operating rate per case, as determined in 12 VAC 30-70-310, times the DRG relative weight, as determined in 12 VAC 30-70-380.

B. Exceptions.

1. Special provisions for calculating the operating payment for transfer cases are provided in 12 VAC 30-70-250.

2. Readmissions shall be considered a continuation of the same stay and shall not be treated as a new case.

12 VAC 30-70-240. Operating payment for per diem cases.

A. The operating payment for acute care psychiatric cases and rehabilitation cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-320, times the covered days for the case.

B. The payment for freestanding psychiatric cases shall be equal to the hospital specific rate per day for freestanding psychiatric cases, as determined in subsection B of 12 VAC 30-70-320, times the covered days for the case.

12 VAC 30-70-250. Operating payment for transfer cases.

A. The operating payment for transfer cases shall be determined as follows:

1. A transferring hospital shall receive the lesser of (i) a per diem payment equal to the hospital's DRG operating payment for the case, as determined in 12 VAC 30-70-230, divided by the arithmetic mean length of stay for the DRG into which the case falls times the length of stay for the case at the transferring hospital or (ii) the hospital's full DRG operating payment for the case, as determined in 12 VAC 30-70-230. The transferring hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-260, if applicable criteria are satisfied.

2. The final discharging hospital shall receive the hospital's full DRG operating payment, as determined in 12 VAC 30-70-230. The final discharging hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-260, if applicable criteria are satisfied.

B. Exceptions.

1. Cases falling into DRGs 456, 639, or 640 shall not be treated as transfer cases. Both the transferring hospital and the final discharging hospital shall receive the full DRG operating payment.

2. Cases transferred to or from a psychiatric or rehabilitation DPU of a general acute care hospital, a freestanding psychiatric facility licensed as a hospital, or a rehabilitation hospital shall not be treated as transfer cases.

12 VAC 30-70-260. Outlier operating payment.

A. An outlier operating payment shall be made for outlier cases. This payment shall be added to the operating payments determined in 12 VAC 30-70-230 and 12 VAC 30-70-250. Eligibility for the outlier operating payment and the amount of the outlier operating payment shall be determined as follows:

1. The hospital's adjusted operating cost for the case shall be estimated. This shall be equal to the hospital's total charges for the case times the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-220, times the adjustment factor specified in 12 VAC 30-70-330 B.

2. The adjusted outlier operating fixed loss threshold shall be calculated as follows:

a. The outlier operating fixed loss threshold shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of the outlier operating fixed loss threshold. Hence, the non-labor portion of the outlier operating fixed loss threshold shall constitute one minus the statewide average labor portion of operating costs times the outlier operating fixed loss threshold.

b. The labor portion of the outlier operating fixed loss threshold shall be multiplied by the hospital's Medicare wage index, yielding the wage adjusted labor portion of the outlier operating fixed loss threshold.

c. The wage adjusted labor portion of the outlier operating fixed loss threshold shall be added to the non-labor portion of the outlier operating fixed loss threshold, yielding the wage adjusted outlier operating fixed loss threshold.

3. The hospital's outlier operating threshold for the case shall be calculated. This shall be equal to the wage adjusted outlier operating fixed loss threshold times the adjustment factor specified in 12 VAC 30-70-330 B plus the hospital's operating payment for the case, as determined in 12 VAC 30-70-230 or 12 VAC 30-70-250.

4. The hospital's outlier operating payment for the case shall be calculated. This shall be equal to the hospital's adjusted operating cost for the case minus the hospital's outlier operating threshold for the case. If the difference is less than or equal to zero, then no outlier operating payment shall be made. If the difference is greater than zero, then the outlier operating payment shall be equal to the difference times the outlier adjustment factor.

B. An illustration of the above methodology is found in 12 VAC 30-70-500.

C. The outlier operating fixed loss threshold shall be recalculated using base year data when the DRG payment system is recalibrated and rebased. The threshold shall be calculated so as to result in an expenditure for outlier operating payments equal to 5.1 percent of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

12 VAC 30-70-270. Payment for capital costs.

A. Until regulations for prospective payment of capital costs are promulgated, capital costs shall continue to be paid on an allowable cost basis and settled at the hospital's fiscal year end, following the methodology described in Supplement III (12 VAC 30-70-10 through 12 VAC 30-70-130).

B. The exception to the policy immediately above in subsection A is that the hospital-specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12 VAC 30-70-320 B, shall be an all-inclusive payment for operating and capital costs.

C. DMAS plans to implement prospective payment for capital costs for all DRG cases, acute care psychiatric cases, and rehabilitation cases. The implementation date will be determined later. Under prospective payment for capital costs, the Department will calculate a hospital specific capital rate and a statewide capital rate, and the two rates will be blended during a transition period. In successive years of the transition period, the statewide capital rate will comprise an increasing portion of the blended rate, until payment for capital costs is entirely based on the statewide capital rate. The two rates will be calculated as follows:

1. The hospital specific capital rate will approximate the hospital's average capital cost per case for DRG cases or the hospital's average capital cost per day for per diem cases.

Initially, this rate will be based on settled cost reports for hospital fiscal years ending in a State Fiscal Year to be established in future regulations. Capital obligated after July 1, 1997 shall not be included in the calculation of the hospital specific capital rate.

2. The statewide capital rate will approximate the statewide average capital cost per case for DRG cases or the statewide average capital cost per day for per diem cases. Initially, this rate will be based on settled cost reports for hospital fiscal years ending in State Fiscal Year 1997.

D. Until prospective payment for capital costs is implemented, the provisions of 12 VAC 30-70-70 regarding recapture of depreciation shall remain in effect.

