Virginia Regulatory Town Hall

Emergency Regulation
Agency Background Document

Agency Name:	Dept. of Medical Assistance Services; 12 VAC 30
VAC Chapter Number:	Chapters 70 and 80
Regulation Title:	Methods and Standards for Establishing Payment Rates-Inpatient Hospital Care and Other Types of Care
Action Title:	Outpatient Hospital Reimbursement and Graduate Medical Ed.
Date:	May 23, 2002; GOV ACTION NEEDED BY JUNE 27, 2002

Section 9-6.14:4.1(C)(5) of the Administrative Process Act allows for the adoption of emergency regulations. Please refer to the APA, Executive Order Twenty-Four (98), and the *Virginia Register Form, Style and Procedure Manual* for more information and other materials required to be submitted in the emergency regulation submission package.

Emergency Preamble

Please provide a statement that the emergency regulation is necessary and provide detail of the nature of the emergency. Section 9-6.14:4.1(C)(5) of the Administrative Process Act states that an "emergency situation" means: (i) a situation involving an imminent threat to public health or safety; or (ii) a situation in which Virginia statutory law, the Virginia appropriation act, or federal law requires that a regulation shall be effective in 280 days or less from its enactment, or in which federal regulation requires a regulation to take effect no later than 280 days from its effective date. The statement should also identify that the regulation is not otherwise exempt under the provisions of § 9-6.14:4.1(C)(4).

Please include a brief summary of the emergency action. There is no need to state each provision or amendment.

This regulatory action qualifies as an emergency, pursuant to the authority of the *Code of Virginia*, 1950 as amended, § 2.2-4011, because it is responding to a change in the Virginia Appropriations Act that must be effective within 280 days from the date of enactment of the Appropriations Act (HB 30 Item 325 T and U) and this regulatory action is not otherwise exempt under the provisions of the *Code* § 2.2-4006. Since DMAS intends to continue regulating the two issues contained in this emergency regulation past the effective period permitted by this emergency action, it is also requesting approval of its Notice of Intended Regulatory Action in conformance to § 2.2-4007.

This regulatory action proposes two changes in reimbursement methodologies: outpatient hospital services and direct graduate medical education. These issues will be discussed in this order.

OUTPATIENT HOSPITAL REIMBURSEMENT

This action amends the Title XIX State Plan for Medical Assistance to continue to reimburse outpatient hospital services using Medicare principles of cost reimbursement that were in effect as of June 30, 2000. This action is necessary because the Medicare program changed its hospital outpatient reimbursement methodology to Ambulatory Payment Classifications (APCs) effective August 1, 2000. Presently, DMAS' regulations incorporate by reference these Medicare regulations. Failure to remove this direct link from the regulations would require DMAS to automatically follow Medicare's lead with the use of the APC payment methodology. Presently, the DMAS MMIS system is not able to process and pay claims by APCs. Such a change would require significant changes to the current DMAS MMIS. It is anticipated that with implementation of the Department's new MMIS sometime in 2003, the DMAS may consider switching to an APC payment methodology.

DIRECT GRADUATE MEDICAL EDUCATION

This action also amends the Title XIX State Plan for Medical Assistance to revise the means of payment to certain hospital providers for direct Graduate Medical Education (GME) costs. This change is needed in order to provide appropriate Medicaid reimbursement of GME costs at several teaching hospitals.

Basis

Please identify the state and/or federal source of legal authority to promulgate the emergency regulation. The discussion of this emergency statutory authority should: 1) describe its scope; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. Full citations of legal authority and web site addresses, if available for locating the text of the cited authority, should be provided.

Please provide a statement that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the emergency regulation and that it comports with applicable state and/or federal law.

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 the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

OUTPATIENT HOSPITAL REIMBURSEMENT

These provisions on Medicare hospital outpatient reimbursement are codified in Sec. 1833(t) of the *Social Security Act*, and were directed by the Balanced Budget Act of 1997 section 4523.

DIRECT GRADUATE MEDICAL EDUCATION

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 Medicare authority for direct graduate medical education is the Social Security Act §1886(h) and as set forth in 42 *Code of Federal Regulations* § 413.86.

Substance

Please detail any changes, other than strictly editorial changes, that would be implemented. Please outline new substantive provisions, all substantive changes to existing sections, or both where appropriate. Please provide a cross-walk which includes citations to the specific sections of an existing regulation being amended and explain the consequences of the proposed changes. The statement should set forth the specific reasons the agency has determined that the proposed regulatory action would be essential to protect the health, safety or welfare of Virginians. The statement should also delineate any potential issues that may need to be addressed as a permanent final regulation is developed.

