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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

CHAPTER 70.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES; INPATIENT HOSPITAL CARE.

PART V.
INPATIENT HOSPITAL PAYMENT SYSTEM.

Article 1.
Application of Payment Methodologies.

12 VAC 30-70-200. Repealed.

12 VAC 30-70-201. Application of payment methodologies.

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) of this part describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) of this part describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals shall be subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Inpatient hospital facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be reimbursed costs except for inpatient psychiatric services furnished under early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals younger than age 21. These inpatient services shall be reimbursed according to 12 VAC 30-70-415 and shall be provided according to the requirements set forth in Attachment 3.1 A&B, Supplement 1, Item 4b (pp 6 et seq. of 45) (12 VAC 30-50-130) and Attachment 3.1 C (p 1.1 of 43 et seq. (12 VAC 30-60-25(H)). Facilities may also receive disproportionate share hospital (DSH) payments. The criteria for DSH eligibility and the payment amount shall be based on subsection G of 12VAC30-70-50. If the DSH limit is exceeded by any facility, the excess DSH payments shall be distributed to all other qualifying DBHDS facilities in proportion to the amount of DSH they otherwise receive.

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D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pre-transplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. These services shall continue to be subject to 12 VAC 30-50-100 through 12 VAC 30-50-310 and 12 VAC 30-50-540.

D. Reduction of Payments Methodology.

1. For state fiscal years (FYEs) 2003 and 2004, the DMAS shall reduce payments to hospitals participating in the Virginia Medicaid Program by $8,935,825 total funds, and $9,227,815 total funds respectively. For purposes of distribution, each hospital's share of the of the total reduction amount shall be determined as follows:

2. Determine base for revenue forecast:

   a. The Department of Medical Assistance Services (DMAS) shall use, as a base for determining the payment reduction distribution for hospitals Type I and Type II, net Medicaid inpatient operating reimbursement and out patient reimbursed cost, as recorded by the DMAS for state fiscal year 1999 from each individual hospital settled cost reports. This figure is further reduced by 18.73%, which represents the estimated state wide HMO average percent of Medicaid business for those hospitals engaged in HMO contracts, to arrive at net baseline proportion of non-HMO hospital Medicaid business.

   b. For freestanding psychiatric hospitals, the DMAS shall use estimated Medicaid revenues for the 6 month period (1-1-01 through 6-30-01), times two, and adjusted for inflation by 4.3% for state fiscal '02, 3.1% for state fiscal '03, and 3.7% for state fiscal '04 as reported by DRI-WEFA, Inc.'s hospital input price level percentage moving average.

3. Determine forecast revenue:

   a. Each Type I hospital's individual state fiscal '03 & '04 forecast reimbursement is based on the proportion of non-HMO business (see 2. a. above) with respect to DMAS forecast of SFY '03 & '04 inpatient and out patient operating revenue for Type I hospitals.

   b. Each Type II, including freestanding psychiatric, hospital's individual state fiscal '03 & '04 forecast reimbursement is based on the proportion of non-HMO business (see 2. a. and 2. b above) with respect to the DMAS forecast of SFY '03 & '04 inpatient and out patient operating revenue for Type II hospitals.

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4. Each hospital's total yearly reduction amount is equal to their respective state fiscal '03 and '04 forecast reimbursement as described above in 3.a. and 3.b., times 3.235857 percent for state fiscal '03, and 3.235857 percent, for the first two quarters of state fiscal '04 and 2.88572 percent for the last two quarters of state fiscal year '04, not to be reduced by more than $500,000 per year.

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in 4 above. Payment reduction offsets not covered by claims remittance by May 15, 2003 and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30.

F. Provider Preventable Conditions.

Effective July 1, 2012, reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

1. Payment for Hospital Acquired Conditions (HACs) shall be adjusted in the following manner. For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by DMAS. For example, an inpatient claim with 45 covered days identified with an HAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

2. No payment shall be made for inpatient services for the following Never Events: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; (iii) surgical or other invasive procedure performed on the wrong patient.

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3. No reduction in payment for a provider preventable condition shall be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

4. Reductions in provider payment may be limited to the extent that the following apply:

a. The identified provider-preventable conditions would otherwise result in an increase in payment.

b. The Commonwealth can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

5. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

6. In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

12 VAC 30-70-205. REPEALED.

Article 2.
Prospective (DRG-Based) Payment Methodology.

12 VAC 30-70-210. Repealed.

12 VAC 30-70-211. Reserved.

12 VAC 30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

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1. As stipulated in 12 VAC 30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times the relative weight of the DRG to which the case is assigned.

2. As stipulated in 12 VAC 30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12 VAC 30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12 VAC 30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12 VAC 30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12 VAC 30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. For Type Two hospitals, payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full time equivalent (FTE) interns and residents as reported on the cost report. Effective April 1, 2012, payment for direct graduate medical education (GME) for interns and residents for Type One hospitals shall be 100 percent of allowable costs.

7. As stipulated in 12 VAC 30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12 VAC 30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is re-based and re-calibrated. In subsequent re-basing, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

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"Base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" reflects the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases".

"Cost" means allowable cost as defined in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid inpatient utilization rate in excess of 14%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

3. Subdivision 2 of this definition does not apply to a hospital:

   a. At which the inpatients are predominantly individuals under 18 years of age; or

   b. Which does not offer non-emergency obstetric services as of December 21, 1987.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

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"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days and non-paid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth. Effective July 1, 2014, the definition for Medicaid utilization percentage is defined in Attachment 4.19-A, page 10.1 (12 VAC 30-70-301 B).

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The costs shall be calculated by multiplying the per diems and ancillary cost-to-charge ratios from each hospital's cost report ending in the state fiscal year used as the base year to the corresponding days and ancillary charges by revenue code for each hospital's groupable cases.

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"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and include (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A&B (12 VAC 30-50-95 through 12 VAC 30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" occur when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute

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care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. "Type Two" hospitals means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper. Effective October 1, 2014, "ungroupable cases" means cases assigned to DRG 955 (ungroupable) and DRG 956 (ungroupable) as determined by the APR-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Effective October 1, 2014, DMAS shall replace the AP-DRG grouper with the All Patient Refined Diagnosis Related Groups (APR-DRG) grouper for hospital inpatient reimbursement. The APR-DRG Grouper will produce a DRG as well as a severity level ranging from 1 to 4. DMAS shall phase in the APR-DRG weights by blending in 50 opercent of the full APR-DRG weights with 50 percent of FY 2014 AP-DRG weights for each APR-DRG group and severity level in the first year. In the second year, the blend will be 75 percent of full APR-DRG weights and 25 percent of the FY 2014 AP-DRG weights. Full APR-DRG weights shall be used in the third year and succeeding years for each APR-DRG group and severity. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identified key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology

Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports

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Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims History File
Outlier adjustment factor	Federal Register

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12 VAC 30-70-230. Repealed.