12 VAC 30-70-280. Payment for direct medical education costs.

A. Until the Department notifies hospitals otherwise, direct medical education shall continue to be paid on an allowable cost basis. Payments for direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for direct medical education costs shall be equal to the hospital's Medicaid utilization percentage times the hospital's total direct medical education costs. As defined in subsection C of

12 VAC 30-70-220, the Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

C. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

12 VAC 30-70-290. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

$$\text{IME Percentage for Type One Hospitals} = [1.89 \times ((1 + r)^{0.405} - 1)]$$

2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

$$\text{IME Percentage for Type Two Hospitals} = [1.89 \times ((1 + r)^{0.405} - 1)] \times 0.4043$$

In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This payment shall be equal to the hospital's hospital-specific operating rate per case, as determined in 12 VAC 30-70-310, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

12 VAC 30-70-300. 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 E of this section.

B. Hospitals qualifying under the 15 percent 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 the sum of (i) the hospital's Medicaid utilization percentage in excess of 15 percent, times 11, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of 30 percent, times 11, times the hospital's Medicaid operating reimbursement, times 1.4433.

2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 15 percent, times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of 30 percent, times the hospital's Medicaid operating reimbursement, times 1.2074.

C. Hospitals qualifying under the 25 percent 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 percent, times 11, 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 percent, times the hospital's Medicaid operating reimbursement.

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

D. No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 §13621. A DSH payment during a fiscal year shall not exceed the sum of:

1. Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year. Costs and payments for Medicaid recipients enrolled in capitated managed care programs shall be considered Medicaid costs and payments for the purposes of this section.

2. Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

E. Each hospital's eligibility for DSH payment and the amount of the DSH payment shall be calculated each year 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.

1. Each hospital with a Medicaid-recognized Neonatal Intensive Care Unit (NICU), a unit having had a unique NICU operating cost limit under number 6 of 12 VAC 30-70-60, shall have its DSH payment calculated separately for the NICU and for the remainder of the hospital as if the two were separate and distinct providers. This calculation shall follow the methodology provided in 12 VAC 30-70-300.

2. 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.

12 VAC 30-70-310. Hospital specific operating rate per case.

The hospital specific operating rate per case shall be equal to the labor portion of the statewide operating rate per case, as determined in 12 VAC 30-70-330, times the hospital's Medicare wage index plus the non-labor portion of the statewide operating rate per case.

12 VAC 30-70-320. Hospital specific operating rate per day.

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12 VAC 30-70-340, times the hospital's Medicare wage index plus the non-labor portion of the statewide operating rate per day.

B. The hospital specific rate per day for freestanding psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases.

C. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases.

D. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals.

E. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from VHI.

12 VAC 30-70-330. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12 VAC 30-70-360, times the inflation values specified in 12 VAC 30-70-350 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals and shall be the ratio of the following two numbers:

1. The numerator of the factor is the aggregate total Medicaid operating payments to affected hospitals in hospital fiscal years ending in the calendar year ending six months prior to the start of the state fiscal year used as the base year. For example, for State Fiscal Year

1999, the base year shall be State Fiscal Year 1997, and the calendar year that ends six months prior to the start of State Fiscal Year 1997 is Calendar Year 1995.

2. The denominator of the factor is the aggregate total Medicaid allowable operating cost as determined from settled cost reports from the same hospitals in the same year.

12 VAC 30-70-340. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12 VAC 30-70-370, times the inflation values specified in 12 VAC 30-70-350 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor for acute care psychiatric cases and rehabilitation cases shall be the one specified in subsection B of 12 VAC 30-70-330.

12 VAC 30-70-350. Updating rates for inflation.

Each July, the DRI-Virginia moving average values as compiled and published by DRI/McGraw-Hill under contract with the Department shall be used to update the base year standardized operating costs per case, as determined in 12 VAC 30-70-360, and the base year standardized operating costs per day, as determined in 12 VAC 30-70-370, to the midpoint of the upcoming state fiscal year. The

most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by DRI/McGraw-Hill in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.

12 VAC 30-70-360. Base year standardized operating costs per case.

A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12 VAC 30-70-220, the following methodology shall be used to calculate the base year standardized operating costs per case:

1. The operating costs for each DRG case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-220.

2. The standardized operating costs for each DRG case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the non-labor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the non-labor portion of operating costs, yielding standardized operating costs.

3. The case-mix neutral standardized operating costs for each DRG case shall be calculated by dividing the standardized operating costs for the case by the hospital's case-mix index.

4. The base year standardized operating costs per case shall be calculated by summing the case-mix neutral standardized operating costs for all DRG cases and dividing by the total

number of DRG cases.

5. The base year standardized operating costs per case shall be reduced by 5.1 percent to create a pool for outlier operating payments. Eligibility for outlier operating payments and the amount of the outlier operating payments shall be determined in accordance with 12 VAC 30-70-260.

C. Because the current cost report format does not separately identify psychiatric costs, claims data shall be used to calculate the base year standardized operating costs per case, as well as the base year standardized operating costs per day described in 12 VAC 30-70-320. At such time as the cost report permits the separate identification of psychiatric costs and the DRG payment system is recalibrated and rebased, cost report data shall be used to calculate the base year standardized operating costs per case and base year standardized operating costs per day.

12 VAC 30-70-370. Base year standardized operating costs per day.

A. For the purpose of calculating the base year standardized operating costs per day, base year claims data for per diem cases shall be used. Base year claims data for DRG cases shall not be used. Separate base year standardized operating costs per day shall be calculated for Type One and Type Two hospitals.

B. Using the data elements identified in subsection E of 12 VAC 30-70-220, the following methodology shall be used to calculate the base year standardized operating costs per day:

1. The operating costs for each per diem case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-220.

2. The standardized operating costs for each per diem case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the non-labor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the non-labor portion of operating costs, yielding standardized operating costs.

3. The base year standardized operating costs per day for acute care psychiatric cases shall be calculated by summing the standardized operating costs for acute care psychiatric cases and dividing by the total number of acute care psychiatric days. This calculation shall be repeated separately for freestanding psychiatric cases and rehabilitation cases.

C. For general acute care hospitals with psychiatric DPUs, the psychiatric operating cost-to-charge ratio shall be used in the above calculations.

12 VAC 30-70-380. DRG relative weights and hospital case-mix indices.

A. For the purposes of calculating DRG relative weights and hospital case-mix indices, base year claims data for all groupable cases shall be used. Base year claims data for ungroupable cases and per diem cases shall not be used. In calculating the DRG relative weights, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12 VAC 30-70-220, the following methodology shall be used to calculate the DRG relative weights:

1. The operating costs for each groupable case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in

subsection C of 12 VAC 30-70-220. Similarly, the capital costs for each groupable case shall be calculated by multiplying the hospital's total charges for the case by the hospital's capital cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-220.

