Virginia Regulatory Town Hall

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# Exempt Action Final Regulation
# Agency Background Document

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| **Agency name** | DEPT 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 Provider Types, and Long Term Care Services |
| **Action title** | 2011 Technical Corrections for Reimbursement Regulations |
| **Final agency action date** | |
| **Document preparation date** | |

When a regulatory action is exempt from executive branch review pursuant to § 2.2-4002 or § 2.2-4006 of the Virginia Administrative Process Act (APA), the agency is encouraged to provide information to the public on the Regulatory Town Hall using this form.

Note: While posting this form on the Town Hall is optional, the agency must comply with requirements of the Virginia Register Act, the *Virginia Register Form, Style, and Procedure Manual*, and Executive Orders 36 (06) and 58 (99).

## Summary

*Please provide a brief summary of all regulatory changes, including the rationale behind such changes. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.*

The sections of the State Plan for Medical Assistance that are affected by this action are Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services (12 VAC 30-70), Methods and Standards for Establishing Payment Rates-Other Types of Services (12 VAC 30-80), and Methods and Standards for Establishing Payment Rates-Long Term Care Services (12 VAC 30-90).

All of these affected regulations, Chapters 70, 80, and 90, set out the reimbursement methodologies for all Medicaid covered services.

Chapter 70 contains the reimbursement methodology for inpatient hospital services and includes provisions for inflation, disproportionate share adjustments, incentive plans, and an outlier

adjustment for most hospitals that are subject to the Diagnosis Related Grouping (DRG) methodology as well as long stay hospitals which are not subject to DRG. None of these elements are substantively changing. The changes made in 12 VAC 30-70-50 and 12 VAC 30-70-351 are necessary to conform the Virginia Administrative Code to changes that have been made in the State Plan for Medical Assistance at the direction of the Centers for Medicare and Medicaid Services (CMS). CMS is the federal funding agency for Virginia Medicaid and, as such, has the authority to require DMAS to make changes in submitted State Plan language. To prevent discrepancies between its VAC regulations and the State Plan (by which DMAS claims federal matching funds), DMAS makes every effort to maintain consistency between them for the VAC chapters that also occur in the State Plan. 12 VAC 30-70-50 is modified to remove outdated language and add clarifying text as required by CMS. 12 VAC 30-70-201 is modified to clarify that all facilities operated by DBHDS are retrospectively reimbursed costs. 12 VAC 30-70-351 is modified to remove outdated language and add clarification at CMS' requirement.

Chapter 80 contains reimbursement methodologies, both cost-based and fee-for-service, for all other services not addressed by Chapter 70 (hospitals) and Chapter 90 (nursing facilities). The changes to this chapter conform cost report filing requirements to actual practice and eliminate existing text within Chapter 80 because reimbursement for inpatient hospital services is covered in Chapter 70.

Chapter 90 contains reimbursement methodologies for long term care (nursing facilities) services. These changes update federal and state agency names, clarify the reimbursement methodology for facilities operated by Department of Veterans Services and for Intermediate Care Facilities for the Mentally Retarded, and codify the agency's practice of granting exceptions to providers of the NF occupancy requirements.

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 and 325, 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.

All of these changes are technical in nature, effecting no changes in current policies or reimbursement methodologies. Therefore, these changes meet the exemption provided at § 2.2-4006(A)(3) of the Code of Virginia.

## 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 Agency Background document with the attached amended State Plan pages entitled 2011 Technical Corrections for Reimbursement Regulations (12VAC 30-70-50, 12 VAC 30-70-351, 12 VAC 30-80-20, 12 VAC 30-90-10, 12 VAC 30-90-20 and 12 VAC 30-90-60) 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.

_____ _____

Date

Gregg A. Pane, M.D., MPA, Director

Dept. of Medical Assistance Services

## Substance

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

The sections of the State Plan for Medical Assistance that are affected by this action are the Methods and Standards for Establishing Payment Rates—Inpatient Hospital Services (12 VAC 30-70-50, 70-201, and -70-351), Methods and Standards for Establishing Payment Rates-Other Types of Providers (12 VAC 30-80-20) and Methods and Standards for Establishing Payment Rates-Long Term Care Services (12 VAC 30-90-10, -90-20, -90-60).