12 VAC 30-70-231. Operating payment for DRG cases.

A. The operating payment for DRG cases that are not transfer cases shall be equal to the hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the DRG relative weight, as determined in 12 VAC 30-70-381.

B. Exceptions.

1. Special provisions for calculating the operating payment for transfer cases are provided in 12 VAC 30-70-251.

2. Readmissions shall be considered a continuation of the same stay and shall not be treated as a new case.

12 VAC 30-70-240. Repealed.

12 VAC 30-70-241. Operating payment for per diem cases.

A. The operating payment for acute care psychiatric cases and rehabilitation cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321, times the covered days for the case.

B. The payment for freestanding psychiatric cases shall be equal to the hospital specific rate per day for freestanding psychiatric cases, as determined in subsection B of 12 VAC 30-70-321, times the covered days for the case.

12 VAC 30-70-250. Repealed.

12 VAC 30-70-251. Operating payment for transfer cases.

A. The operating payment for transfer cases shall be determined as follows:

1. A transferring hospital shall receive the lesser of (i) a per diem payment equal to the hospital's DRG operating payment for the case, as determined in 12 VAC 30-70-231, divided by the arithmetic mean length of stay for the DRG into which the case falls times the length of stay for the case at the transferring hospital or (ii) the hospital's full DRG operating payment for the case, as determined in 12 VAC 30-70-231. The transferring hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

2. The final discharging hospital shall receive the hospital's full DRG operating payment, as determined in 12 VAC 30-70-231. The final discharging hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

B. Exceptions.

1. Cases falling into DRG 456, 639, or 640 shall not be treated as transfer cases. Effective October 1, 2014, cases falling into DRG 580 and 581 shall not be treated as transfer cases. Both the transferring hospital and the final discharging hospital shall receive the full DRG operating payment.

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2. Cases transferred to or from a psychiatric or rehabilitation DPU of a general acute care hospital, a freestanding psychiatric facility licensed as a hospital, or a rehabilitation hospital shall not be treated as transfer cases.

12 VAC 30-70-260. Repealed.

12 VAC 30-70-261. Outlier operating payment.

A. An outlier operating payment shall be made for outlier cases. This payment shall be added to the operating payments determined in 12 VAC 30-70-231 and 12 VAC 30-70-251. Eligibility for the outlier operating payment and the amount of the outlier operating payment shall be determined as follows:

1. The hospital's adjusted operating cost for the case shall be estimated. This shall be equal to the hospital's total charges for the case times the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221, times the adjustment factor specified in 12 VAC 30-70-331 B.

2. The adjusted outlier operating fixed loss threshold shall be calculated as follows:

a. The outlier operating fixed loss threshold shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of the outlier operating fixed loss threshold. Hence, the nonlabor portion of the outlier operating fixed loss threshold shall constitute one minus the statewide average labor portion of operating costs times the outlier operating fixed loss threshold.

b. The labor portion of the outlier operating fixed loss threshold shall be multiplied by the hospital's Medicare wage index, yielding the wage adjusted labor portion of the outlier operating fixed loss threshold.

c. The wage adjusted labor portion of the outlier operating fixed loss threshold shall be added to the nonlabor portion of the outlier operating fixed loss threshold, yielding the wage adjusted outlier operating fixed loss threshold.

3. The hospital's outlier operating threshold for the case shall be calculated. This shall be equal to the wage adjusted outlier operating fixed loss threshold times the adjustment factor specified in 12 VAC 30-70-331 B plus the hospital's operating payment for the case, as determined in 12 VAC 30-70-231 or 12 VAC 30-70-251.

4. The hospital's outlier operating payment for the case shall be calculated. This shall be equal to the hospital's adjusted operating cost for the case minus the hospital's outlier operating threshold for the case. If the difference is less than or equal to zero, then no outlier operating payment shall be made. If the difference is greater than zero, then the outlier operating payment shall be equal to the difference times the outlier adjustment factor.

B. The outlier operating fixed loss threshold shall be recalculated using base year data when the DRG payment system is recalibrated and rebased. The threshold shall be calculate so as to

result in an expenditure for outlier operating payments equal to 5.1% of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

12 VAC 30-70-270. Repealed.

12 VAC 30-70-271. Payment for capital costs.

A. Inpatient capital costs shall be determined on an allowable cost basis and settled at the hospital's fiscal year end. Allowable cost shall be determined following the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130).

B. For hospitals with fiscal years that are in progress and do not begin on July 1 inpatient capital costs for the fiscal year in progress on those dates shall be apportioned in accordance with subdivisions 1 through 6 of this subsection.

1. Inpatient capital costs apportioned before July 1, 2003, shall be settled at 100% of allowable cost.

2. Effective July 1, 2003 through June 30, 2009, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals shall be settled at 80% of allowable cost.

3. Effective July 1, 2009 through June 30, 2010, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

4. Effective July 1, 2010 through September 30, 2010, inpatient capital costs of Type One hospitals shall be settled at 97% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 72% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 77% of allowable cost.

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5. Effective October 1, 2010 through June 30, 2011, inpatient capital costs of Type One hospitals shall he settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

6. Effective July I, 2011, inpatient capital costs of Type One hospitals shall be settled at 96% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 71% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 76% of allowable cost.

7. Effective July 1, 2019, inpatient capital rates for critical access hospitals shall be increased to 100% of cost reimbursement.

C. The exception to the policy in subsection B of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12VAC30-70-321 B, shall be an all-inclusive payment for operating and capital costs. The capital rate per day determined in 12VAC30-70-321 will be multiplied by the same percentage of allowable cost specified in subsection B of this section.

12 VAC 30-70-280. Repealed.

12 VAC 30-70-281. Payment for direct medical education costs.

A. Direct medical education costs of nursing schools and paramedical programs shall be paid on an allowable cost basis.

1. Payments for these direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

2. Final payment for these direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

B. Effective with cost reporting periods beginning on or after July I, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis, subject to cost settlement as outlined below except that on or after April I, 2012, payment for direct medical education for interns and residents for Type One hospitals shall be 100% of allowable costs as described in Subsection C.

I. The methodology provides for the determination of a hospital-specific base period per-resident amount to initially be calculated from cost reports with fiscal years ending in state fiscal year 1998 or as may be re-based in the future and provided to the public in an agency guidance document. The per-resident amount for new qualifying facilities shall be calculated from the most recently settled cost report. This per-resident amount shall be calculated by dividing a hospital's Medicaid allowable direct CME costs for the base period by its number of interns and residents in the base period yielding the base amount.

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C. The base amount shall be updated annually be the DRI-Virginia moving average values as compiled and published by DRI WEFA, Inc. (12 VACJ0-70-351). The updated per-resident amount will then be multiplied by the weighted number of full time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTEs reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

D. Type One hospitals shall be reimbursed l00 percent of Medicaid allowable FFS and MCO GME costs for interns and residents.