2. The standardized operating costs for each groupable case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the non-labor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the non-labor portion of operating costs, yielding the standardized operating costs.

3. The standardized capital costs for each groupable case shall be calculated by dividing the capital costs for the case by the hospital's Medicare geographic adjustment factor.

4. The average standardized cost per DRG shall be calculated by summing the standardized operating costs and the standardized capital costs for all groupable cases in the DRG and dividing that amount by the number of groupable cases classified in the DRG.

5. The average standardized cost per case shall be calculated by summing the standardized operating costs and standardized capital costs for all groupable cases and dividing that amount by the total number of groupable cases.

6. The average standardized cost per DRG shall be divided by the average standardized cost per case to determine the DRG relative weight.

C. Statistical outliers shall be eliminated from the calculation of the DRG relative weights. Within each DRG, cases shall be eliminated if (i) their standardized costs per case are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per case and (ii) their standardized costs per day are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per day. To eliminate a case, both conditions must be satisfied.

D. In calculating the DRG relative weights, a threshold of five cases shall be set as the minimum number of cases required to calculate a reasonable DRG relative weight. In those instances where there are five or fewer cases, the Department's Medicaid claims data shall be supplemented with Medicaid claims data from another state or other available sources. The DRG relative weights

calculated according to this methodology will result in an average case weight that is different from the average case weight before the supplemental claims data was added. Therefore, the DRG relative weights shall be normalized by an adjustment factor so that the average case weight after the supplemental claims data were added is equal to the average case weight before the supplemental claims data were added.

E. The DRG relative weights shall be used to calculate a case-mix index for each hospital. The case-mix index for a hospital is calculated by summing, across all DRGs, the product of the number of groupable cases in each DRG and the relative weight for each DRG and dividing this amount by the total number of groupable cases occurring at the hospital.

12 VAC 30-70-390. Recalibration and Rebasing Policy.

The Department recognizes that claims experience or modifications in federal policies may require adjustment to the DRG payment system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the DRG relative weights and hospital case-mix indices) and rebase (review and update the base year standardized operating costs per case and the base year standardized operating costs per day) the DRG payment system at least every other year. Recalibration and rebasing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12 VAC 30-70-490. When rebasing is carried out, if new rates are not calculated before their required effective date, hospitals required to file cost reports and freestanding psychiatric facilities licensed as hospitals shall be settled at the new rates, for discharges on and

after the effective date of those rates, at the time the hospitals' cost reports for the year in which the rates become effective are settled.

Article 3.

~~Diagnosis Related Groups (DRG) Reimbursement Methodology~~. Other Provisions for Payment of Inpatient Hospital Services

~~12 VAC 30-70-220. General.~~

~~A. Reimbursement of operating costs for cases which are subject to DRG rates shall be equal to the relative weight of the DRG in which the patient falls, times the hospital-specific operating rate per case. Reimbursement of outliers, transfer cases, cases still subject to per diem reimbursement, capital costs, and medical education costs shall be as provided in this article.~~

~~B. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG reimbursement methodology. Effective July 1, 1996, and until notification of a change is given, Version 12 of this grouper shall be used. DMAS shall notify hospitals by means of a Medicaid memo when updating the system to later grouper versions.~~

~~12 VAC 30-70-230. Calculation of DRG weights and hospital case mix indices.~~

~~A. The relative weight measures the cost and, therefore, the reimbursement level of each DRG relative to all other DRGs. The hospital case mix index measures the hospital's average case mix complexity (costliness) relative to all other hospitals.~~

~~B. The relative weight for each DRG was determined by calculating the average standardized cost for cases assigned to that DRG, divided by the average standardized cost for cases assigned to all DRGs. For the purpose of~~

~~calculating relative weights, groupable cases (cases having coding data of sufficient quality to support DRG assignment) and transfer cases (groupable cases where the patient was transferred to another hospital) were used. Ungroupable cases and rehabilitation, psychiatric, and transplant cases were not used. DMAS' hospital computerized claims history file for discharges in hospital fiscal years ending in calendar year 1993 was used. All available data from all enrolled, cost reporting general acute care hospitals were used, including data from state-owned teaching hospitals. Cost report data from hospital fiscal years ending in calendar year 1993 were also used.~~

~~C. Before relative weights were calculated for each DRG, each hospital's total charges were disaggregated into operating charges and capital charges, based on the ratio of operating and capital cost to total cost. Operating charges and capital charges were standardized for regional variation, and then both operating charges and capital charges were reduced to costs using ratios of costs to charges (RCCs) obtained from the Medicaid cost report database. Direct medical education costs were eliminated from the relative weight calculations since such costs will be addressed outside the DRG rates. These steps, detailed in subsection D of this section, were completed on a case-by-case basis using the data elements identified in the following table.~~

~~Data Elements for Relative Weight and Case Mix Index Calculations~~

~~Data Elements~~	~~Source~~
~~Total charges for each groupable case~~	~~Claims Database~~
~~Total charges for each transfer case~~	~~Claims Database~~
~~Ratio of operating costs to total costs for each hospital~~	~~Medicaid Cost Report Database~~

~~Ratio of capital costs to total costs for each hospital~~	~~Medicaid Cost Report Database~~
~~Ratio of Direct Medical Education costs to total costs for each hospital~~	~~Medicaid Cost Report Database~~
~~Statewide average labor portion of operating costs~~	~~Virginia Health Services Cost Review Council~~
~~Medicare wage index for each hospital~~	~~Federal Register~~
~~Medicare Geographic Adj. Factor (GAF) for each hospital~~	~~Federal Register~~
~~RCC for each hospital~~	~~Medicaid Cost Report Database~~

~~D. Steps in calculation of relative weights.~~

~~1. The total charges for each case were split into operating charges, capital charges, and Direct Medical Education charges using hospital specific ratios obtained from the cost report database.~~

~~2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps.~~

~~a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.~~

~~b. The labor portion of operating charges was divided by the hospital specific Medicare wage index yielding the standardized labor portion of operating charges.~~

c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.

