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TO: **EMILY MCCLELLAN**
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FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **August 10, 2018**

SUBJECT: **Fast-Track Regulations – Sunset Supplemental Payments (5101/8353)**

I have reviewed the attached fast-track regulations regarding the supplemental payment to private hospital partners of Type One hospitals. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to amend the regulations and if the regulations comport with state and federal law.

I have reviewed these regulations. Based on my review, it is my view that the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, under Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Under Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the Virginia Department of Medical Assistance Services shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

It is my understanding that the proposed changes will amend the State Plan and DMAS is in the process of obtaining the necessary approvals for such amendments from the Centers for Medicare and Medicaid Services. If you have any questions, please contact me at 786-6005.

cc: Kim F. Piner, Esq.

Attachment

Project 5596 - Fast-Track

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Sunset Supplemental Payments

12VAC30-70-428. Supplemental payments for private hospital partners of Type One hospitals.

A. Effective for dates of service on or after October 25, 2011, quarterly supplemental payments will be issued to qualifying private hospitals for inpatient services rendered during the quarter. These supplemental payments will cease effective for dates of service on or after the effective date of the state plan amendments authorizing increased payments to qualifying hospitals from the Provider Rate Assessment Fund established pursuant to Va. Code § 32.1-331.02 and approved by CMS.

B. Qualifying criteria. In order to qualify for the supplemental payment, the hospital must be enrolled currently as a Virginia Medicaid provider and must be owned or operated by a private entity in which a Type One hospital has a nonmajority interest.

C. Reimbursement methodology.

1. Hospitals not participating in the Medicaid disproportionate share hospital (DSH) program shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in any fiscal year shall be the lesser of:

a. The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the fiscal year; or

b. $14,620 per Medicaid discharge for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor) under contract with the department.

2. Hospitals participating in the Medicaid DSH program shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in any fiscal year shall be the lesser of:

a. The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the fiscal year;

b. $14,620 per Medicaid discharge for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor) under contract with the department; or

c. The difference between the limit calculated under § 1923(g) of the Social Security Act and the hospital's DSH payments for the applicable payment period.

D. Limit. Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit per state fiscal year.

12VAC30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed in this section shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 1 e of this section. The upper limit for reimbursement shall be no

higher than payments for Medicare patients in accordance with 42 CFR 447.321. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform Centers for Medicare and Medicaid Services-approved cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, DMAS or its designee shall take action in accordance with its policies to assure that an overpayment is not being made. All cost reports shall be reviewed and reconciled to final costs within 180 days of the receipt of a completed cost report. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form provided by DMAS, with signed certification;

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), and a statement of changes in financial position;

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

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. For dates of service prior to January 1, 2014, outpatient hospital services, including rehabilitation hospital outpatient services and excluding laboratory services.

a. Definitions. The following words and terms when used in this section shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services rendered in emergency departments that DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.

c. Limitation of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at various percentages as noted in subdivisions 1 c (1) and 1 c (2) of this subsection of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

(2) Type Two hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be 77% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be 76% of allowable cost.

d. The last cost report with a fiscal year end on or after December 31, 2013, shall be used for reimbursement for dates of service through December 31, 2013, based on this section. Reimbursement shall be based on charges reported for dates of service prior to January 1, 2014. Settlement will be based on four months of runout from the end of the provider's fiscal year. Claims for services paid after the cost report runout period will not be settled.

e. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

2. Rehabilitation agencies or comprehensive outpatient rehabilitation.

a. Effective July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities that are operated by community services boards or state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

b. Effective October 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities operated by state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

3. Supplement payments to Type One hospitals for outpatient services.

a. In addition to payments for services set forth elsewhere in the State Plan, DMAS makes supplemental payments to qualifying state government owned or operated hospitals for outpatient services furnished to Medicare members on or after July 1, 2010. To qualify for a supplement payment, the hospital must be part of the state academic health system or part of an academic health system that operates under a state authority.

b. The amount of the supplemental payment made to each qualifying hospital shall be equal to the difference between the total allowable cost and the amount otherwise actually paid for the services by the Medicaid program based on cost settlement.

c. Payment for furnished services under this section shall be paid at settlement of the cost report.

4. Supplemental payments for private hospital partners of Type One hospitals. Effective for dates of service on or after October 25, 2011, quarterly supplemental payments shall be issued to qualifying private hospitals for outpatient services rendered during the quarter. These supplemental payments will cease effective for dates of service on or after the effective date of the state plan amendments authorizing increased payments to qualifying hospitals form the Provider Rate Assessment Fund established pursuant to Va. Code § 32.1-331.02 and approved by CMS.

a. In order to qualify for the supplemental payment, the hospital shall be enrolled currently as a Virginia Medicaid provider and shall be owned or operated by a private entity in which a Type One hospital has a nonmajority interest.

b. Reimbursement methodology.

(1) Hospitals not participating in the Medicaid disproportionate share hospital (DSH) program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in a fiscal year shall be the lesser of:

(a) The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid individuals during the fiscal year; or

(b) $1,894 per Medicaid outpatient visit for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor) under contract with the department.

(2) Hospitals participating in the DSH program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in a fiscal year shall be the lesser of:

(a) The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid individuals during the fiscal year;

(b) $1,894 per Medicaid outpatient visit for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor) under contract with the department; or

(c) The difference between the limit calculated under § 1923(g) of the Social Security Act and the hospital's DSH payments for the applicable payment period.

c. Limit. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.