I. Type One hospitals shall submit annually separate FFS and MCO GME cost schedules, approved by the agency, using GME per diems and GME RCCs (ratios of cost to charges) from the Medicare and Medicaid cost reports and FFS and MCO days and charges. Type One hospitals shall provide information on managed care days and charges in a format similar to FFS,

2. Interim lump sum GME payment for interns and residents shall be made quarterly based on the total cost from the most recently audited cost report divided by four and will be final settled in the audited cost report for the fiscal year end in which the payments are made.

E. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

F. DMAS will make supplemental payments to hospitals for qualified graduate medical residencies. Residency programs (along with their hospital partners) will submit applications for this funding each year. The applications will be scored and the top applicants will receive funding. The supplemental payment for each new qualifying residency slot will be $100,000 annually and shall be made for up to four (4) years. Payments to hospitals will be made quarterly. Additional criteria include:

I. Sponsoring institutions or the primary clinical site must be:
   a. Physically located in Virginia;
   b. An enrolled hospital provider in Virginia Medicaid and continue as a Medicaid-enrolled provider for the duration of the funding;
   c. Not subject to a limit on Medicaid payments by the Centers for Medicare and Medicaid Services; and
   d. Accredited-through either the American Osteopathic Association (AOA) or the American Council for Graduate Medical Education (ACGME).
2. Applications must:
   a. Be complete and submitted by the posted deadline;
   b. Request funding for primary care (care (General Pediatrics, General Internal Medicine, or Family Practice) or high-need specialty residencies; and
   c. Provide substantiation of the need for the requested primary care or specialty residency.
3. Programs that are awarded funding in the full must attest (by June I) that the resident(s) have been hired for the start of the academic year and have continued employment with the program each year thereafter.

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12VAC 30-70-290. Repealed.

12VAC30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education. Out-of-state cost reporting hospitals are eligible for this payment only if they have Virginia Medicaid utilization in the base year of at least 12 percent of total Medicaid days. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:
1. Type One hospitals (this formula also applied to Children's Hospital of the King's Daughters (CHKD) effective July 1, 2013) shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

$$\text{IME Percentage for Type One Hospitals} = [1.89 \text{ X } ((1 + r)^{0.405} - 1) \text{ X (IME Factor)}$$

An IME factor shall be calculated for each Type One hospital and shall equal a factor that, when used in the calculation of the IME percentage, shall cause the resulting IME payments to equal what the IME payments would be with an IME factor of one, plus an amount equal to the difference between operating payments using the adjustment factor specified in subdivision B I of 12VAC30-70-331 and operating payments using an adjustment factor of one in place of the adjustment factor specified in subdivision B 1 of 12 VAC 30-70-331.

2. Type Two hospitals (excluding CHKD) shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

$$\text{IME Percentage for Type Two Hospitals} = [1.89 \text{ X } ((1 + r)0.405\text{-}1)] \text{ X } 0.5695$$

In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

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C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

I. For Type Two hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

2. For Type One hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as dete1mined in 12 VAC 30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section. Effective April I, 2012, the operating rate per case used in the formula shall be revised to reflect an adjustment factor of one and case mix adjusted by multiplying the operating rate per case in this subsection by the weight per case for FFS discharges that is determined during rebasing. This formula applied to CHKD effective July 1, 2017.

D. An additional IME payment not to exceed $200,000 in total shall be apportioned among Type Two Hospitals excluding freestanding children's hospitals with Medicaid NICU utilization in excess of 50 percent as reported to the Department of Medical Assistance Services as of March 1, 2004. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

E. An additional IME not to exceed $500,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU days in excess of 4,500 as reported to the Department of Medical Assistance Services as of March 1, 2005, that do not otherwise receive an additional IME payment under subsection D of this section. These payments shall be total of these days among eligible hospitals as reported by March I, 2003.

F. Effective July 1, 2013, total payments of IME in combination with other payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 may not exceed the federal uncompensated care cost limit that disproportionate share hospital payments are subject to. Effective July 1, 2017, IME payments cannot exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject, excluding third party reimbursement for Medicaid eligible patients.

G. Effective July 1, 2018, an additional $362,360 IME payment shall be added to the IME payment calculated in Section B.2 for the Children's National Medical Center.

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12 VAC 30-70-300. Repealed

12 VAC 30-70-301. Payment to disproportionate share hospitals.

A.Definitions. The following words and terms shall have the following meanings unless the context clearly indicates otherwise:

"Uncompensated care costs" or "UCC" means unreimbursed costs incurred by hospitals from serving self-pay, charity, or Medicaid patients without regard to the disproportionate share adjustment payments.

B.Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis and shall be final subject to provisions in subsections E, G, and H.

C.Effective July I, 2014, in order to qualify for DSH payments, DSH eligible hospitals shall have a total Medicaid inpatient utilization rate equal to 14 percent or higher in the base year using Medicaid days eligible for Medicare DSH defined in 42 USC§ 1396r-4(b)(2) or a low income utilization rate defined in 42 USC§ 1396r-4(b)(3) in excess of25 percent. Eligibility for out- of-state cost reporting hospitals shall be based on total Medicaid utilization or on total Medicaid neonatal intensive care unit (NICU) utilization equal to 14 percent or higher. Effective July 1, 2018, Children's National Medical Center (CNMC) shall not be eligible for DSH payments.

D. Effective July 1, 2014, the DSH reimbursement methodology for all hospitals except Type One hospitals shall be the following:

1.Each hospital's DSH payment shall be equal to the DSH per diem multiplied by each hospital's eligible DSH days in a base year. Days reported in provider fiscal years in state FY 2011 (available from the Medicaid cost report through the Hospital Cost Report Information System (HCRIS) as of July 30, 2013) will be the base year for FY 2015 prospective DSH payments. DSH shall be recalculated annually with an updated base year. Future base year data shall be extracted from Medicare cost report summary statistics available through HCRIS as of October 1 prior to next year's effective date.

2.Eligible DSH days are the sum of all Medicaid inpatient acute, psychiatric and rehabilitation days above 14 percent for each DSH hospital subject to special rules for out- of-state cost reporting hospitals. Eligible DSH days for out-of-state cost reporting hospitals shall be the higher of the number of eligible days based on the calculation in the first sentence times Virginia Medicaid utilization (Virginia Medicaid days as a percent of total Medicaid days) or the Medicaid NICU days above 14 percent times Virginia NICU Medicaid utilization (Virginia NICU Medicaid days as a percent of total NICU Medicaid days). Eligible DSH days for out-of-state cost reporting hospitals who qualify for DSH but that have less than 12 percent Virginia Medicaid utilization shall be 50 percent of the days that would have otherwise been eligible DSH days.

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3.Additional eligible DSH days are days that exceed 28 percent Medicaid utilization for Virginia Type Two hospitals, excluding Children's Hospital of the Kings Daughters (CHKD).