3. The standardized operating charges were multiplied by the hospital specific RCC yielding standardized operating costs.

4. The capital charges obtained in Step 1 were divided by the hospital specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.

5. The standardized capital charges were multiplied by the hospital specific cost-to-charge ratio yielding standardized capital costs.

These five steps were repeated for all groupable cases and transfer cases. Once this was done, the cases were sorted by DRG category resulting in the total cases and the total standardized cost of each DRG. Total cost divided by total cases yielded the average standardized cost of each DRG. The average standardized cost of each DRG was divided by the average standardized cost across all DRGs yielding the relative weight for each DRG. To address the unavailability of charge data related to adult hospital days beyond 21 days, an adjustment was estimated for certain DRGs and added to the weights as calculated above. This adjustment for adult days over 21 is necessary only until the first recalibration of weights becomes effective in July 1998 (see 12 VAC 30-70-380).

The relative weights were then used to calculate a case mix index for each hospital. The case mix index for a hospital was determined by summing for all DRGs the product of the number of groupable cases and transfer cases in each DRG and the relative weight for each DRG. This sum was then divided by the total number of cases yielding the case mix index. This process was repeated on a hospital by hospital basis.

12 VAC 30-70-240. Calculation of standardized costs per case.

A. Standardized costs per case were calculated using all DRG cases (groupable, ungroupable, and transfer cases). Cases entirely subject to per diem rather than DRG reimbursement and cases from state-owned teaching

hospitals were not used. Using the data elements identified in the following table, the seven steps outlined in subsection B of this section were completed on a case-by-case basis.

Data Elements for Standardized Costs Per Case Calculations

Data Elements	Source
Total charges for each groupable case	Claims Database
Total charges for each ungroupable case	Claims Database
Total charges for each transfer case	Claims Database
Ratio of operating costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of capital costs to total costs for each hospital	Medicaid Cost Report Database
Ratio of [durable medical equipment Direct Medical Education] costs to total costs for each hospital	Medicaid Cost Report Database

~~Statewide average labor portion of operating costs~~	~~Virginia Health Services Cost Review Council~~
~~Medicare wage index for each hospital~~	~~Federal Register~~
~~Medicare GAF for each hospital~~	~~Federal Register~~
~~RCC for each hospital~~	~~Medicaid Cost Report Database~~
~~Case-mix index for each hospital~~	~~Calculated~~
~~Total number of groupable cases~~	~~Claims Database~~
~~Total number of ungroupable cases~~	~~Claims Database~~
~~Total number of transfer cases~~	~~Claims Database~~

~~B. Steps in calculation of standardized cost per case.~~

~~1. The total charges for each case were split into operating charges, capital charges, and Direct Medical Education charges using hospital specific ratios obtained from the cost report database.~~

~~2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps.~~

a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.

b. The labor portion of operating charges was divided by the hospital specific Medicare wage index yielding the standardized labor portion of operating charges.

c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.

3. The standardized operating charges were multiplied by the hospital specific RCC yielding standardized operating costs.

4. The capital charges obtained in Step 1 were divided by the hospital specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.

5. The standardized capital charges were multiplied by the hospital specific cost to charge ratio yielding standardized capital costs.

6. The standardized operating costs obtained in Step 3 were divided by the hospital specific case mix index yielding case mix neutral standardized operating costs.

7. The standardized capital costs obtained in Step 5 were divided by the hospital specific case mix index yielding case mix neutral standardized capital costs.

These seven steps were repeated for all DRG cases. Once this was done, the case mix neutral standardized operating costs for all DRG cases were summed and an average was calculated. This yielded what is referred to as standardized operating costs per case. A similar average was computed for capital yielding standardized capital costs per case.

~~12 VAC 30-70-250. Calculation of statewide operating rate per case for SFY1997.~~

~~The statewide operating rate per case that shall be used to calculate the DRG portion of operating reimbursement for cases admitted and discharged in state fiscal year 1997 is equal to the standardized operating cost per case, updated to the midpoint of SFY1997 and multiplied by an additional factor. The update shall be done by multiplying the standardized operating cost per case by the DRI Virginia moving average value as compiled and published by DRI/McGraw Hill under contract with DMAS. The additional factor is equal to 0.6247. This factor is the ratio of two numbers:~~

~~1. The numerator of the factor is the aggregate amount of operating reimbursement for hospitals included in the data base used for the calculations described above that DMAS and the Virginia Hospital and Healthcare Association (VHHA) jointly determined would be made by Medicaid in state fiscal year 1997 if the rate methodology in effect on June 30, 1996, were to continue. This amount was further adjusted by agreement between DMAS and the VHHA to carry out specific policy agreements with respect to various elements of reimbursement.~~

~~2. The denominator of the factor is the estimated aggregate operating amount for the same hospitals identified in subdivision 1 of this section, calculated using the standardized operating cost per case and standardized operating cost per day as calculated in 12 VAC 30-70-230 and 12 VAC 30-70-320, and adjusted for inflation as in subdivision 1.~~

~~12 VAC 30-70-260. Calculation of statewide capital rate per case. (Reserved)~~

~~12 VAC 30-70-270. Hospital specific operating rate per case.~~

~~Each hospital specific operating rate per case shall be the labor portion of the statewide operating rate per case multiplied by the Medicare wage index applicable to the hospital's geographic location plus the nonlabor portion of~~

~~the statewide operating rate per case. The Medicare wage index shall be the one in effect for Medicare in the base period used in the calculation of the standardized costs per case (1993 for the calculation of 1997 rates).~~

~~12 VAC 30-70-280. Hospital specific capital rate per case (geographic adjustment). (Reserved)~~

~~12 VAC 30-70-290. Outliers.~~

~~A. An outlier case shall be one whose estimated cost exceeds the applicable DRG payment plus the applicable fixed loss threshold.~~

~~B. Total payment for an outlier case shall be calculated according to the following methodology (an example of the application of this methodology is found in 12 VAC 30-70-500):~~