Chapter 70 contains the reimbursement methodology for inpatient hospital services and includes provisions for inflation, disproportionate share adjustments, incentive plans, and an outlier adjustment. None of these elements are substantively changing. The changes made in 12 VAC 30-70-50 and 12 VAC 30-70-351 are necessary to conform the Virginia Administrative Code to changes that have been made in the State Plan for Medical Assistance at the direction of the Centers for Medicare and Medicaid Services (CMS). To prevent discrepancies between its VAC regulations and the State Plan (by which DMAS claims federal matching funds), DMAS makes every effort to maintain consistency between them for the VAC chapters that also occur in the State Plan.

12VAC 30-70 sections 50, 201, and 351

12 VAC 30-70-50 sets out a number of various elements for the inpatient hospital reimbursement system that preceded the current Diagnosis Related Grouping (DRG) methodology (located at 12 VAC 30-70-200 et seq.). DMAS retains this older methodology for those few participating hospitals (long stay hospitals) for which the DRG methodology is not appropriate.

DMAS is re-stating, for improved clarity, that the escalation factor is equal to the allowance for inflation at the direction of CMS during its process of reviewing a State Plan Amendment (the tenth paragraph of item B). DMAS is modifying the second paragraph of item D because the more general term 'capital' is understood in the industry to include depreciation and capital interest. The example table, in paragraph E, is being removed as it is no longer up to date. The entire item F is being removed because the types of facilities which are subject to the 12 VAC 30-70-50 methodology do not offer neonatal services thereby rendering this provision unnecessary.

12 VAC 30-70-201 is included in this action as the new location for the provision concerning cost based reimbursement for mental disease hospitals caring for persons over 65 years of age. DMAS removed this item from 12 VAC 30-80-20 (Attachment 4.19-B in the State Plan for Medical Assistance).

12 VAC 30-70-351 is part of the current DRG methodology and sets out how DMAS will update its inpatient hospital rates for inflation. Outdated language in paragraph A is deleted as it is no longer necessary. The changes to paragraph B simply restate DMAS' current policy in response to CMS' request for clarity. New paragraph C is labeled to conform to the Registrar's formatting requirements as set out in the Style Manual.

12 VAC 30-80-20

The enrolled cost-based services providers of hospital outpatient services are required to file cost reports. This action permits these providers more time to do so after the close of their fiscal years. The change from 90 to 150 days (as set out in 12 VAC 30-80-20 B) is consistent with the change made many years ago to the cost report requirements for hospital inpatient services in 12 VAC 30-70-450 and is also consistent with agency practice. The provision for inpatient hospital services to persons over 65 years of age in mental disease hospitals (12 VAC 30-80-20 D) is being removed consistent with federal directions. Such reimbursement is included in Chapter 70 (12 VAC 30-70-201). The reference to tuberculosis hospitals for persons over 65 years of age is being removed entirely because there are no longer any such institutions in the Commonwealth. The item that lists rehabilitation hospital outpatient services currently at 12 VAC 30-80-20 D 4 is simply being moved to a new location at 12 VAC 30-80-20 D. These regulatory changes are technical in nature.

12 VAC 30-90 sections, -10, -20, and -60

Superseded references to the Department of Mental Health, Mental Retardation, and Substance Abuse Services are updated to the agency's new name of the Department of Behavioral Health and Developmental Services (DBHDS) (12 VAC 30-90-10). The reference to the Virginia Veterans Care Center is being replaced with a more general reference to nursing facilities which are operated by the Dept. of Veterans Services (12 VAC 30-90-10). Superseded references to the Health Care Financing Administration (the Medicaid federal funding agency) are updated to the current name of the Centers for Medicare and Medicaid Services (CMS) (12 VAC 30-90-20). 12 VAC 30-90-20 is modified to clarify long standing agency policy that Intermediate Care Facilities for the Mentally Retarded are reimbursed retrospectively on the basis of reasonable costs but limited to the highest rate paid to such state institutions, as determined each July 1st.

And finally, DMAS has been granting, in practice, exceptions for nursing facilities (NF) occupancy requirements, as benefits providers, when the NF needed to conduct renovations. This technical change codifies the practice in order to have consistent regulatory standards and operational requirements (12 VAC 30-90-60).

## Family impact

*Assess the impact of this regulatory action on the institution of the family and family stability.*

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.