4.The DSH per diem shall be calculated in the following manner:

a.The DSH per diem for Type Two hospitals is calculated by dividing the total Type Two DSH allocation by the sum of eligible DSH days for all Type Two DSH hospitals. For purposes of DSH, Type Two hospitals do not include CHKD or any hospital whose reimbursement exceeds its federal uncompensated care cost limit. The Type Two hospital DSH allocation shall equal the amount of DSH paid to Type Two hospitals in state FY 2014 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act (P.L. 111-148) adjusted for the state fiscal year. Effective July 1, 2018, the Type Two hospital DSH allocation shall be reduced by the amount of DSH allocated to the Children's National Medical Center in state FY 2018.

b.The DSH per diem for state inpatient psychiatric hospitals is calculated by dividing the total state inpatient psychiatric hospital DSH allocation by the sum of eligible DSH days. The state inpatient psychiatric hospital DSH allocation shall equal the amount of DSH paid in state FY 2013 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act (P.L. 111-148), adjusted for the state fiscal year. Effective July I, 2017, the annual DSII payment shall be calculated separately for each eligible hospital by multiplying each year's state inpatient psychiatric hospital DSH allocation described above by the ratio of each hospital's uncompensated care cost for the most recent DSH audited year completed prior to the DSH payment year to the uncompensated care cost of all state inpatient hospitals for the same audited year.

c.The DSH per diem for CI-IKD shall be three times the DSH per diem for Type Two hospitals.

5.Each year, the department shall determine how much Type two DSH has been reduced as a result of the Affordable Care Act (P,L. 11 1-148) and adjust the percent of cost reimbursed for outpatient hospital reimbursement.

E.Effective July 1, 2014, the DSH reimbursement methodology for Type One hospitals shall be to pay its uncompensated care costs up to the available allotment. Interim payments shall be made based on estimates of the UCC and allotment. Payments shall be settled at cost report settlement and at the conclusion of the DSH audit.

F.Prior to July I, 2014, hospitals qualifying under the 14% inpatient Medicaid utilization percentage shall receive a DSH payment based on the hospital's type and the hospital's Medicaid utilization percentage.

1. Type One hospitals shall receive a DSH payment equal to:

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a. The sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433.

b. Multiplied by the Type One hospital DSH Factor. The Type One hospital DSH factor shall equal a percentage that when applied to the DSH payment calculation yields a DSH payment equal to the total calculated using the methodology outlined in subdivision 1 a of this subsection using an adjustment factor of one in the calculation of operating payments rather than the adjustment factor specified in subdivision B 1 of 12 VAC 30-70-331.

2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times the hospital's Medicaid operating reimbursement, times 1.2074. Out-of-state cost reporting hospitals with Virginia utilization in the base year of less than 12% of total Medicaid days shall receive 50% of the payment described in this subsection.

3. Hospitals qualifying under the 25% low-income patient utilization rate shall receive a DSH payment based on the hospital's type and the hospital's low-income utilization rate.

a. Type One hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 2%, times 17, times the hospital's Medicaid operating reimbursement.

b. Type Two hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

c. Calculation of a hospital's low-income patient utilization percentage is defined in 42 USC § 1396r-4(b)(3).

4. Each hospital's eligibility for DSH payment and the amount of the DSH payment shall be calculated at the time of each rebasing using the most recent reliable utilization data and projected operating reimbursemnt data available.

a. The utilization data used to dermine eligibility for DSH payment and the amount of the DSH payment shall include days for Medicaid recipeints enrolled in capitated managed care programs.

b. In years when DSH payments are not rebased in the way described above, the previous year's amounts shall be adjusted for inflation.

c. For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recently settled Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

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5. Effective July 1, 2010, DSH payments shall be rebsed for all hospitals with the final calculation reduced by a uniform percentage such that the expenditures in FY 2011 do not exceed expenditures in FY 2010 seaprately for Type One and Type Two hospitals. The reduction shall be calculated after determination of eligiblity. Payments determined in FY 2011 shall not be adjusted for inflation in FY 2012.
6. Effective July 1, 2013, DSH payments shall not be rebased for all hosptials in FY 2014 and shall be frozen at the payment levels for FY 2013 eligible providers.

G. To be eligible for DSH, a hospital shall also meet the requirements in 42 USC § 1396r 4(d). No DSH payment shall exceed any applicable limitations upon such payment established by 42 USC § 1396r 4(g).

H. If making the DSH payments prescribed in the State Plan would exceed the DSH allotment, DMAS shall adjust DSH payments to Type One hospitals. Any DSH payment not made as prescribed in the State Plan as a result of the DSH allotment shall be made upon determination that there is available allotment.

I. Effective July, 1, 2020 a supplemental DSH payment shall be made quarterly for non-state government, public acute care hospitals up to each hospital's hospital-specific DSH (OBRA '93 DSH limit) as determined pursuant to 42 USC § 1396r-4(g). The annual payment total shall be based upon the hospital's disproportionate share limit for the most recent year for which the disproportionate share limit has been calculated subject to the availability of DSH funds under the federal allotment of such funds to the department.

12 VAC 30-70-310. Repealed.

12 VAC 30-70-311. Hospital specific operating rate per case.

A. The hospital's specific operating rate per case shall be equal to the labor portion of the statewide operating rate per case, as determined in 12VAC30-70-331, times the hospital's Medicare wage index plus

B. the nonlabor portion of the statewide operating rate per case.

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12 VAC 30-70-320. Repealed.

12 VAC 30-70-321. Hospital specific operating rate per day.

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12 VAC 30-70-341, times the hospital's Medicare wage index plus the non-labor portion of the statewide operating rate per day.

B. For rural hospitals, the hospital's Medicare wage index used in this section shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher.

C. Effective July 1, 2008, and ending after June 30, 2010, the hospital-specific operating rate per day shall be reduced by 2.683 percent.

12 VAC 30-70-330. Repealed.

12 VAC 30-70-331. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals:

1. For Type One hospitals the adjustment factor 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;

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For Type Two hospitals the adjustment factor shall be:

a. 0.7800 effective July I, 2006 through June 30, 2010.

b. 0.7500 effective July l, 2010 through September 30, 2010.

c. 0.7800 effective October I, 2010 through June 30, 2011.

C. For critical access hospitals, the operating rate shall be increased by using an adjustment factor of 1.0, effective July I, 2019.

12VAC30-70-340. Repealed.

12 VAC 30-70-341. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12 VAC 30-70-371, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B or C of this section.

B. The adjustment factor for acute care rehabilitation cases shall be the one specified in subsection B of 12 VAC30-70-331.

C. The adjustment factor for acute care psychiatric cases for:

I. Type One hospitals shall be the one specified in subdivision BI of 12VAC30-70-33 l times the factor in subdivision C2 of 12 VAC 30-70-341 divided by the factor in subdivision B 2 of 12VAC30-70-331.

2. Type Two hospitals shall be:

a. 0.7800 effective July l, 2006, through June 30, 2007.

b. 0.8400 effective July l, 2007, through June 30, 2010.

c. 0.8100 effective July l, 2010, through September 30, 2010.

d. 0.8400 effective October l, 2010, through September 30, 2010.