~~1. The operating cost for the case shall be estimated. Operating cost for the case shall be the charges for the case times the hospital's operating cost-to-charge ratio based on the hospital's cost report data in the base period used to establish the rates in effect in the period for which outlier payment is being calculated.~~

~~2. The hospital specific operating cost amount for the DRG shall be calculated. This shall be equal to the sum of the labor portion of the standardized operating cost per case times the Medicare wage index, and the nonlabor portion of the standardized operating cost per case, multiplied by the relative weight applicable to the case.~~

~~3. The hospital specific operating cost outlier threshold is calculated as follows:~~

~~a. An outlier fixed loss threshold times the statewide average labor portion of operating cost times the Medicare wage index for the hospital, plus~~

~~b. The nonlabor portion of the fixed loss threshold, plus~~

~~c. The DRG operating cost amount for the case (subdivision 2 above).~~

~~4. The case specific excess over the hospital specific operating outlier threshold is calculated. This shall be equal to the difference between the estimated operating cost for the case (subdivision 1 above) and the hospital~~

specific operating cost outlier threshold (subdivision 3 above), multiplied by the cost adjustment factor for outliers.

5. The total payment for the case is calculated. This shall be equal to the sum of the DRG operating cost amount for the case (subdivision 2 above) and the case specific excess over the hospital specific operating threshold (subdivision 4 above), multiplied by the factor that is used to adjust the standardized operating cost per case in 12 VAC 30-70-250.

C. Data element definitions. Factors and variables used in the above calculation and not already defined are defined as follows:

1. The "outlier fixed loss threshold" is a fixed dollar amount in SFY1997, applicable to all hospitals, that shall be adjusted each year. It shall be calculated each year, based on the most recent available estimates so as to result in a total operating expenditure for outliers equal to 5.1% of total operating expenditures, including outliers. In SFY1997, this amount shall be $15,483. If in any year revised estimates are unavailable the previous year's value shall be used updated for inflation using the same factor applied to hospital rates.

2. The "statewide average labor proportion of operating cost" is a fixed percentage, equal to .5977. This figure may be updated with revised data when rates are rebased/recalibrated.

3. The "adjustment factor for outliers" is a fixed factor, published by Medicare in the Federal Register, and equal to 0.80. This figure shall be updated based on changes to the Medicare factor, upon the next rebasing of the system described in this part.

4. The "Medicare wage index applicable to the hospital" is as published by the Health Care Financing Administration in the year used as the base period.

~~12 VAC 30-70-300. Transfers and readmissions.~~

~~A. Transfer cases shall be defined as (i) patients transferred from one general acute care hospital to another and (ii) patients discharged from one general acute care hospital and admitted to another for the same or similar diagnosis (similar diagnoses shall be defined as ones with the first three digits the same) within five days of that discharge.~~

~~B. Readmissions shall be defined as cases readmitted to the same hospital for the same or 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 admission or case (a separate DRG payment shall not be made).~~

~~C. Exceptions.~~

~~1. Cases falling into DRGs 456, 639, or 640 shall not be treated as transfer cases, but the full DRG rate shall be paid to the transferring hospital. These DRGs are designed to be populated entirely with transfer patients.~~

~~2. Cases transferred to or from a distinct part psychiatric or rehabilitation units of a general acute care hospital shall not be treated as transfer cases.~~

~~D. Transfer methodology. When two general acute care hospitals provide inpatient services to a patient defined as a transfer case:~~

~~1. The transferring hospital shall receive the lesser of (i) a per diem payment equal to the DRG payment for the transferring hospital, divided by the arithmetic mean length of stay for the DRG in all hospitals for which data are available, times the patient's length of stay at the transferring hospital or (ii) the full DRG payment for the transferring hospital. The transferring hospital shall be eligible for outlier payments if the applicable criteria are met.~~

2. The receiving hospital, if it is the final discharging hospital, shall receive DRG payment. A receiving hospital that later transfers the patient to another hospital, including the first transferring hospital, shall be reimbursed as a transferring hospital. Only the final discharging hospital shall receive DRG payment. The receiving hospital shall be eligible for outlier payments if the applicable criteria are met.

12 VAC 30-70-310. Per diem reimbursement in the DRG methodology.

Cases that will continue to be reimbursed on a per diem basis are (i) covered psychiatric cases in general acute care hospitals and psychiatric units of general acute care hospitals, (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals, and (iii) rehabilitation cases in both general acute care and rehabilitation hospitals. Psychiatric cases are 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 the Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1A&B (12 VAC 30-50-95 through 12 VAC 30-50-310).

12 VAC 30-70-320. Calculation of standardized costs per day.

A. Standardized operating costs per day and standardized capital costs per day were calculated separately, but using the same calculation methodology, for psychiatric cases in general acute care hospitals, psychiatric acute care in freestanding psychiatric facilities licensed as hospitals, and rehabilitation cases (per diem cases). Using the data elements identified in the following table, the first five steps outlined below were completed on a case-by-case basis.

Data Elements for Calculating Total Costs for Per Diem Cases

Data Elements	Source
Total charges for each acute care psychiatric case	Claims Database

~~Total charges for each freestanding acute care psychiatric case~~	~~Claims Database~~
~~Total charges for each rehabilitation case~~	~~Claims Database~~
~~Ratio of operating costs to total costs for each hospital~~	~~Medicaid Cost Report Database~~
~~Ratio of capital costs to total costs for each hospital~~	~~Medicaid Cost Report Database~~
~~Ratio of Direct Medical Education costs to total costs for each hospital~~	~~Medicaid Cost Report Database~~
~~Statewide average labor portion of operating costs~~	~~Virginia Health Services Cost Review Council~~
~~Medicare wage index for each hospital~~	~~Federal Register~~
~~Medicare GAF for each hospital~~	~~Federal Register~~
~~RCC for psychiatric distinct part unit for each hospital~~	~~Medicare Cost Report~~

RCC for each hospital	Medicaid Cost Report Database
Number of acute care psychiatric days at each hospital	Claims Database
Number of freestanding acute care psychiatric days at freestanding psychiatric facilities licensed as hospitals	Claims Database
Number of rehabilitation days at each acute care hospital and freestanding rehabilitation hospital	Claims Database

B. Steps in calculation of standardized cost per day.

1. The total charges for the case were split into operating charges, capital charges, and Direct Medical Education charges using hospital specific ratios obtained from the cost report database.

