Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30, Chapters 70, 80
Regulation title	Methods and Standards for Establishing Payment Rates-Inpatient and Outpatient Hospitals and Intermediate Care Facilities for the Mentally Retarded
Action title	Methods and Standards for Establishing Payment Rates-Inpatient and Outpatient Hospitals and Intermediate Care Facilities for the Mentally Retarded
Document preparation date	10/26/2003; NEED GOV APPROVAL BY

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

Brief summary

Please provide a brief summary of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation. Do ***not*** *state each provision or amendment or restate the purpose and intent of the regulation.*

This regulation authorizes Medicaid to make supplemental payments to non-state government-owned or operated hospitals and clinics and state government-owned hospitals and clinics equal to the difference between the maximum permitted under federal law and regulations and what they are currently paid under Medicaid.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended regulatory pages Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services (12 VAC 30-70-425 and 12 VAC 30-70-426) and Methods and Standards for Establishing Payment Rates-Other Types of Care (12 VAC 30-80-20 and 12 VAC 30-80-30) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

10/26/2003

Date

/s/ P. W. Finnerty

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Legal basis

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

If the final text differs from the text at the proposed stage, please indicate whether the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the final regulation and that it comports with applicable state and/or federal law.

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

Chapter 899, Items 325CC, 325DD and 325RR of the *2002 Acts of Assembly* authorized the Department of Medical Assistance Services to increase reimbursement for government-owned public nursing homes, hospitals, and clinics consistent with the maximum amount allowed under federal laws and regulations and to enact emergency regulations to carry out these directives. Federal regulations (42 CFR 447.272 and 42 CFR 447.321) allow aggregate payments for government-owned or operated hospitals, nursing homes, ICFs-MR, or clinics up to 100 percent of a reasonable estimate of the amount that would be paid by Medicare.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons it is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The purpose of this regulation is to maximize federal revenue for the state. Under this methodology, DMAS makes supplemental payments to government-owned or operated provider facilities, and receives federal financial participation (FFP) for those payments. DMAS will negotiate transfer agreements prior to making the Medicaid supplemental payments. Assuming that the government-owned or operated providers that receive supplemental payments transfer those payments back to the agency, DMAS is able to make the supplemental payment at no net cost to either the state or the providers. This action is not expected to protect the health, safety or welfare of citizens.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The sections of the State Plan for Medical Assistance affected by this amendment are Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services [Attachment 4.19-A (12 VAC 30-70)], Methods and Standards for Establishing Payment Rates-Other Types of Care [Attachment 4.19-B (12 VAC 30-80)] and Methods and Standards for Establishing Payment Rates-Long-Term Care Services [Attachment 4.19-D (12 VAC 30-90)], sections of which are being deleted.

Under previous regulations, the Department paid most government-owned nursing homes, hospitals, and clinics according to a reimbursement methodology comparable to that applied to other nursing homes, ICFs-MR, hospitals and clinics. The proposed regulation provided for supplemental payments to non-state government-owned hospitals and clinics, and state government-owned nursing homes, ICFs-MR, hospitals, and clinics for inpatient and outpatient services. Previously existing regulations already provided for supplemental payments to non-state government-owned nursing homes. In this final regulation, however, DMAS is deleting the provisions regarding payments to government-owned nursing facilities and ICFs-MR.

Under the previously existing regulations, the total reimbursement to non-state government-owned hospitals and clinics, and state government-owned nursing homes, ICFs-MR, hospitals, and clinics was less than the maximum allowable amount under then current federal law and regulations. The proposed regulatory action provided for DMAS to establish separate reimbursement pools for non-state government-owned hospitals and clinics, and for state government-owned nursing homes, ICFs-MR, hospitals, and clinics for inpatient and outpatient services equal to the difference between current aggregate reimbursement and the maximum

aggregate amount allowed under federal regulations. Each pool was distributed in the form of a supplemental payment to government-owned nursing homes, ICFs-MR, hospitals, and clinics.
The proposed regulations provided supplemental reimbursement for inpatient and outpatient services provided by non-state government-owned hospitals and clinics up to the Medicaid upper payment limit as defined under 42 CFR 447.272 and 42 CFR 447.321. This would include services performed in hospitals or clinics owned or operated by local hospital authorities (Lake Taylor Hospital, Southside Regional Medical Center and Chesapeake General Hospital), some local health departments (Fairfax, Arlington and Richmond), and local community services boards. The maximum reimbursement for non-state government owned or operated hospitals and clinics was a reasonable estimate of the amount that would be paid by Medicare.

