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Fast-Track Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation(s)	_12_ VAC_30_-_70__
Regulation title(s)	Methods and Standards for Establishing Payment Rates—Inpatient Hospital Services
Action title	All Patient Refined Diagnosis-Related Group Payment Methodology; Reimbursement for Non-cost reporting hospitals
Date this document prepared	4/13/2015

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 (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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 regulation replaces the All Patient Diagnosis-Related Group (AP-DRG) classification system with the All Patient Refined Diagnosis-Related Group (APR-DRG) system for inpatient hospital operating reimbursement. Effective October 1, 2014, the new grouper described in the regulatory action replaces the existing DRG classification system. This action also updates reimbursement for non-cost-reporting hospitals.

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 entitled All Patient Refined Diagnosis-Related Group Payment Methodology; Reimbursement for Non-cost-reporting hospitals with the attached amended regulations (12 VAC 30-70-221; 12 VAC 30-70-251; 12 VAC 30-70-420) and adopt the action stated therein. I certify that this fast track regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

4/13/2015 /signature/

Date Cynthia B. Jones, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including: 1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable; and 2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person'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.

Based on authority under Item 301 VVV of Chapter 2 of the *2014 Acts of the Assembly*, this action replaces the existing DRG classification system for all inpatient hospital services.

DMAS is relying on the general authority of the *Code* § 32.1-325 for the authority to remove the 1,000 day threshold to exempt hospitals from filing cost reports.

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 replace the existing DRG classification system for inpatient hospital services. The current methodology is unsustainable given the implementation of the International Classification of Disease (ICD) version 10 scheduled for October 1, 2015. The purpose is also to improve the accuracy of pricing and reimbursement by capturing differences in severity of illness among patients receiving inpatient hospital services.

This action also updates reimbursement for non-cost-reporting hospitals removing the 1,000 days threshold as a requirement to exempt non-cost-reporting hospitals from filing cost reports.

Rationale for using fast-track process

Please explain the rationale for using the fast-track process in promulgating this regulation. Why do you expect this rulemaking to be noncontroversial?

This proposed regulatory change is being promulgated through the fast track process because it is expected to be non-controversial. Department of Medical Assistance Services (DMAS) consulted with the Virginia Hospital and Healthcare Association (VHHA) and the affected providers and considered the advice of the Hospital Payment Policy Advisory Committee. VHHA actively participated in the development of the new methodology and indicated that it would not object to the new methodology. The affected providers are satisfied with new DRG classification system; therefore, no opposition is expected as a result of this fast track regulatory action.

Removing the 1,000 day threshold for determining whether a hospital is required to file a cost report is expected to be well received by providers so no objections are expected.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.

The sections of the *Virginia Administrative Code* affected by this action are Methods and Standards for Establishing Payment Rates-Inpatient Hospitals Services (12VAC30-70-221: General; 12VAC30-70-251: Operating Payment for Transfer Cases; 12VAC30-70-420: Reimbursement of Non-cost-Reporting General Acute Care Hospital Providers).

Based on authority under Item 301 VVV of Chapter 2 of the *2014 Acts of the Assembly*, the inpatient hospital operating reimbursement methodology is being amended to replace the AP-DRG with a more refined grouper stratifying the severity of illness. This change was originally scheduled for July 1, 2014, but was delayed due to the budget uncertainty.

The AP-DRG methodology in effect prior to October 1, 2014, assigned DRGs based on the diagnosis and procedure codes submitted on inpatient hospital claims excluding inpatient acute psychiatric and rehabilitation hospital services. With the implementation of International Classification of Diseases, edition 10 (ICD-10), the current AP-DRG classification system will no longer be supported by software vendors.

DMAS implemented a new inpatient hospital claim classification system capable of processing ICD-10 claims effective October 1, 2014. The APR-DRG Classification System developed by 3M uses discharge information to classify patients into clinically meaningful groups; the patients grouped into each DRG are similar in terms of both clinical characteristics and the hospital resources they consume. Being a more refined grouper, APR-DRG uses 4 SOI (Severity of Illness) levels to create more specific groupings.