2. The operating charges obtained in Step 1 were standardized for regional variations in wages. This involved three substeps.

a. The operating charges were multiplied by 59.77% yielding the labor portion of operating charges.

b. The labor portion of operating charges was divided by the hospital specific Medicare wage index yielding the standardized labor portion of operating charges.

c. The standardized labor portion of operating charges was added to the nonlabor portion of operating charges (40.23%) yielding standardized operating charges.

3. The standardized operating charges were multiplied by the hospital specific RCCs yielding standardized operating costs.

4. The capital charges obtained in Step 1 were divided by the hospital specific Medicare geographic adjustment factor (GAF) yielding standardized capital charges.

5. The standardized capital charges were multiplied by the hospital specific RCCs yielding standardized capital costs.

These five steps were repeated for all per diem cases. The standardized operating costs for per diem cases were then summed and divided by the total number of per diem days yielding the standardized operating costs per day for per diem cases. Similarly, the standardized capital costs for per diem cases were summed and divided by the total number of per diem days yielding the standardized capital costs per day for per diem cases. These two calculations were done separately for psychiatric cases in freestanding psychiatric facilities licensed as hospitals, for psychiatric cases in general acute care hospitals (including distinct part units) and for rehabilitation cases.

C. Where general acute care hospitals had psychiatric distinct part units (DPUs) reported on their cost reports, separate RCCs were calculated for the DPUs and used in lieu of the hospital specific RCCs. Since DPU specific RCCs are generally higher than hospital specific RCCs, this had the effect of increasing the estimated costs of acute care psychiatric cases. Overall hospital RCCs were used for freestanding acute care psychiatric cases and rehabilitation cases, as well as for psychiatric cases at general acute care hospitals without a psychiatric DPU.

12 VAC 30-70-330. Calculation of statewide operating rate per day.

The statewide hospital operating rate per day that shall be used to calculate the DRG system portion of operating reimbursement for psychiatric and rehabilitation cases admitted and discharged in SFY1997 is equal to the standardized operating cost per day updated to the midpoint of SFY1997 and multiplied by an additional factor. The update shall be done by multiplying the standardized operating cost per day by the DRI Virginia moving average

value as compiled and published by DRI/McGraw Hill under contract with DMAS. The additional factor for per diem cases in general acute care hospitals and rehabilitation hospitals is equal to 0.6290, and 0.6690 for freestanding psychiatric facilities licensed as hospitals. These factors were calculated so that per diem cases will be reimbursed the same percentage of cost as DRG cases based on the data used for rate calculation.

Per diem rates used for acute care hospitals during the transition shall be operating rates only and capital shall be reimbursed on a pass through basis. Per diem rates used for freestanding psychiatric facilities licensed as hospitals shall be inclusive of capital. The capital inclusive statewide per diem rate for freestanding psychiatric facilities licensed as hospitals shall be the standardized cost per day calculated for such hospitals adjusted for the wage index and the geographic adjustment factor (GAF) and multiplied by the factor above.

12 VAC 30-70-340. Calculation of hospital specific operating rate per day.

Each hospital specific operating rate per day shall be the labor portion of the statewide operating rate per day multiplied by the Medicare wage index applicable to the hospital's geographic location plus the nonlabor portion of the statewide operating rate per day. The Medicare wage index shall be the one in effect for Medicare in the base period used in the calculation of the standardized costs per case (1993 for the calculation of 1997 rates).

The hospital specific rate per day for freestanding psychiatric facilities licensed as hospitals shall be inclusive of capital cost, and shall have a capital portion which shall be adjusted by the GAF and added to the labor and nonlabor operating elements calculated as described above. The geographic adjustment factor shall be taken from the same time period as the Medicare wage index.

12 VAC 30-70-350. Prospective per case reimbursement of capital after transition period (1998). (Reserved)

12 VAC 30-70-360. Indirect medical education (IME).

Hospitals with programs in graduate medical education shall receive a rate adjustment for associated indirect costs. This reimbursement for IME costs recognizes the increased use of ancillary services associated with the

~~educational process and the higher case-mix intensity of teaching hospitals. The IME adjustment shall employ the equation shown below.~~

~~$\text{IME percentage} = 1.89 \times ((1 + r)^{0.405} - 1)$~~

~~In this equation, r is the ratio of interns and residents to staffed beds. The IME adjustment shall be the IME percentage, times 0.4043, times operating reimbursement for DRG cases and per diem cases.~~

~~12 VAC 30-70-370. Updating rates for inflation.~~

~~DRG system rates in SFY1997 shall be as provided in 12 VAC 30-70-270 and 12 VAC 30-70-340. Rates for state fiscal years after SFY1997 shall be updated for inflation as follows:~~

~~1. The statewide operating rate per case as calculated in 12 VAC 30-70-250 and the statewide rates per day as calculated in 12 VAC 30-70-310 shall be converted to a price level at the midpoint of state fiscal year 1993, using the same inflation values as were used to establish the amounts used in subdivision 1 of 12 VAC 30-70-250. The resulting rates are the base period operating rates per case and the base period rates per day.~~

~~2. Rates shall be updated each July first by increasing the 1993 base period rates to the midpoint of the upcoming state fiscal year using the DRI Virginia moving average value as compiled and published by DRI/McGraw Hill under contract with DMAS. The most current table available prior to the effective date of the new rates shall be used. By means of this method, each year, corrections made by DRI/McGraw Hill in the moving averages that were used to update rates for previous years shall automatically be incorporated as adjustments to the update calculation used for the upcoming year. For each new year's rate calculation that uses a base year prior to 1997, the inflation values shall be the DRI/McGraw Hill values plus two percentage points for each year through SFY1997.~~

~~12 VAC 30-70-380. Recalibration/rebasing policy.~~

~~DMAS recognizes that claims experience during the transition period or modifications in federal policies may require adjustment to the DRG system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the weights assigned to cases) and rebase (review and update as appropriate the cost basis on which the rate is developed) the DRG system at least every other year. The first such recalibration and rebasing shall be done prior to full implementation~~ of the ~~DRG methodology in SFY1999. Recalibration and rebasing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12 VAC 30-70-490.~~