3. Effective July I, 2019, for critical access hospitals, the inpatient operating rate per day shall be increased using an adjustment factor or percent of cost reimbursement equal to I00%.

D. Effective July l, 2009, for freestanding psychiatric facilities, the adjustment factor shall be 1.0000.

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12 VAC 30-70-351. Updating rates for inflation.

A. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department shall be used to update the base year standardized operating costs per case, as determined in Attachment 4.19-A, page 13 (12VAC30-70-361), and the base year standardized operating costs per day, as determined in Attachment 4.19-A, page 14 (12VAC30-70-371), to the midpoint of the upcoming state fiscal year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by Global Insight (or its successor), in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.

B. The inflation adjustment for hospital operating rates, disproportionate share hospitals (DSH) payments, and graduate medical education payments shall be eliminated for fiscal year (FY) 2010, with the exception of long stay hospitals.

C. In FY 2011, hospital operating rates shall be rebased; however the 2008 base year costs shall only be increased 2.58% for inflation. For FY 2011 there shall be no inflation adjustment for graduate medical education (GME) or freestanding psychiatric facility rates. The inflation adjustment shall be eliminated for hospital operating rates, GME payments, and freestanding psychiatric facility rates for FY 2012. The inflation adjustment shall be 2.6 percent for inpatient hospitals, including hospital operation rates, GME payments, DSH payments, and freestanding psychiatric facility rates for FY 2013 and 0.0 percent for the same facilities for FY 2014 and 2015. For FY 2017, the inflation adjustment shall be 50% of the adjustment calculated in subsection A above with the exception of 100% inflation for the Children's Hospital of the King's Daughters.

12 VAC 30-70-360. Repealed.

12 VAC 30-70-361. Base year standardized operating costs per case.

A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

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B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per day:

1. The operating costs for each per diem case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

2. The standardized operating costs for each per diem case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs.

3. The base year standardized operating costs per day for acute care psychiatric cases shall be calculated by summing the standardized operating costs for acute care psychiatric cases and dividing by the total number of acute care psychiatric days. This calculation shall be repeated separately for freestanding psychiatric cases and rehabilitation cases.

4. The base year standardized operating costs per case shall be calculated by summing the case-mix neutral standardized operating costs for all DRG cases and dividing by the total number of DRG cases.

5. The base year standardized operating costs per case shall be reduced by 5.1% to create a pool for outlier operating payments. Eligibility for outlier operating payments and the amount of the outlier operating payments shall be determined in accordance with 12 VAC 30-70-261.

C. Because the current cost report format does not separately identify psychiatric costs, claims data shall be used to calculate the base year standardized operating costs per case, as well as the base year standardized operating costs per day described in 12 VAC 30-70-321. At such time as the cost report permits the separate identification of psychiatric costs and the DRG payment system is recalibrated and rebased, cost report data shall be used to calculate the base year standardized operating costs per case and base year standardized operating costs per day.

12 VAC 30-70-370. Repealed.

12 VAC 30-70-371. Base year standardized operating costs per day.

A. For the purpose of calculating the base year standardized operating costs per day, base year claims data for per diem cases shall be used. Base year claims data for DRG cases shall not be used. Separate base year standardized operating costs per day shall be calculated for Type One and Type Two hospitals.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per day:

1. The operating costs for each per diem case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

2. The standardized operating costs for each per diem case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs.

3. The base year standardized operating costs per day for acute care psychiatric cases shall be calculated by summing the standardized operating costs for acute care psychiatric cases and dividing by the total number of acute care psychiatric days. This calculation shall be repeated separately for freestanding psychiatric cases and rehabilitation cases.

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C. For general acute care hospitals with psychiatric DPUs, the psychiatric operating cost-to-charge ratio shall be used in the above calculations.

12 VAC 30-70-380. Repealed.

12 VAC 30-70-381. DRG relative weights and hospital case-mix indices.

A. For the purposes of calculating DRG relative weights and hospital case-mix indices, base year claims data for all groupable cases shall be used. Base year claims data for ungroupable cases and per diem cases shall not be used. In calculating the DRG relative weights, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 4.19-A, page 5 (12 VAC 30-70-221), the following methodology shall be used to calculate the DRG relative weights:

1. The operating costs for each groupable case shall be calculated by multiplying the per diems and ancillary cost-to-charge ratios from each hospital's cost report ending in the state fiscal year used as the base year to the corresponding days and ancillary charges by revenue code for each hospital's groupable cases.

2. The standardized operating costs for each groupable case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of all operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding the standardized operating costs.

3. The average standardized cost per DRG shall be calculated by dividing the standardized operating costs for all groupable cases in the DRG by the number of groupable cases classified in the DRG.

4. The average standardized cost per case shall be calculated by dividing the standardized operating costs for all groupable cases by the total number of groupable cases.

5. The average standardized cost per DRG shall be divided by the average standardized cost per case to determine the DRG relative weight.

C. Statistical outliers shall be eliminated from the calculation of the DRG relative weights. Within each DRG, cases shall be eliminated if (i) their standardized costs per case are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per case and (ii) their standardized costs per day are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per day. To eliminate a case, both conditions must be satisfied.

D. In calculating the DRG relative weights, a threshold of five cases shall be set as the minimum number of cases required to calculate a reasonable DRG relative weight. In those instances where there are five or fewer cases, the department's Medicaid claims data shall be supplemented with Medicaid claims data from another state or other available sources. The DRG relative weights calculated according to this methodology will result in an average case weight that is different from the average case weight before the supplemental claims data was added. Therefore, the DRG relative weights shall be normalized by an adjustment factor so that the average case weight after the supplemental claims data were added is equal to the average case weight before the supplemental claims data were added.

E. The DRG relative weights shall be used to calculate a case-mix index for each hospital. The case-mix index for a hospital is calculated by summing, across all DRGs, the product of the number of groupable cases in each DRG and the relative weight for each DRG and dividing this amount by the total number of groupable cases occurring at the hospital.

12 VAC 30-70-390. Repealed.

12 VAC 30-70-391. Recalibration and re-basing policy.

A. The department recognizes that claims experience or modifications in federal policies may require adjustment to the DRG payment system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the DRG relative weights and hospital case-mix indices) and re-base (review and update the base year standardized operating costs per case and the base year standardized operating costs per day) the DRG payment system at least every three years. Recalibration and re-basing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12 VAC 30-70-490. When re-basing is carried out, if new rates are not calculated before their required effective date, hospitals required to file cost reports and freestanding psychiatric facilities licensed as hospitals shall be settled at the new rates, for discharges on and after the effective date of those rates, at the time the hospitals' cost reports for the year in which the rates become effective are settled.

B. Effective July 1, 2009, rates for freestanding psychiatric facilities shall be re-based using 2005 cost data as the base year. Future re-basings shall be consistent with re-basing for all other hospitals.

C. Effective July 1, 2010, rates for freestanding psychiatric facilities shall not be rebased.

Article 3.
Other Provisions for Payment of Inpatient Hospital Services.

