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Final Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-80-20, 80-36, and 80-40
Regulation title(s)	Methods and Standards for Establishing Payment Rates; Other Types of Care
Action title	Enhanced Ambulatory Patient Group Outpatient Hospital Reimbursement Methodology
Date this document prepared	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

This action implements a prospective payment methodology for outpatient hospital services. The current cost-based methodology is out-of-date, inefficient and costly. The Enhanced Ambulatory Patient Group (EAPG) methodology assigns outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization to EAPG codes. DMAS converted inpatient hospital services to a similar prospective reimbursement methodology, Diagnosis-Related Groups, in the 1990s. DMAS proposes to implement the EAPG methodology that is a more efficient and predictable reimbursement methodology to pay hospitals that furnish services to Medicaid recipients in an outpatient hospital setting.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

"Enhanced Ambulatory Patient Group (EAPG)" means a defined group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Disease (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

"EAPG relative weight" means the expected average costs for each EAPG divided by the relative expected average costs for visits assigned to all EAPGs.

"Base year" means the state fiscal year for which data is used to establish the EAPG base rate. The base year will change when the EAPG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Cost" means the reported cost as defined in 12VAC30-80-20.A.

"Medicare wage index" is published annually in the Federal Register by the Centers for Medicare and Medicaid Services. The indices used in this section shall be those in effect in the base year.

"Cost-to-charge ratio" equals the hospital's total costs divided by the hospital's total charges. The cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

Statement of final agency action

Please provide a statement of the final action taken by the agency including:1) the date the action was taken;2) the name of the agency taking the action; and 3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages entitled Enhanced Ambulatory patient Group Outpatient Hospital Reimbursement Methodology (12 VAC 30-80-20, 12 VAC 30-80-36, and 12 VAC 30-80-40) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

_____ _____

Date

Cynthia B. Jones, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

The 2013 *Acts of the Assembly*, Chapter 806, Item 307 XX gave the agency the authority to implement the Enhanced Ambulatory Patient Group (EAPG) reimbursement methodology for outpatient hospital services.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The purpose of this action is to produce a permanent regulation from the emergency authority provided in the previous regulatory action. That emergency regulation proposed to implement a prospective payment methodology for outpatient hospital services. The current cost-based methodology is out-of-date, inefficient and costly. DMAS is proposing to implement the EAPG methodology that is a more efficient and predictable reimbursement methodology for hospitals that furnish services to Medicaid recipients in an outpatient hospital setting.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both.

The section of the regulations that is affected by this action is the Methods and Standards for Establishing Payment Rates-Other Types of Care (12 VAC 30-80-20, 36, and 40).

CURRENT POLICY and ISSUES

Medicaid currently reimburses Type Two hospitals 76 percent of operating and capital costs for services furnished in an outpatient hospital setting. Medicaid reimburses lab and outpatient non-emergency hospital emergency departments' claims separately. (See 12 VAC 30-80-30 D 1(b) for explanation of non-emergency ER claims.) Type One hospitals are reimbursed separate percentages of costs for operating and capital costs. Cost-based reimbursement is out-of-date, inefficient, and unpredictable. The proposed prospective EAPG reimbursement methodology is predictable, efficient, and promotes quality of care. DMAS converted inpatient hospital services to a similar prospective reimbursement methodology, Diagnosis-Related Groups, in the 1990s. Inpatient hospital services are reimbursed case rates for DRGs on a prospective basis. EAPGs will be used to reimburse outpatient hospital services on a prospective basis as well and will include reimbursement for lab and non-emergency ER claims.

RECOMMENDATIONS

The new EAPG methodology defines EAPGs as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by hospitals in an outpatient setting. Each EAPG group is assigned an EAPG relative weight that reflects the relative average cost for each EAPG compared to the relative cost for all other EAPGs. For Type Two hospitals, a statewide base rate for outpatient hospital visits shall be calculated using base year cost data inflated to a rate year. The base year costs shall be adjusted to reflect the agency reimbursement policies for emergency room, laboratory, therapy, and pharmacy services. For Type One hospitals, a separate, budget neutral base rate shall be calculated.

The statewide base rate will be adjusted to be hospital-specific based on the geographic location of the hospital facility. The hospital-specific base rate is to be determined by adjusting the labor portion of the statewide base rate by the wage index for the hospital's geographic location and adding the non-labor portion of statewide base rate. The hospital-specific base rate for children's hospitals will reflect a 5-percent differential. The total allowable reimbursement per visit will be determined by multiplying the hospital-specific base rate times the sum of the EAPG relative weights assigned to an outpatient hospital visit. To maintain budget neutral expenditures for outpatient hospital services the base rate will be rebased at least every three years.

The EAPG methodology will be transitioned over a three-and-a-half-year period in 25-percent increments. The transition rates will blend cost-based reimbursement and EAPG reimbursement. DMAS will also calculate a budget neutrality adjustment every six months for up to the first six years of implementation.

The EAPG relative weights implemented will be the weights determined and published periodically by DMAS. The weights will be updated at least every three years at rebasing. New outpatient procedures and new relative weights will be added as necessary between the scheduled weight and rate updates.

To maintain reimbursement of drug rebates for outpatient hospital services, each drug administered in the outpatient hospital setting shall be reimbursed separately to be eligible for drug rebate claiming.

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

This action increases the efficiency and predictability of reimbursement for outpatient hospital services. It also reduces the costs of settlement of reimbursement for outpatient hospital services. This regulatory action poses no disadvantages to the public or the Commonwealth.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

This action does not contain any requirements that are more restrictive than applicable federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

This action does not produce any material impact on any particular locality as it will apply statewide.

Family Impact

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

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

Changes made since the proposed stage

*Please list all changes that made to the text of the proposed regulation and the rationale for the changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. *Please put an asterisk next to any substantive changes.*

Section number	Requirement at proposed stage	What has changed	Rationale for change
12 VAC 30-80-36 A	Definition of 'base year' refers to the Common-wealth notifying providers of changes to base years as they periodically roll up.	Commonwealth has changed to DMAS.	Clarity.
12 VAC 30-80-36 B 3 (c)	Cost percentages are to be adjusted to reflect services paid at the nonemergency reduced rate in the last base year prior to 1/1/2014.	'Base year' was changed to just 'year'.	Also for clarity and to be able to use the most current, full year claims data rather than several years prior to the current date. DMAS needs to use the most recent full year claims history data as it will most accurately reflect providers' costs and billings to Medicaid.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate. Please distinguish between comments received on Town Hall versus those made in a public hearing or submitted directly to the agency or board.

DMAS submitted its proposed stage regulations to the Registrar of Regulations on December 10, 2014, for publication in the December 29, 2014, *Virginia Register* (VR 31:9). The comment period ran from December 29, 2014 through February 27, 2015. No comments were received.

All changes made in this regulatory action

Please list all changes that are being proposed and the consequences of the proposed changes. Describe new provisions and/or all changes to existing sections. Explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC 30-80-20		Describes reimbursement for outpatient hospital services on a cost basis.	End dates cost-based reimbursement for outpatient hospital services but maintains cost reporting requirements and the definition of emergency room triage services for transition purposes.
	12VAC 30-80-36		Implements the EAPG methodology for outpatient hospital reimbursement in a budget neutral manner.
12VAC 30-80-40		Describes reimbursement for pharmacy services.	Defines drug reimbursement under the new EAPG methodology so that drug payments will still be eligible for drug rebates.