~~12 VAC 30-70-390. Disproportionate Share Hospital (DSH) payments after transition period (1998). (Reserved)~~

~~Article 4.~~

~~Revised Per Diem Methodology.~~

12 VAC 30-70-400. Determination of per diem rates.

This Article shall be applicable to only those claims for discharges prior to July 1, 1999. Each hospital's revised per diem rate or rates to be used during the transition period (SFY 1997 and SFY 1998) shall be based on the hospital's previous peer group ceiling or ceilings that were established under the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, with the following adjustments:

1. All operating ceilings will be increased by the same proportion to effect an aggregate increase in reimbursement of $40 million in SFY1997. This adjustment incorporates in per diem rates the system-wide aggregate value of payment that otherwise would be made through the payment adjustment fund. This adjustment will be calculated using estimated 1997 rates and 1994 days.

2. Starting July 1, 1996, operating ceilings will be increased for inflation to the midpoint of the state fiscal year, not the hospital fiscal year. Inflation shall be based on the DRI-Virginia moving average value as compiled and

published by DRI/McGraw-Hill under contract with DMAS, increased by two percentage points per year. The most current table available prior to the effective date of the new rates shall be used.

For services to be paid at SFY1998 rates, per diem rates shall be adjusted consistent with the methodology for updating rates under the DRG methodology (12 VAC 30-70-370).

3. There will be no disproportionate share hospital (DSH) per diem.

4. To pay capital cost through claims, a hospital specific adjustment to the per diem rate will be made. At settlement of each hospital fiscal year, this per diem adjustment will be eliminated and capital shall be paid as a pass-through.

5. This methodology shall be used after the transition period to reimburse days of hospital stays with admission dates before July 1, 1996.

6. This methodology shall be used after the transition period to make interim payments until such time as the DRG payment methodology is operational.

12 VAC 30-70-410. State university teaching hospitals.

For hospitals that were state owned teaching hospitals on January 1, 1996, all the calculations which support the determination of hospital specific rate per case and rate per day amounts under the ~~DRG reimbursement~~ prospective payment methodology shall be carried out separately from other hospitals, using cost data taken only from state university teaching hospitals. Rates to be used ~~effective July 1, 1996,~~ shall be determined on the basis of cost report and other applicable data ~~pertaining to the~~ facility ~~fiscal year ending June 30, 1993~~ from the most recent year for which reliable data are available at the time of rebasing. ~~For these hospitals the factors used to establish rates shall~~

~~be as listed below according to the section in Article 3 (12 VAC 30-70-220 et seq.) of this part where corresponding factors for other hospitals are set forth:~~

~~1. 12 VAC 30-70-250. 0.8432~~

~~2. 12 VAC 30-70-330. 0.8470~~

12 VAC 30-70-420. Reimbursement of ~~nonenrolled~~ non-cost-reporting-general acute care hospital providers.

~~During the transition period, nonenrolled general acute care hospitals (general acute care hospitals that are not required to file cost reports) shall be reimbursed according to the previous methodology for such hospitals (12 VAC 30-70-120 A). Effective with discharges after June 30, 1998, these hospitals shall be paid based on DRG rates unadjusted for geographic variation.~~ Non-Cost-reporting general acute care hospitals (general acute care hospitals that are not required to file cost reports) shall be paid based on the methodology specified in 12 VAC 30-70-120 until such time as the Department can implement the DRG claims payment methodology. Once the DRG claims payment methodology is operational, non-cost-reporting general acute care hospitals shall be paid based on the statewide operating rate per case (12 VAC 30-70-330) increased by the average capital percentage among hospitals filing cost reports in a recent year. Effective with discharges after the operational date of the DRG claims payment system, these hospitals shall be paid based on DRG rates unadjusted for geographic variation. General acute care hospitals shall not file cost reports if they have less than 1000 days per year (in the most recent provider fiscal year) of inpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.

Prior approval must be received from DMAS when a referral has been made for treatment to be received from a nonenrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

12 VAC 30-70-430. Medicare upper limit.

For participating and nonparticipating facilities, the state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2) or the lesser of reasonable cost or customary charges in 42 CFR 447.250.

12 VAC 30-70-440. Repealed.

12 VAC 30-70-450. Cost reporting requirements.

Except for ~~nonenrolled~~ non-cost-reporting general acute care hospitals and freestanding psychiatric facilities licensed as hospitals, all hospitals shall submit cost reports. All cost reports shall be submitted on uniform reporting forms provided by the state agency and by Medicare. Such cost reports shall cover a 12-month period. Any exceptions must be approved by the state agency. The cost reports are due not later than 150 days after the provider's fiscal year end. All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the program shall take action in accordance with its policies to ensure that an overpayment is not being made. When cost reports are delinquent, the provider’s interim rate shall be reduced to zero. The reductions shall start on the first day of the following month when the cost report is due. After the delinquent cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to the state agency. The cost report will be judged complete when the state agency has all of the following:

1. Completed cost reporting form or forms provided by DMAS, with signed certification or certifications.

2. The provider's trial balance showing adjusting journal entries.

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of changes in financial position, and footnotes to the financial statements. Multi-level facilities shall be governed by 12 VAC 30-70-450 (5 below).

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report.

5. Hospitals which are part of a chain organization must also file:

a. Home office cost report;

b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report, and footnotes to the financial statements;

c. The hospital's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value.

6. Such other analytical information or supporting documents requested by the state agency when the cost reporting forms are sent to the provider.

12 VAC 30-70-460. Hospital settlement.

A. During the transition period claims will be processed and tentative payment made using per diem rates. Settlements will be carried out to ensure that the correct blend of DRG and per diem-based payment is received by each general acute care and rehabilitation hospital and to settle reimbursement of pass-through costs. There shall be no settlement of freestanding psychiatric facilities licensed as hospitals except with respect to disproportionate share hospital (DSH) payment, if necessary (see ~~12 VAC 30-70-210 E 3).~~12 VAC 30-70-300 E)

B. The transition blend percentages which determine the share of DRG system and of revised per diem system reimbursement that is applicable in a given period shall change with the change of the state fiscal year, not the hospital fiscal year.

