Virginia Regulatory Town Hall

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Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12VAC 30 - 70-291 AND 70-301
Regulation title	Methods and Standards for Establishing Payment Rates-Inpatient Hospital Care
Action title	Elimination of Disproportionate Share Hospital Payment for Medicaid-Recognized Neonatal Intensive Care Unit Programs and Modification of Indirect Medical Education Payments
Document preparation date	; NEED GOV APPROVAL BY

This form is used when an agency wishes to promulgate an emergency regulation (to be effective for up to one year), as well as publish a Notice of Intended Regulatory Action (NOIRA) to begin the process of promulgating a permanent replacement regulation.

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).

Preamble

The APA (Section 2.2-4011) states that an "emergency situation" is: (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.

1) Please explain why this is an "emergency situation" as described above.
2) Summarize the key provisions of the new regulation or substantive changes to an existing regulation.

The Administrative Process Act (Section 2.2-4011) states that an "emergency situation" is: (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. This suggested emergency regulation meets the standard at *COV* 2.2-4011(ii) as discussed below.

The Governor is hereby requested to approve this agency's adoption of the emergency regulations entitled Methods and Standards for Establishing Payment Rates-Inpatient Hospital Care: Elimination of Disproportionate Share Hospital Payment for Medicaid-Recognized Neonatal Intensive Care Unit Programs and Modification of Indirect Medical Education Payments (12 VAC 30-70-291 and 70-301) and also authorize the initiation of the permanent rule promulgation process provided for in § 2.2-4007.

Purpose

Please describe the subject matter and intent of the planned regulatory action. Also include a brief explanation of the need for and the goals of the new or amended regulation.

This regulatory action proposes to eliminate the Disproportionate Share Hospital (DSH) payment for Medicaid-recognized Neonatal Intensive Care Unit (NICU) programs and to modify indirect medical education payments.

Legal basis

Other than the emergency authority described above, please identify the state and/or federal legal authority to promulgate this proposed regulation, including: 1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and 2) promulgating entity, i.e., 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.

Item 326(OO) ***(verify after Act is signed)*** of 2004 Appropriations Act directs DMAS to eliminate a separate Disproportionate Share Hospital (DSH) payment calculation for hospitals with state-recognized Neonatal Intensive Care Unit (NICU) programs and to increase Indirect Medical Education (IME) payments, in total, to offset any net reduction in net payments as a result of this action. This regulatory action eliminates the language directing a separate DSH payment for recognized NICU providers, and amends the current multiplier used in the calculation of IME payments to private hospitals to generate additional IME payments for private hospitals to compensate for the net reduction to private hospital DSH payments caused by the elimination of NICU DSH.

Substance

Please detail any changes that are proposed. Please outline new substantive provisions, all substantive changes to existing sections, or both where appropriate. Set forth the specific reasons why the regulation is essential to protect the health, safety, or welfare of Virginians. Delineate any potential issues that may need to be addressed as a permanent final regulation is developed.

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

The budget language calls for the elimination of Neonatal Intensive Care Unit Disproportionate Share Hospital (NICU DSH) payments but makes this change budget neutral through an enhancement in Indirect Medical Education (IME) payments.

Currently, the Commonwealth provides Medicaid DSH funding separately based on medical/surgery hospital utilization (including psychiatric hospital utilization), NICU utilization (for certain recognized programs), and rehabilitation hospital utilization. Under the current methodology, Virginia's Medicaid program recognizes NICU programs in six private hospitals (including two out-of-state hospitals) and both Type One hospitals (MCV/VCU and UVa).

Under current regulations, Medicaid pays DSH monies specifically based on Medicaid NICU utilization percentages at these eight hospitals. The same methodology for calculation of Medicaid DSH payments is followed for NICU DSH as is followed for medical/surgery care DSH and rehabilitation DSH in terms of the thresholds for qualification and the basic formula to calculate payment. There are significant differences, however, in the methods used between the private hospitals and the Type One (public) hospitals.

For both types of hospitals (public and private), however, this calculation is dependent on an estimation of Medicaid operating payments specific to these NICU programs based on a percentage of total Medicaid operating payments derived from 1997 allowable costs data. DMAS has not been able to collect more current data comparable to the 1997 data since the shift to the Diagnosis Related Groups (DRG) payment system. DMAS has had concerns that the 1997 data has become obsolete, which was the impetus for the elimination of the NICU DSH payment methodology.

With the elimination of NICU DSH for these providers, the Medicaid NICU days and the estimate of Medicaid NICU operating payments are rolled back into the total, which is used in the calculation of medical/surgery disproportionate share. This serves to increase overall Medicaid utilization at these hospitals, and serves to increase their estimated operating payments – both of these variables drive the calculation of the medical/surgery disproportionate share amount. This results in an increase in medical/surgery disproportionate share payment at those NICU DSH hospitals that that also qualify for the medical/surgery disproportionate share payment.

The increase in medical/surgery disproportionate share payment related to this methodology change, however, does not fully offset the loss in NICU DSH payments for the private hospitals. Therefore, the net loss in DSH is offset by a concomitant increase in IME payments for private hospitals through a modification to the IME formula. In that formula, the payment is dependent upon a multiplier – this multiplier has been modified to provide additional funding across the IME program for private hospitals equal to the net loss in DSH funding due to the elimination of NICU DSH. Because the IME formula is not hospital specific, it is not possible for this methodology change to produce budget neutrality on the individual hospital level, but rather the methodology produces budget neutrality among the private hospitals as a group.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-70-301		Sets forth the formula for calculating the DSH payment, including NICU	Elimination of a NICU DSH calculation
12VAC30-70-291		Sets forth formula for calculating the IME payments	Modification to IME formula to offset net DSH loss from elimination of NICU DSH

Alternatives

Please describe all viable alternatives to the proposed regulatory action that have been or will be considered to meet the essential purpose of the action.

These items were defined by the Appropriations Act and therefore no alternatives are possible.

Family impact

Please assess the impact of the emergency 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.