12 VAC 30-70-400. Determination of per diem rates.

This section shall be applicable to only those claims for discharges prior to July 1, 1999. Each hospital's revised per diem rate or rates to be used during the transition period (SFY 1997 and SFY 1998) shall be based on the hospital's previous peer group ceiling or ceilings that were established under the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, with the following adjustment:

1. All operating ceilings will be increased by the same proportion to effect an aggregate increase in reimbursement of $40 million in SFY 1997. This adjustment incorporates in per diem rates the system-wide aggregate value of payment that otherwise would be made through the payment adjustment fund. This adjustment will be calculated using estimated 1997 rates and 1994 days.

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2.Starting July 1, 1996, operating ceilings will be increased for inflation to the midpoint of the statefiscal year, not the hospital fiscal year. Inflation shall be based on the ORI-Virginia moving average value as compiled and published by ORI/McGraw-Hill under contract with DMAS, increased by two percentage points per year. The most current table available prior to the effective date of the new rates shall be used.

For services to be paid at SFY 1998 rates, per diem rates shall be adjusted consistent with the methodology for updating rates under the DRG methodology 12 VAC 30-70-351.

3.There will be no disproportionate share hospital (DSH) per diem.

4.To pay capital cost through claims, a hospital specific adjustment to the per diem rate will be made. At settlement of each hospital fiscal year, this per diem adjustment will be eliminated and capital shall be paid as a pass-through.

5.This methodology shall be used after the transition period to reimburse days of hospital stays with admission dates before July 1, 1996.

6.This methodology shall be used after the transition period to make interim payments until such time as the DRG payment methodology is operational.

12VAC 30-70-410. State university teaching hospitals

For hospitals that were state owned teaching hospitals on January 1, 1996, all the calculations which support the determination of hospital specific rate per case and rate per day amounts under the prospective payment methodology shall be carried out separately from other hospitals, using cost data taken only from state university teaching hospitals. Rates to be used shall be determined on the basis of cost report and other applicable data from the most recent year for which reliable data are available at the time ofrebasing.

12 VAC 30-70-411. Supplemental payments for certain teaching hospitals

Effective for dates of service on or after July 1, 2017, 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 October 1, 2018

A.Qualifying Criteria. The primary teaching hospitals affiliated with an LCME accredited medical school located in Planning District 23 that is a political subdivision of the Commonwealth and an LCME accredited medical school located in Planning District 5 that has a partnership with a public university.

B.Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter equal to the difference between the hospital's Medicaid payments and the hospital's disproportionate share limit (OBRA 93 DSH limit) for the most recent year for which the disproportionate share limit has been calculated divided by four. The supplemental payment amount will be determined prior to the beginning of the fiscal year.

C.Limit. Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit per state fiscal year. In SFYl 9, the upper payment limit shall be prorated for the time period these supplemental payments are in effect.

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12 VAC 30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.
A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12 VAC 30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio of total capital cost to total charges of the hospital, using data available from Medicare cost report.

E. Effective July 1,2014, services provided under arrangement, as defined in 12 VAC 30-50-130(BX6Xa) and (b), shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in Attachment 4.19-B (12 VAC 30-80), to a provider of services under arrangement if all of the following are met:

1. The services are included in the active treatment plan of care developed and signed as described in section 12 V AC 30-60-25(C)(4) and
2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team ' through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.

12 VAC 30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.

A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.
B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all service provided under arrangement that are reimbursed in the manner described in subsection D of this section.
C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the program shall take action in accordance with its policies to assure that an overpayment is not being made'

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A. Effective July 1, 2014, services provided under arrangement, as defined in 12 VAC 30-50-130(B)96)(c), shall be reimbursed directly by DMAS according to the reimbursment methodology prescribed for these providers in 12 VAC 30-80, to a provider of serivces under arrangement if all of the following are met:

1. The services provided under arrangement are inlcuded int eh active written treatment plan of care developed and signed as described in section 12 VAC 30-130-890 and

2. The services provided under arrangement are arranged and overseen by the residential treatment facility treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the residential treatment facility or under contract for sevices provided under arrangement.

12 VAC 30-70-420. Reimbursement of non-cost-reporting general acute care hospital providers.

A. Effective July 1, 2000, non-cost-reporting (general acute care hospitals that are not required to file cost reports) shall be paid based on DRG rates unadjusted for geographic variation increased by the average capital percentage among hospitals filing cost reports in a recent year. General acute care hospitals shall not file cost reports if they have less than 1,000 days per year (in the most recent provider fiscal year) of inpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.

B. Effective July 1, 2011, out-of-state hospitals shall be reimbursed the lesser of the amount reimbursed by the Medicaid program in the facility's home state or the rate defined in the subsection A of this section.

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12 VAC 30-70-420. Reimbursement of non-cost-reporting general acute care hospital providers. (continued)

C. Prior approval must be received from DMAS when a referral has been made for treatment to be received from a non-participating acute care facility (in-state or out-of-state). Prior approval will be granted for inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia under any one of the following conditions. It shall be the responsibility of the non-participating hospital, when requesting prior authorization for the admission of the Virginia resident to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is general practice for recipients in a particular locality to use medical resources in another state except in the case of an emergency because medical resources or supplementary resources are more readily available in another state.

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12 V AC 30-70-425. Supplemental Payments for Non-State Government-Owned Hospitals for Inpatient Services.

A. In addition to payments made elsewhere, effective July 1, 2005, DMAS shall draw down federal funds to cover unreimbursed Medicaid costs for inpatient services provided by non-state government-owned hospitals as certified by the provider through cost reports.

B. A non-state government-owned hospital is owned or operated by a unit of government other than a state.

C.Effective July 1, 2018, additional supplemental payments will be issued to each non-state government owned acute care hospital for inpatient services provided to Medicaid patients.

D.Reimbursement Methodology. The supplemental payment shall equal inpatient hospital clam payments times the Upper Payment Limit (UPL) gap percentage.

a.The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each non-state government owned acute care hospitals between a reasonable estimate of the amount that would be paid under Medicare payment principles for inpatient hospital services provided to Medicaid patients (calculated in accordance with 42 CFR § 447.272) and what Medicaid paid for such services and the denominator is Medicaid claim payments to each hospital for inpatient hospital services provided to Medicaid patients in the same years used in the numerator.

b.The UPL gap percentage will be calculated annually for each hospital using data for the most recent year for which comprehensive annual data are available and inflated to the state fiscal year for which payments are to be made.

c.Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit. If inpatient payments for non-state government owned state nursing facilities would exceed the upper payment limit, the numerator in the calculation of the UPL gap percentage shall be reduced proportionately.

2. Quarterly Payments. After the close of each quarter, beginning with the July l, 2018, to September 30, 2018 quarter, each qualifying hospital shall receive supplemental payments for the inpatient services paid during the prior quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated by multiplying the Medicaid inpatient hospital payments paid in that quarter by the annual UPL gap percentage for each hospital.

