Virginia Regulatory Town Hall

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Fast Track Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation	12 VAC 30-70, 30-80 and 30-90
Regulation title	Methods and Standards for Establishing Payment Rates: Inpatient Hospital Services, Other Types of Providers, and Long Term Care
Action title	2006 Reimbursement Changes
Document preparation date	

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

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

This action promulgates three health care provider reimbursement enhancements that became effective July 1, 2006, by direct action of the Virginia General Assembly through the 2006 Appropriation Act. These changes are: raising the adjustment factor for private hospitals from 76 percent to 78 percent, a 5 percent reimbursement increase for Pediatric Physician Services**,** and an adjustment of various cost ceilings for nursing facilities that leads to an overall increase in available reimbursement for nursing facilities.

Statement of agency final 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 Agency Background Document with the attached amended State Plan pages: Methods and Standards for Establishing Payment Rates: Inpatient Hospital Services (12 VAC 30-790-331), Other Types of Providers (12 VAC 30-80-190), and Long Term Care (12 VAC 30-90-41, --271 and --290). I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-40 12.1, of the Administrative Process Act and is full, true, and correctly dated.

_____ _____

Date

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 General Assembly bill and chapter numbers, if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the scope of the legal authority and the extent to which the authority is mandatory or discretionary.

The *Code of Virginia* (1950) as amended, 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by §1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services. This Fast-Track regulation is based upon legislative mandates set forth in the 2006 Appropriation Act, Items 302 DD, KK and PP.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal and the problems the proposal is intended to solve.

This regulatory action is intended to implement the mandated rate increases included in the 2006 Appropriation Act, effective July 1, 2006, prior to the completion of the regulatory process. Item 302 DD of the 2006 Appropriation Act changes the methodology for determining nursing facility ceilings and eliminates limits on certain costs effective July 1, 2006. It also clarifies how costs for periods prior to July 1, 2005 will be adjusted in the prospective reimbursement rate-setting. Item 302 KK directed various physician rate increases with effective dates of July 1, 2006. Specifically, the Act mandated a 5 percent increase for Pediatric Services effective July 1, 2006. The other physician rate increases, required to be in effect on July 1, 2007, will be addressed in a future separate regulation package. Finally, Item 302 PP directs the Department of Medical Assistance Services (DMAS) to increase the adjustment factor for private inpatient hospitals

from 76 percent to 78 percent effective July 1, 2006. This action is designed to protect the health and welfare of the Commonwealth; increasing provider reimbursement helps ensure that sufficient medical providers remain in the Medicaid provider network to maintain care coverage for Medicaid enrollees.

Rationale for using fast track process

Please explain why the fast track process is being used to promulgate this regulation.

Please note: If an objection to the use of the fast-track process is received within the 60-day public comment period from (1) 10 or more persons, (2) any member of the applicable standing committee of either house of the General Assembly or (3) any member of the Joint Commission on Administrative Rules, the agency shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

These reimbursement changes are not controversial. The General Assembly mandates were very specific leaving little discretion for the Agency. These changes are currently in effect via direct legislative action; therefore the Fast-Track process appeared the best and most efficient option for implementing permanent regulations as quickly as possible.

Substance

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

The sections of the State Plan for Medical Assistance that are affected by this change are the Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services (12 VAC 30-70-331), Methods and Standards for Establishing Payment Rates-Other Types of Care (12 VAC 30-80-190), and Methods and Standards for Establishing Payment Rates-Long Term Care [12 VAC 30-90-41 (Nursing facility reimbursement formula)] and 12 VAC 30-90-290 (Cost reimbursement limitations).

12 VAC 30-70-331 is being amended to set the adjustment factor to 0.7800. Under the 2005 Appropriation Act, the adjustment factor for private (Type Two) hospitals was set to 0.7600 effective July 1, 2005. The 2006 Appropriation Act has increased the adjustment factor for private hospitals to .7800 effective July 1, 2006. An adjustment factor of .7800 translates to a discount taken by the Virginia Medicaid program of 22 percent relative to the statewide average cost for inpatient hospital care reimbursed through the fee-for-service Medicaid program.

