Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12VAC30, Chapter 70
Regulation title	Methods and Standards for Establishing Payment Rates—Inpatient Hospital Services
Action title	Inpatient Operating, DSH, and IME Payments for Type One Hospitals
Document preparation date	10/26/2003; NEED GOV APPROVAL BY DEC 15TH

This information is required for executive review (www.townhall.state.va.us/dpbpages/apaintro.htm#execreview) and the Virginia Registrar of Regulations (legis.state.va.us/codecomm/register/regindex.htm), pursuant to the Virginia Administrative Process Act (www.townhall.state.va.us/dpbpages/dpb_apa.htm), Executive Orders 21 (2002) and 58 (1999) (www.governor.state.va.us/Press_Policy/Executive_Orders/EOHome.html), and the *Virginia Register Form, Style and Procedure Manual* (http://legis.state.va.us/codecomm/register/download/styl8_95.rtf).

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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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. Do ***not*** *state each provision or amendment or restate the purpose and intent of the regulation.*

The proposed regulation sets forth two parallel actions: (i) to reduce fee-for-service (FFS) operating rates for state teaching hospitals (referred to as "Type One hospitals") to a level commensurate with all other hospitals (referred to as "Type Two hospitals"); and, (ii) to increase payments to Type One hospitals through other means (modifying Indirect Medical Education payments) to compensate for revenue losses due to a federal regulatory change that now precludes the previously used pass-through payments based on Medicaid managed care rates. These suggested changes will not result in new revenues to the Type One hospitals but will maintain the overall previous revenue levels because operating revenues must now be reduced due to federal regulatory changes. These methodology changes will permit the continuation of managed care payments commensurate with fee-for-service (FFS) payments. The goal of these actions is to maintain reimbursements for Type One hospitals at their current levels and thus maintain for Medicaid managed care clients' access to the medical services these hospitals provide.

Basis

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

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements.

The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail 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.

This regulatory action has the potential for a significant impact on the health, safety or welfare of Virginia citizens. The intent of this proposed regulation is to provide changes to the reimbursement methodologies for operating reimbursement, disproportionate share hospital (DSH) payments, and indirect medical education (IME) payments to Type One hospitals. In the absence of these changes, the reduction in reimbursement to Type One hospitals will create a significant disincentive for the Type One hospitals to continue participation in the Medallion II program. If the Type One hospitals choose to not participate in the Medicaid managed care program, the viability of the managed care program in the areas of the Commonwealth served by these hospitals will be threatened. As such, access to a proper level of care will be impeded, therefore threatening the public health.

Substance

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

The section of the State Plan for Medical Assistance that is affected by this action is Methods and Standards for Establishing Payment Rates—Inpatient Hospital Services (Attachment 4.19-A (12 VAC 30-70-291, 70-301, and 70-331)).

Due to a change in federal regulations (42 CFR § 438.6) regarding the actuarial soundness of capitation rates, DMAS is now prohibited from making supplemental payments to Type One hospitals for services these providers render in the DMAS managed care program (Medallion II). This prohibition, effective as of August 13th, 2003, creates a significant disincentive for the Type One hospitals to continue participation in the Medallion II program. If the Type One hospitals choose to not participate in the Medicaid managed care program, the viability of the managed care program in the areas of the Commonwealth served by these hospitals will be threatened. This has the potential to reduce access to medical services for the Medicaid population. This proposed regulation changes the reimbursement methodologies for operating reimbursement, disproportionate share hospital (DSH) payments, and indirect medical education (IME) payments to Type One hospitals. These suggested changes will not result in new revenues to the Type One hospitals but will maintain previous payment levels to Type One hospitals for the reasons set forth above. These methodology changes will permit the continuation of managed care payments commensurate with fee-for-service payments.

In 1991, DMAS determined it would be appropriate to place the state teaching hospitals in their own peer group (named Type One hospitals) for purposes of Disproportionate Share adjustment payments, known as DSH payments. DSH payments are made to those hospitals that render proportionately higher amounts of care to low-income patients relative to other hospitals. Over the years, Medicaid DSH payments to Type One hospitals have figured significantly in these hospitals' revenues. In addition, Type One hospitals' operating rates are subject to an adjustment factor of one, while Type Two hospitals adjustment factors have historically been less than one. This has contributed to higher payment rates for Type One hospitals relative to Type Two hospitals.

These higher rates are significant in the determination of the capitated rates DMAS pays to participating managed care organizations (MCOs) in the Medallion II program. In calculating capitation rates, DMAS considers all providers' rates. Because Type One hospitals are paid significantly higher rates (due to the adjustment factor), DMAS does not include the Type One hospital rates in the calculations of the Medallion II rates. Instead, Type One hospital fee-for-service data is assigned a "community rate" for capitation rate setting purposes, and this rate is less than those facilities' actual fee-for-service cost experience. To promote participation by the Type One hospitals in Medallion II, DMAS had made supplemental payments to the Type One hospitals based on the difference in payment under fee-for-service versus payment under Medallion II with the lower community rate. In light of the recently initiated federal managed care requirements, regarding the capitation rates' actuarial soundness, DMAS is no longer able to continue this approach. Thus the need arose to adjust payment to Type One hospitals through an alternative methodology in order to avoid the loss of these providers from the Medallion II program.