The 3M APR-DRG software improves the accuracy of pricing and reimbursement by capturing differences in severity of illness among patients. While the primary goal of transitioning to APR-DRG is to improve the accuracy of pricing and reimbursement, the current AP-DRG software will not be updated for ICD-10 diagnosis codes while the APR-DRG software will be. By implementing now, providers will have a year of experience with APR-DRG using ICD-9 diagnoses before the transition to ICD-10 diagnoses effective for dates of discharge on or after October 1, 2015.

DMAS is transitioning to APR-DRG by blending AP-DRG and APR-DRG weights over a three-year period. Operating rates were developed based on the blend of the current AP-DRG weights and the new APR-DRG weights. Using a three-year transition period, the weights will be based on the following blend of AP-DRG and APR-DRG weights:

- SFY 2015 – 50% APR-DRG and 50% AP-DRG
- SFY 2016 – 75% APR-DRG and 25% AP-DRG
- SFY 2017 – 100% APR-DRG (Full Implementation)

This action is estimated to be budget neutral in the aggregate. Individual facility payments may increase or decrease under the new methodology; however, the new payment methodology is not expected to increase inpatient hospital operating payments for hospitals in the aggregate.

DMAS is removing the 1,000 day threshold for exempting non-cost-reporting hospitals from filing cost reports. Non cost-reporting hospitals will be reimbursed the in-state average DRG rates.

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 actions identified in the regulation package do not impact the public or citizens of the Commonwealth. These actions change the reimbursement methodology for inpatient hospital services. The primary advantage for hospitals of these changes is the availability of commercial software to support their implementation of the ICD-10 as federally required. There are no disadvantages to the hospitals of this change of the APR-DRG methodology. There are also no disadvantages to non-cost-reporting hospitals of the removal of threshold for filing cost reports.

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.

There are no requirements that exceed 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.

There will be no localities that are more affected than others as these requirements will apply statewide.

Regulatory flexibility analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

This regulatory action was undertaken to adjust the inpatient hospital operating reimbursement methodology based on Chapter 2 of the *2014 Acts of the Assembly*, Item 301 VVV.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

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**	The action is budget neutral in aggregate.
Projected cost of the new regulations or changes to existing regulations on localities.	None.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	All hospitals providing inpatient hospital services.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	There are approximately 100 in-state and out-of-state cost reporting hospitals serving Virginia Medicaid members. Only a few of them would qualify as small businesses.
All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including: **a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and** **b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.**	This action is budget neutral. No additional administrative cost is expected for providers.
Beneficial impact the regulation is designed to produce.	This action allows the State to comply with federal mandates to convert to ICD-10 and recognize differences in the severity of illness for inpatient hospital stays. This action also clarifies reimbursement for non-cost-reporting hospitals.

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. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

This regulatory action was undertaken to meet federal mandates and produce a sustainable payment methodology for hospitals that serve the impoverished and medically needy. The Hospital Payment Policy Advisory Council considered alternatives, including delaying the implementation.

Public participation notice

If an objection to the use of the fast-track process is received within the 30-day 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 agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register; and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

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.

Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please list separately: (1) all differences between the **pre**-emergency regulation and this proposed regulation; and 2) only changes made since the publication of the emergency regulation.*

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements

12VAC 30-70-221		Established the Medicaid prospective payment methodology that uses a Diagnosis Related Group (DRG) methodology and applies it to acute care hospitals, rehabilitation hospitals, and freestanding psychiatric hospitals. Defines needed terms for this methodology.	Replaces the All Patient-DRG version with All Patient Refined-DRG grouper for hospital inpatient reimbursement. The APR-DRG method adds a severity level to patients' rankings in order to more accurately determine appropriate reimbursement based on resource utilization. The new APR-DRG system will be phased in over three years.
12VAC 30-70-251		Defines operating payment for transfer cases.	Identifies the APR-DRGs which are not to be treated as transfer cases.
12VAC30-70-420		Establishes reimbursement requirements for non-cost-report filing general acute care hospitals.	Non-cost-reporting hospitals will be reimbursed the in-state average DRG rates. Removes 1,000-day cost-reporting threshold requirement.