12 VAC 30-80-190 is amended to provide a 5 percent increase to Pediatric Physician Services effective July 1, 2006.

12 VAC 30-90-41 will be amended to delete the provision increasing the ceilings by $3 per day and to set the direct care ceiling at 117 percent and the indirect care ceiling at 107 percent of the day-weighted median of base year cost, effective July 1, 2006.

12VAC30-90-271 will be amended to add IV therapy to the list of covered ancillary services. IV therapy is currently covered only under specialized care. DMAS eliminated specialized care for adult complex health and comprehensive rehabilitation in 2003 because it felt that residents with these needs would receive adequate reimbursement under the regular nursing home methodology with minor adjustments after the 2002 implementation of the case mix system based on Resource Utilization Groups. At that time, kinetic services, previously covered only under specialized care, was added as a covered ancillary service under regular nursing home care. DMAS overlooked IV therapy, which should have also been added as a covered ancillary service under regular nursing home care.

12VAC30-90-290 will be amended to eliminate administrator salary limits, medical director salary limits and management fee limits, except when the administrator, medical director or contracted management firm is a related party. These limits within limits are unnecessary since there is already an overall ceiling on direct and indirect costs.

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 the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

The regulatory action poses no disadvantages to the agency, public or the Commonwealth. The advantages of these reimbursement increases is that with more competitive reimbursement rates, the Medicaid program helps ensure continued access to medical care for the Medicaid population. The only disadvantage is that increased revenues are required in order to fund the reimbursement increase.

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures	**12 VAC 30-70**: SFY '07 -- $7.5 million (GF) and $7.5 million (NGF), and SFY '08 -- $8.4 million (GF) and $8.4 million (NGF). **12 VAC 30-80**: SFY '07 -- $7,000,717 in total funds ($3,323,923 GF, $3,683,793 NGF).

	12 VAC 30-90: SFY '07 -- $3,904,150 (GF) and $7,808,300 total funds. SFY '08 -- $4,036,891 and $8,073,782 total funds. For the addition of IV therapy to the list of covered ancillary services: $7,100 (GF) per year.
Projected cost of the regulation on localities	None.
Description of the individuals, businesses or other entities likely to be affected by the regulation	All the following types of Medicaid providers: hospitals, physicians serving pediatric patients, and skilled nursing facilities.
Agency's best estimate of the number of such entities that will be affected	Approx. 96 hospitals, 6,900 physicians and approx. 260 nursing facilities.
Projected cost of the regulation for affected individuals, businesses, or other entities	No net costs to the individual businesses affected.

Alternatives

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

No other feasible alternatives are available since the General Assembly mandate was so specific.

Family impact

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

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment and is not expected to affect disposable family income.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes.

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

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12 VAC 30-70-331		Sets the adjustment factor to 0.7600 for Type Two hospitals.	Effective July 1, 2006, sets the adjustment factor for Type Two hospitals to 0.7800.
12 VAC 30-80-190	n/a	Defines the RBRVS rate setting methodology for professional fees	The language is modified to increase pediatric fees by five percent and to modify the RBRVS methodology to perpetuate this rate increase in future calculations.
12 VAC 30-90-41		Sets the direct care ceiling at 112 percent and the indirect care ceiling at 103.9 percent of the day weighted median. Adds $3 to the ceilings that would otherwise be calculated effective July 1, 2006 and specifies how costs for periods prior to July 1, 2005 will be adjusted for the $3 when setting facility specific rates based on those costs.	Effective July 1, 2006, eliminates the $3.00 increase in ceilings effective and sets the direct care ceiling at 117 percent and the indirect care ceiling at 107 percent of the day-weighted median. The regulation also clarifies how costs for periods prior to July 1, 2005 will be adjusted for the $3 when setting facility specific rates based on those costs.
12 VAC 30-90-271(C)		List of covered ancillary services reimbursed under regular nursing home care	Adds IV Therapy to the list of covered ancillary services reimbursed by Medicaid.
12 VAC 30-90-290		Establishes cost limits for management fees, medical director fees and administrator/owners.	Effective July 1, 2006, the cost limits apply only to related parties.