To address this situation, this proposed regulation sets forth two parallel actions: (i) to reduce FFS operating rates for Type One hospitals to a level commensurate with Type Two hospitals; and, (ii) to increase payments to the Type One hospitals through other means to compensate them for revenue losses due to the federal regulatory change.

Equalizing Type One and Type Two Operating Payments

The Medicaid program recognizes that Type One hospitals incur higher operating costs because of their disproportionately higher share of Medicaid patients. The recently reduced Type One hospital adjustment factor is not sufficient to address these additional costs. Therefore, DMAS is proposing a methodology change that will calculate an adjustment factor that causes the Type One hospital statewide operating rate per case to equal the statewide operating rate per case as calculated for the Type Two hospitals. This serves to bring fee-for-service reimbursement at Type One hospitals in line with reimbursement levels utilized in calculating the managed care capitation rates under Medallion II.

An undesirable consequence of the reduction in operating payments to Type One hospitals is also a reduction in DSH payments. DSH payments are directly related to the fee-for-service operating payments, so any reduction in operating payments will serve to reduce the DSH payments as well. Consequently, DMAS is proposing to incorporate a "DSH factor" into the calculation of Type One hospital DSH payments that will essentially equal those payments in relation to the effect of the reduction in operating payments. Essentially, the DSH factor will produce DSH payment amounts for Type One hospitals that are equivalent to current Type One DSH payment levels.

Increasing Type One Hospital Payments Through Other Means

In order to maintain total Medicaid payments to Type One hospitals at current levels, the reduction in operating payments on the fee-for-service side must be offset with additional payments elsewhere. DMAS is proposing to offset the operating payment reductions through enhancement of the indirect medical education (IME) payment levels for the Type One hospitals. The basic goal is to provide IME payments equaling payments calculated under the current IME methodology, plus an additional amount equaling the reduction on the fee-for-service operating side under the new adjustment factor. DMAS has determined that a multiplier applied to the current IME percentage is the most efficient way to accomplish this goal. Because IME is calculated for Medicaid managed care business as well, this multiplier will result in additional IME payment to cover what DMAS had previously paid Type One hospitals as supplemental payments described above.

The net effect of these three changes will be the maintenance of overall payment levels to Type One hospitals. Because this is simply a shifting of payments currently in the fee-for-service operating side and the Medallion II program to the IME program, with DSH payments held harmless, there is no additional financial impact on the Commonwealth nor is there added pressure to upper payment limits imposed on the program.

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.

The net effect of these three changes will be the maintenance of payment levels that would be achieved had the current methodology, with the additional payments for Medallion II claims to Type One hospitals, continued unchanged. Because this is simply a shifting of payments currently in the fee-for-service operating side and the Medallion II program to the IME program, with DSH held harmless, there is no additional financial impact on the Commonwealth nor is there added pressure to upper payment limits imposed on the program.

Financial impact

Please identify the anticipated financial impact of the proposed regulation and at a minimum provide the following information:

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures	There is no cost to the state to implement this regulation
Projected cost of the regulation on localities	There is no cost to localities to implement this regulation
Description of the individuals, businesses or other entities likely to be affected by the regulation	Since the purpose of this regulation is to maintain the status quo, no individuals, businesses or other entities are likely to be affected
Agency's best estimate of the number of such entities that will be affected	Two
Projected cost of the regulation for affected individuals, businesses, or other entities	No cost is projected as this item is budget neutral

Alternatives

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

DMAS was unable to identify any viable alternatives to the suggested proposed regulation.

Public comment

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

DMAS' emergency regulations were published in the September 8, 2003, *Virginia Register* (19:26) along with the Notice of Intended Regulatory Action (NOIRA). No comments were received on the emergency regulations or on the NOIRA notice (September 8th through October 8th).

Impact on family

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

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

Detail of changes

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

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

Current section number	Current requirement	Proposed change and rationale
12VAC30-70-291	Sets forth formula for calculating the IME percentage for Type One hospitals	Inserts a clause stating that the IME Factor in the formula is to be assigned a value for each Type One hospital to insure that the total payments (operating payments plus fee-for-

		service IME) remain the same as calculated under the previous methodology.
12VAC30-70-301	Sets forth the formula for calculating the DSH payment for Type One hospitals	Inserts a clause stating that the formula values are to be adjusted to insure that current DSH payments to Type One hospitals remain the same as under the previous methodology
12VAC30-70-331	Sets forth the formula for calculating the statewide operating rate per case	Inserts a clause stating that the adjustment factor for Type One hospitals shall be a calculated percentage that causes the Type One Hospital statewide operating rate per case to equal the Type Two Hospital statewide operating rate per case