The regulatory action applicable to hospital outpatient reimbursement affects the Methods and Standards for Establishing Payment Rates-Other Types of Care: Services Reimbursed on a Cost Basis (Attachment 4.19-B of the State Plan for Medical Assistance (12VAC 30-80-20)). The regulatory action applicable to inpatient hospital Direct Graduate Medical Education (GME) costs revises the regulation section for payment for direct medical education costs (Attachment 4.19-A (12VAC 30-70-281).

OUTPATIENT HOSPITAL REIMBURSEMENT

Currently, Medicaid reimburses outpatient hospital services at 100% of the reasonable costs less a 10% reduction for capital costs and a 5.8% reduction for operating costs. This is the same payment methodology used by Medicare prior to August 1, 2000.

Effective August 1, 2000, the Medicare program changed its outpatient hospital reimbursement methodology to Ambulatory Patient Categories (APC). The APC methodology for outpatient services parallels the Diagnosis Related Groups methodology developed by Medicare for inpatient hospital services. This methodology serves as a way to classify patients, and thereby bill for services rendered, in a systematic, relative manner.

With the implementation of APCs by Medicare, the 10% reduction for capital costs and the 5.8% reduction to operating costs, previously utilized by Medicare and historically relied upon by DMAS, no longer exists. If DMAS were to convert to the new Medicare APC methodology, it would require significant changes to the MMIS. Therefore, since the capital and operating cost reductions are no longer utilized under the Medicare regulations, the Department is stating its intention to retain the Medicare payment methodology in effect before August 1, 2000.

Approximately 101 enrolled hospitals will be affected by this change. Because the Department is not changing the payment methodology, there will be no fiscal impact.

DIRECT GRADUATE MEDICAL EDUCATION

Currently, Medicaid reimburses hospitals for direct medical education costs on an allowable cost basis. Payments for direct medical education costs are made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end. Final payment for direct medical education costs is based retrospectively on the ratio of Medicaid inpatient and outpatient costs to total allowable costs.

Recent revisions to Medicare cost reporting standards require certain teaching hospitals to accumulate and report costs and charges in such a manner that dilutes the ratio of Medicaid charges and costs to total charges and costs. This will result in an inappropriate reduction in the apportionment of Graduate Medical Education (GME) costs related to interns and residents to be reimbursed by Medicaid. The conversion to the proposed prospective method will allow these affected teaching hospitals to retain a more appropriate level of Medicaid reimbursement for GME related costs.

The hospitals that will be affected by this change are those organizations that operate graduate medical education programs for interns and residents. GME costs will be reimbursed prospectively based on a per-resident amount Medicaid-reimbursable GME costs determined for the base year ended in State Fiscal Year 1998 (base year).

As proposed, the reimbursement of GME-related costs will be made on a prospective basis, based on the affected hospitals' GME costs incurred in the base year. This amount will be converted to a per-resident amount for the base period. This per-resident amount will be updated annually by the DRI-Virginia moving average values published by DRI•WEFA, Inc. The updated per-resident amount for each hospital will be multiplied by the full-time resident equivalents reported on the most recent cost report to determine the amount of Medicaid allowable GME costs for that cost reporting period.

Converting the direct Graduate Medical Education reimbursement to the prospective method will allow the affected teaching hospitals to retain their present level of Medicaid reimbursement of GME costs, or approximately $15.5 million for all affected providers and especially $2.0 million for the University of Virginia Hospital System. Failure to implement this change will result in either the absorption of the $2.0 million loss by UVA or payment with 100% General Fund dollars. Making this change in the Medicaid State Plan enables the Commonwealth to claim federal matching dollars for this change thereby reducing the state budget impact.

Alternatives

Please describe the specific alternatives that were considered and the rationale used by the agency to select the least burdensome or intrusive method to meet the essential purpose of the action.

OUTPATIENT HOSPITAL REIMBURSEMENT

Following the Medicare conversion to the use of the APC methodology would require MMIS system changes. Retaining the Medicare principles of reimbursement for hospital outpatient services in effect prior to August 1, 2000, is the most reasonable alternative policy. It will not require any implementation costs or computer system changes and will not require increased staffing or other resources to maintain.

DIRECT GRADUATE MEDICAL EDUCATION

Conversion to the proposed prospective reimbursement method of direct Graduate Medical Education costs based on a per-resident amount is the more appropriate alternative policy. It will require only minor computer system changes and will not require increased staffing or other resources to maintain. As noted above, this conversion to the proposed prospective method of reimbursement of Graduate Medical Education costs will allow the State teaching hospitals to retain a more appropriate level of Medicaid reimbursement for GME related costs. The proposed methodology will not adversely effect other hospitals.

Family Impact Statement

Please provide a preliminary analysis of the potential impact of the emergency action on the institution of the family and family stability including to what extent the 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 regulatory actions will not have any negative effects on the institution of the family or family stability. They will not increase or decrease disposable family income or erode the marital commitment. They will not discourage economic self-sufficiency, self-pride, nor the assumption of family responsibilities.