The proposed regulations also provided for supplemental reimbursement for inpatient and outpatient services provided by state government-owned nursing homes, ICFs-MR, hospitals, and clinics up to the Medicaid upper payment limit as defined under 42 CFR 447.272 and 42 CFR 447.321. This would include services provided by UVA Medical Center, the VCU Health System, the Virginia Department of Health, and the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. The maximum reimbursement for state government-owned or operated nursing homes, hospitals, and clinics for inpatient and outpatient services was a reasonable estimate of the amount that would be paid by Medicare. In this final regulation, however, the two sections providing for supplemental payments to government-owned or operated nursing facilities and ICFs-MR are being deleted.

Supplemental payments to individual providers may also be subject to limits related to charges and/or disproportionate share hospital (DSH)) payments.

Because approximately 50% of Medicaid payments are federally funded, by maximizing payments to government-owned nursing homes, hospitals, and clinics, the Commonwealth will maximize the federal funding available to Virginia through these increased Medicaid payments. No disadvantages to the public have been identified in connection with this regulation. The agency projects no negative issues involved in implementing this regulatory change.

Providers affected by this action are non-state government-owned hospitals and clinics and state government-owned hospitals and clinics. Localities affected are those having government-owned hospitals, or clinics. Other providers and localities are not affected, and recipients are not affected.

DMAS and the government-owned or operated providers will enter into transfer agreements so that the providers will provide the state match funding for the supplemental payment.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.
If there are no disadvantages to the public or the Commonwealth, please indicate.

Government-owned or operated providers fulfill an important and unique role within the Virginia health care system as safety net providers. Many safety-net providers incur costs for which they are not currently reimbursed that are above and beyond the costs incurred by private providers.

Because approximately 50% of Medicaid payments are federally funded, by maximizing payments to government-owned or operated providers, the Commonwealth will maximize the federal funding available to the public sector in Virginia through these increased Medicaid payments. No disadvantages to the public have been identified in connection with this regulation. The agency projects no negative issues involved in implementing this regulatory change.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

Section number	Requirement at proposed stage	What has changed	Rationale for change
12 VAC 30-70 425.A	All non-state government-owned hospitals would receive a supplemental payment for inpatient services provided on or after July 1, 2002.	Only non-state government-owned hospitals who have signed a transfer agreement would receive a supplemental payment for inpatient services provided on or after December 16, 2001.	Change negotiated with Centers for Medicare and Medicaid Services (CMS) in conjunction with their review of the State Plan Amendment (SPA)
12 VAC 30-70 425.B-E	Describes how the amount to be paid to each participating hospital will be determined and how often it will be paid.	Adds a subsection describing the methodology for determining the total supplemental payment and revises the distribution methodology.	CMS required more detailed methodology; this methodology was accepted by CMS
12 VAC 30-70 426.A	To qualify for a supplemental payment for hospital inpatient services, the hospital must be owned/operated by state.	The state hospital must be part of an academic health system.	Change negotiated with CMS in conjunction with their review of the SPA
12 VAC 30-70 426.B-D	Describes how the amount to be paid to each hospital will be determined.	Adds a subsection describing the methodology for determining the total supplemental payment and revises the distribution methodology.	Change negotiated with CMS in conjunction with their review of the SPA

12 VAC 30-80-20.D.6.a	All non-state government-owned hospitals would receive a supplemental payment for outpatient services provided on or after July 1, 2002.	Only non-state government-owned hospitals that have signed a transfer agreement would receive a supplemental payment for outpatient services provided on or after December 16, 2001.	Change negotiated with CMS in conjunction with their review of the SPA
12 VAC 30-80-20.D.6.b-e	Describes how the amount to be paid to each participating hospital will be determined and how often it will be paid.	Adds a subsection describing the methodology for determining the total supplemental payment and revises the distribution methodology.	Change negotiated with CMS in conjunction with their review of the SPA
12 VAC 30-80-20.D.7.a	To qualify for a supplemental payment for hospital outpatient services, the hospital must be owned or operated by the state.	The state hospital must be part of an academic health system.	Change negotiated with CMS in conjunction with their review of the SPA
12 VAC 30-80-20.D.7.b-d	Describes how the amount to be paid to each hospital will be determined.	Adds a subsection describing the methodology for determining the total supplemental payment and revises the distribution methodology.	Change negotiated with CMS in conjunction with their review of the SPA
12 VAC 30-80-30.A.16.a	To qualify for a supplemental payment for outpatient services, the clinic must be owned or operated by the state.	Payments will be made to Children's Specialty Services, a state government-owned and operated clinic.	Change for administrative efficiency accepted by CMS
12 VAC 30-80-30.A.16.b-d	Describes how the amount to be paid to each state government-owned clinic will be determined.	Adds a subsection describing the methodology for determining the total supplemental payment and revises the distribution methodology.	Change negotiated with CMS in conjunction with their review of the SPA
12 VAC 30-80-30.A.18.a	To qualify for a supplemental payment for outpatient services, the clinic must be non government-owned or operated.	Payments will be made to clinics with estimated payments in 2003 of more than $100,000 and that serve areas covered by managed care prior to January 1, 1998.	Change for administrative efficiency accepted by CMS
12 VAC 30-80-30.A.18.b-d	Describes how the amount to be paid to each non-state government-owned clinic will be determined.	Adds a subsection describing the methodology for determining the total supplemental payment and revises the distribution methodology.	Change negotiated with CMS in conjunction with their review of the SPA
12 VAC 30-90-17	Adds a section providing for supplemental payments to state government-owned or operated ICFs-MR.	Deleted.	DMAS determined that the amount of the supplemental payment was not financially significant
12 VAC 30-90-18	Adds a section providing for supplemental payments to state government-owned or operated nursing homes.	Deleted.	DMAS determined that the amount of the supplemental payment was not financially significant