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12 VAC 30-70-428. Supplemental Payments for Private Hospital Partners of Type One Hospitals.

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 October I, 2018.

A.Qualifying criteria. In order to qualify for the supplemental payment, the hospital must be currently enrolled as a Virginia Medicaid provider, and must be owned or operated by a private entity where a Type One hospital has a non-majority interest. Qualifying hospitals and their effective dates are listed below:

1. Culpeper Hospital, effective October 25, 2011

2.Prince William Hospital, effective February 11, 2017

3.Haymarket Hospital, effective February 11, 2017

B.Reimbursement methodology. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than 2 years after the year in which the qualifying hospitals' entitlement arises. The annual supplemental payments in any fiscal year will be the lesserof:

1.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

2. $14,620 per Medicaid discharge at Culpeper Hospital for state plan rate year 2012, $9,741 per Medicaid discharge for state plan rate year 2015 for Prince William Hospital and $8,596 per Medicaid discharge for state plan rate year 2015 for Haymarket Hospital. 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).

3.For hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the limit calculated under the Social Security Act§ I923(g) and the hospital's DSH payments for the applicable payment period.

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

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12 VAC 30-70-429. Supplemental Payments for Private Acute Care Hospitals.

A. Effective October 1, 2018, supplemental payments will be issued to qualifying hospitals for inpatient services provided to Medicaid patients.

B. Definitions. As used in this section:

"Acute care hospital" means any hospital that provides emergency medical services on a 24-hour basis.

"Children's hospital" means a hospital (i) whose inpatients are predominantly under 18 years of age and (ii) which is excluded from the Medicare prospective payment system pursuant to the Social Security Act.

"Critical access hospital" means a facility that meets the requirements of the State Medicare Rural Hospital Flexibility Program (Flex), 42 U.S.C. 1395i-4, for such designation.

"Freestanding psychiatric and rehabilitation hospital" means a freestanding psychiatric hospital, which means a hospital that provides services consistent with 42 CFR 482.60, or a freestanding rehabilitation hospital, which means a hospital that provides services consistent with 42 CFR 482.56.

"Hospital" means a medical care facility licensed as an inpatient hospital or outpatient surgical center by the Department of Health or as a psychiatric hospital by the Department of Behavioral Health and Developmental Services.

"Long stay hospital" means specialty facilities that serve individuals receiving medical assistance who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide.

"Long-term acute care hospital" or "LTACH" means an inpatient hospital that provides care for patients who require a length of stay greater than 25 days and is, or proposes to be, certified by CMS as a long- term care inpatient hospital pursuant to 42 CFR Part 412. A LTACH may be either a freestanding facility or located within an existing or host hospital.

"Public hospital" means a hospital that is solely owned by a government or governmental entity.

"Supplemental payment" means an increased payment to a qualifying hospital up to the upper payment limit gap from the Health Care Provider Rate Assessment Fund as authorized in the 2018 Appropriation Act.

"Upper payment limit" means the limit on payment for inpatient services for recipients of medical assistance established in accordance with 42 CFR 447.272 and on payment for outpatient services for recipients of medical assistance pursuant to 42 CFR 447.321 for private hospitals.

"Upper payment limit gap" means the difference between the amount of the private acute care hospital upper payment limits estimated for the rate year using the last available cost report data and the amount estimated would otherwise be paid for the same rate year pursuant to the reimbursement methodology for inpatient and outpatient services. The upper payment limit payment gap shall be updated annually for each rate year.

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C. Qualifying Criteria. Qualifying hospitals are all in-state private acute care hospitals excluding public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, long- term acute care hospitals and critical access hospitals.

D. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital claim payments times the "UPL gap percentage".

1. The annual UPL gap percentage is the percentage calculated when the numerator is the upper payment limit gap for inpatient services for private hospitals and the denominator is Medicaid claim payments to all qualifying hospitals for inpatient hospital services provided to Medicaid patients in the same year used in the numerator.

2. The UPL gap percentage will be calculated annually.

E. Quarterly Payments. After the close of each quarter, beginning with the quarter including the CMS effective date of all necessary state plan amendments authorizing increased payments to qualifying hospitals, each qualifying hospital shall receive supplemental payments for the inpatient services paid during that quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated based on the Medicaid inpatient hospital payments paid in that quarter multiplied by the annual UPL gap percentage.

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12 VAC 30-70-435. Lump sum payment.

1. In addition to the DRG payment, DMAS shall make a one-time, lump sum payment of $12,243,204 to eligible Virginia hospitals participating in the Medicaid program. This payment shall be made in two equal, semi-annual amounts during fiscal year 2001. For purposes of distribution, each hospital's share of the total amount shall be determined as follows:

a. DMAS shall determine the total operating payments due each hospital for inpatient hospital services provided from January 1, 2000, through June 30, 2000, using hospital claims data from discharges in that period.

b. DMAS shall determine the total operating payments that would have been due each hospital for the same services, had the inpatient hospital rates and weights applicable in fiscal year 1998 been continued with inflation for fiscal years 1999 and 2000.

c. The difference between the two values calculated in (i) and (ii) above, summed across all hospitals, is the "statewide difference." Each hospital-specific difference divided by the statewide difference is the hospital-specific percent share of the statewide difference.

d. The hospital-specific percent share of the statewide difference, times the total funds provided by this appropriation, is the hospital-specific lump sum payment to be paid in two equal semi-annual payments during fiscal year 2001. This payment shall be made as an increase to reimbursement for services provided to Medicaid recipients during state fiscal year 2001. For each hospital, the hospital-specific lump sum payment amount shall be divided by the number of DRG cases in the hospital discharged from July 1, 2000, through December 31, 2000, on or before April 30, 2001. This per case amount shall be paid to each hospital for each of the cases discharged by the hospital during this specified time period, as determined by DMAS.

2. The Department of Medical Assistance Services shall provide the data used, specific calculation, and mechanics of the payment adjustment to the Virginia Medicaid Hospital Policy Advisory Council.

12 VAC 30-70-440. Repealed.

12 VAC 30-70-450. Cost reporting requirements.

Except for non-cost-reporting general acute care hospitals and freestanding psychiatric facilities licensed as hospitals, all hospitals shall submit cost reports. All cost reports shall be submitted on uniform reporting forms provided by the state agency and by Medicare. Such cost reports shall cover a 12-month period. Any exceptions must be approved by the state agency. The cost reports are due not later than 150 days after the provider's fiscal year end. All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the program shall take action in accordance with its policies to ensure that an overpayment is not being made. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. The reductions shall start on the first day of the following month when the cost report is due. After

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the delinquent cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to the state agency. The cost report will be judged complete when the state agency has all of the following:

1. Completed cost reporting form or forms provided by DMAS, with signed certification or certifications.

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), a statement of changes in financial position, and footnotes to the financial statements. Multi-level facilities shall be governed by subdivision 5 of this subsection.

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

5. Hospitals which are part of a chain organization must also file:

a. Home office cost report;

b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report, and footnotes to the financial statements;

c. The hospital'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 cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value.