C. If a hospital's fiscal year does not end June 30, its first year ending after June 30, 1996, contains one or more months under the previous methodology, a "split" settlement shall be done of that hospital's fiscal year. Services rendered through June 30, 1996, shall be reimbursed under the previous reimbursement methodology and services rendered after June 30, 1996, will be reimbursed as described in subsection G of this section.

D. For cases subject to settlement under the blend of DRG and per diem methodologies (cases with an admission date after June 30, 1996), the date of discharge determines the year in which any inpatient service or claim related to the case shall be settled. This shall be true for both the DRG and the per diem portions of settlement. Interim claims tentatively paid in one hospital fiscal year that relate to a discharge in a later hospital fiscal year, shall be voided and reprocessed in the latter year so that the interim claim shall not be included in the settlement of the first year, but in the settlement of the year of discharge. An exception to this shall be rehabilitation cases, the claims for which shall be settled in the year of the "through" date of the claim.

E. A single group of cases with discharges in the appropriate time period shall be the basis of both the DRG and the per diem portion of settlement. These cases shall be based on claims submitted and, if necessary, corrected by 120 days after the providers FYE. Cases which are based on claims that lack sufficient information to support grouping to a DRG category, and which the hospital cannot correct, shall be settled for purposes of the DRG portion of settlement based on the lowest of the DRG weights.

F. Reimbursement for services in freestanding psychiatric facilities licensed as hospitals shall not be subject to settlement.

G. During the transition period settlements shall be carried out according to the following formulas.

1. Settlement of a hospital's first fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Paid days occurring in the hospital's fiscal year before July 1, 1996, times the per diem in effect before July 1, 1996.

(2) Paid days occurring after June 30, 1996, but in the hospital fiscal year, that are related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective on July 1, 1996.

(3) DRG system payment for DRG and psychiatric cases admitted after June 30, 1996, and discharged within the hospital fiscal year times 1/3.

(4) DRG system payment for rehabilitation claims having a "from" date of July 1, 1996, or later and a "through" date within the hospital fiscal year times 1/3.

(5) Paid days from the cases and claims in subdivisions 1 a (3) and (4) of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

b. DSH reimbursement shall be equal to paid days from the start of the hospital fiscal year through June 30, 1996, times the DSH per diem effective before July 1, 1996. There shall be no settlement of DSH after July 1, 1996, as the lump sum amount shall be final.

c. Pass-throughs shall be settled as previously based on allowable cost related to days paid in subdivisions 1 a (1), (2), and (5) of this subsection.

2. Settlement of a hospital's second fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Days occurring in the hospital fiscal year related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective at the time.

(2) DRG system payment for DRG and psychiatric cases discharged in the hospital fiscal year, but before July 1, 1997, times 1/3.

(3) DRG system payment for rehabilitation claims having a "through" date within the hospital fiscal year but before July 1, 1997, times 1/3.

(4) Covered days from the cases and claims and in subdivisions 2 b and c of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

(5) DRG system payment for DRG and psychiatric cases discharged from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(6) DRG system payment for rehabilitation claims having a "through" date from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(7) Covered days from the cases and claims and in subdivisions 2 a (5) and (6), times the revised system per diem that is effective on July 1, 1997, times 1/3.

b. DSH reimbursement shall be the predetermined lump sum amount.

c. Pass-throughs shall be settled as previously, based on allowable cost related to days paid in subdivisions 2 a (1), (4), and (7).

12 VAC 30-70-470. Underpayments.

When the settlement of a hospital fiscal year indicates that an underpayment has occurred, the state agency shall pay the additional amount to the hospital within 60 days of completion of the settlement.

12 VAC 30-70-480. Refund of overpayments.

A. Lump sum payment. When the settlement of a hospital fiscal year indicates that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where the state agency discovers an

overpayment during desk review, field audit, or final settlement, the state agency shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken unless the hospital disputes the state agency's determination of the overpayment. If the hospital disputes the state agency 's determination, recovery, if any, shall be undertaken after the issue date of any administrative decision issued by the state agency after an informal fact finding conference.

B. Offset. If the hospital has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the hospital has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule. If the hospital cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the hospital shall request an extended repayment schedule at the time of filing or (ii) within 30 days after receiving the DMAS demand letter, the hospital shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a hospital demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the director) may approve a repayment schedule of up to 36 months.

A hospital shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the hospital submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the hospital withdraws from the program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the hospital or by lump sum payments.

D. Extension request documentation. In the request for an extended repayment schedule, the hospital shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the hospital written notification of the approved repayment schedule, which shall be effective retroactive to the date the hospital submitted the proposal.

E. Interest charge on extended repayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the hospital indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the hospital does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, regardless of whether the hospital files a further appeal. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the hospital shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the hospital paid to DMAS.

12 VAC 30-70-490. Medicaid Hospital Payment Policy Advisory Council.

In order to ensure the ongoing relevance and fairness of the prospective payment system for hospital services, the Director of the Department of Medical Assistance Services shall appoint a Medicaid Hospital Payment Policy Advisory Council. The council shall be composed of four hospital or health system representatives nominated by the

Virginia Hospital and Healthcare Association, two senior department staff and one representative each from the Department of Planning and Budget and the Joint Commission on Healthcare. This council will be charged with evaluating and developing recommendations on payment policy changes in areas that include, but are not limited to, the following: (i) utilization reductions directly attributable to the 1995 Appropriations Act utilization initiative and any necessary adjustments to SFY1997 and 1998 DRG rates; (ii) the update and inflation factors to apply to the various components of the delivery system; (iii) the treatment of capital and medical education costs; (iv) the mechanisms and budget implications of recalibration and rebasing approaches; (v) the disproportionate share payment fund and allocation mechanisms; and (vi) the timing and final design of an outpatient payment methodology.

CERTIFIED:

____November 10, 1999____	___/s/ Dennis G. Smith_____
Date	Dennis G. Smith, Director
	Dept. of Medical Assistance Services