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate.

No comments were received during the NOIRA public comment period.

DMAS' proposed regulations were published in Volume 19, Issue 15 of *Virginia Register* for their public comment period from 4/7/2003 through 6/7/2003. No public comments were received. DMAS submitted the proposed regulations to Centers for Medicare and Medicaid Services (CMS) for review and approval, however CMS required significant changes in the regulation before it would approve the State Plan Amendment. These changes are reflected in the final regulation.

All changes made in this regulatory action

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

This regulatory package adds new regulations 12 VAC 30-70-425 for supplemental payments to non-state government-owned hospitals and 12 VAC 30-70-426 for supplemental payments to state government owned hospitals for inpatient services. 12 VAC 30-70-425(A) and –426(A) both state that DMAS will make supplemental payments to non-state government-owned hospitals and to state government owned hospitals, respectively, for inpatient services. 12 VAC 30-70-425(B) and –426(B) each set forth the formula for determining the amount and distribution of the supplemental payments to non-state government-owned hospitals and to state government owned hospitals, respectively. The amount of the supplemental payments will be the difference between the upper payment limit determined by federal regulations and the amount normally paid by Medicaid. This amount is then distributed to the hospitals based on the difference between this cap and the lower of the providers' charges or the DSH limits. 12 VAC 30-70-25(C) and –426(C) each indicate that there will be one or more payments as determined by DMAS.

This regulatory package also adds new subsections 6 and 7 to 12 VAC 30-80-20. Subsection 6 addresses supplemental payments to non-state government-owned hospitals and Subsection 7 addresses supplemental payments to state government-owned hospitals for outpatient services. Subsections 6a and 7a indicate that DMAS will make supplemental payments to non-state government-owned hospitals and state government-owned hospitals, respectively, for outpatient services. Subsections 6b and 7b spell out the formula for determining the amount and distribution of the supplemental payment. The amount of the supplemental payments will be the difference between the upper payment limit determined by federal regulations and the amount normally paid by Medicaid. This amount is then distributed to the hospitals based on the difference between the upper payment limit and the lower of the providers' charges or the DSH

limit. Subsections 6c and 7c indicate that there will be one or more payments as determined by DMAS.
This regulatory package adds new subsections 16 and 18 to 12 VAC 30-80-30. Subsection 16 refers to supplemental payments to state government-owned clinics and Subsection 18 refers to supplemental payments to non-state government-owned clinics for outpatient services. Subsections 16a and 18a state that DMAS will make supplemental payments to state government-owned clinics and non-state government-owned clinics, respectively, for outpatient services. Subsections 16b and 18b set forth the formula for determining the amount and distribution of the supplemental payment. The amount is the difference between the upper payment limit determined by federal regulations and the amount normally paid by Medicaid. This amount is then distributed to the clinics based on their portion of the upper payment limit. Subsections 16c and 18c indicate that there will be one or more payments as determined by DMAS.

The proposed regulatory package added new regulations 12 VAC 30-90-17 for supplemental payments to state government-owned ICFs-MR and 12 VAC 30-90-18 for supplemental payments to state government owned nursing homes for inpatient services. In the final regulation, however, both of these sections are deleted.

Impact on family

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

This regulation has no impact on recipients or their families. It will not strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; encourage or discourage economic self-sufficiency, self-pride; the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; strengthen or erode the marital commitment; nor increase or decrease disposable family income.