6. Such other analytical information or supporting documents requested by the state agency when the cost reporting forms are sent to the provider.

12 VAC 30-70-460. Hospital settlement.

A. During the transition period claims will be processed and tentative payment made using per diem rates. Settlements will be carried out to ensure that the correct blend of DRG and per diem-based payment is received by each general acute care and rehabilitation hospital and to settle reimbursement of pass-through costs. There shall be no settlement of freestanding psychiatric facilities licensed as hospitals except with respect to disproportionate share hospital (DSH) payment, if necessary (see 12 VAC 30-70-301 E).

B. The transition blend percentages which determine the share of DRG system and of revised per diem system reimbursement that is applicable in a given period shall change with the change of the state fiscal year, not the hospital fiscal year.

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C. If a hospital's fiscal year does not end June 30, its first year ending after June 30, 1996, contains one or more months under the previous methodology, a "split" settlement shall be done of that hospital's fiscal year. Services rendered through June 30, 1996, shall be reimbursed under the previous reimbursement methodology and services rendered after June 30, 1996, will be reimbursed as described in subsection G of this section.

D. For cases subject to settlement under the blend of DRG and per diem methodologies (cases with an admission date after June 30, 1996), the date of discharge determines the year in which any inpatient service or claim related to the case shall be settled. This shall be true for both the DRG and the per diem portions of settlement. Interim claims tentatively paid in one hospital fiscal year that relate to a discharge in a later hospital fiscal year, shall be voided and reprocessed in the latter year so that the interim claim shall not be included in the settlement of the first year, but in the settlement of the year of discharge. An exception to this shall be rehabilitation cases, the claims for which shall be settled in the year of the "through" date of the claim.

E. A single group of cases with discharges in the appropriate time period shall be the basis of both the DRG and the per diem portion of settlement. These cases shall be based on claims submitted and, if necessary corrected by 120 days after the providers FYE. Cases which are based on claims that lack sufficient information to support grouping to a DRG category, and which the hospital cannot correct, shall be settled for purposes of the DRG portion of settlement based on the lowest of the DRG weights.

F. Reimbursement for services in freestanding psychiatric facilities licensed as hospitals shall not be subject to settlement.

G. During the transition period settlements shall be carried out according to the following formulas.

1. Settlement of a hospital's first fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Paid days occurring in the hospital's fiscal year before July 1, 1996, times the per diem in effect before July 1, 1996.

(2) Paid days occurring after June 30, 1996, but in the hospital fiscal year, that are related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective on July 1, 1996.

(3) DRG system payment for DRG and psychiatric cases admitted after June 30, 1996, and discharged within the hospital fiscal year times 1/3.

(4) DRG system payment for rehabilitation claims having a "from" date of July 1, 1996, or later and a "through" date within the hospital fiscal year times 1/3.

(5) Paid days from the cases and claims in subdivisions 1 a (3) and (4) of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

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b. DSH reimbursement shall be equal to paid days from the start of the hospital fiscal year through June 30, 1996, times the DSH per diem effective before July 1, 1996. There shall be no settlement of DSH after July 1, 1996, as the lump sum amount shall be final.

c. Pass-throughs shall be settled as previously based on allowable cost related to days paid in subdivisions 1 a (1), (2), and (5) of this subsection.

2. Settlement of a hospital's second fiscal year ending after July 1, 1996:

a. Operating reimbursement shall be equal to the sum of the following:

(1) Days occurring in the hospital fiscal year related to admissions that occurred before July 1, 1996, times the revised system per diem that is effective at the time.

(2) DRG system payment for DRG and psychiatric cases discharged in the hospital fiscal year, but before July 1, 1997, times 1/3.

(3) DRG system payment for rehabilitation claims having a "through" date within the hospital fiscal year but before July 1, 1997, times 1/3.

(4) Covered days from the cases and claims and in subdivisions 2 b and c of this subsection, times the revised system per diem that is effective on July 1, 1996, times 2/3.

(5) DRG system payment for DRG and psychiatric cases discharged from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(6) DRG system payment for rehabilitation claims having a "through" date from July 1, 1997, through the end of the hospital fiscal year, times 2/3.

(7) Covered days from the cases and claims and in subdivisions 2 a (5) and (6) of this subsection, times the revised system per diem that is effective on July 1, 1997, times 1/3.

b. DSH reimbursement shall be the predetermined lump sum amount.

c. Pass-throughs shall be settled as previously, based on allowable cost related to days paid in subdivisions 2 a (1), (4), and (7) of this subsection.

12 VAC 30-70-470. Underpayments.

When the settlement of a hospital fiscal year indicates that an underpayment has occurred, the state agency shall pay the additional amount to the hospital within 60 days of completion of the settlement.

12 VAC 30-70-480. Refund of overpayments.

A. Lump sum payment. When the settlement of a hospital fiscal year indicates that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where the state agency discovers an overpayment during desk review, field audit, or final settlement, the state agency shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken unless the hospital disputes the state agency's determination of the overpayment. If the hospital disputes the state agency's determination, recovery, if any, shall be undertaken after the issue date of any administrative decision issued by the state agency after an informal fact finding conference.

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B. Offset. If the hospital has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the hospital has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule. If the hospital cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the hospital shall request an extended repayment schedule at the time of filing or (ii) within 30 days after receiving the DMAS demand letter, the hospital shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a hospital demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the director) may approve a repayment schedule of up to 36 months.

A hospital shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the hospital submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the hospital withdraws from the program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the hospital or by lump sum payments.

D. Extension request documentation. In the request for an extended repayment schedule, the hospital shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the hospital written notification of the approved repayment schedule, which shall be effective retroactive to the date the hospital submitted the proposal.

E. Interest charge on extended repayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the hospital indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the hospital does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, regardless of whether the hospital files a further appeal. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the hospital shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the hospital paid to DMAS.

12 VAC 30-70-490. Medicaid Hospital Payment Policy Advisory Council.

In order to ensure the ongoing relevance and fairness of the prospective payment system for hospital services, the Director of the Department of Medical Assistance Services shall appoint a Medicaid Hospital Payment Policy Advisory Council. The council shall be composed of four hospital or health system representatives nominated by the Virginia Hospital and Healthcare Association, two senior

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department staff and one representative each from the Department of Planning and Budget and the Joint Commission on Healthcare. This council will be charged with evaluating and developing recommendations on payment policy changes in areas that include, but are not limited to, the following: (i) utilization reductions directly attributable to the 1995 Appropriations Act utilization initiative and any necessary adjustments to SFY1997 and 1998 DRG rates; (ii) the update and inflation factors to apply to the various components of the delivery system; (iii) the treatment of capital and medical education costs; (iv) the mechanisms and budget implications of recalibration and rebasing approaches; (v) the disproportionate share payment fund and allocation mechanisms; and (vi) the timing and final design of an outpatient payment methodology.

12 VAC 30-70-499. Reserved.