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 30-60-70
Regulation title	Standards Established and Methods Used to Assure High Quality of Care: Utilization control for Home Health Services
Action title	Physician Certification Standards Revision
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 regulatory action changes DMAS requirements for physician certification and re-certification of home health patient care, to conform to federal Medicare law and regulation for home health services in order to reduce confusion and errors by home health agencies. The changes are as follows: (i) replace the requirement for the physician to sign and date the certifications/re-certifications for home health patients at least every 60 days with the requirement that the physician review the certifications/re-certifications at least every 60 days; (ii) add that the physician must sign the certifications and re-certifications before the home health agency may bill DMAS; (iii) add the requirement that upon a patient's admission to home health services, a start of care comprehensive assessment must be completed within five calendar days; (iv) add the requirement that a physician re-certification shall be performed within the last five days of each current 60-day certification period, i.e., between and including days 56-60; (v) delete the requirement that the physician plans of care for physical therapy and speech-language pathology services be personally signed and dated by a physician.

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 titled Standards Established and Methods Used to Assure High Quality of Care Utilization Review of Home Health Services (12 VAC 30-60-70) 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 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 § 32.1-325, grants to the Board of Medical Assistance (BMAS) the authority to administer and amend the Plan of Medical Assistance. The Code of Virginia § 32.1-324 grants to the Director of DMAS the authority to administer and amend the Plan of Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code of Virginia also provides, in the Administrative Process Act (APA) § 2.2-4012.1, for this agency's promulgation of fast track regulations subject to the Governor's review.

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.

Without endangering recipients' health and safety, this action decreases the administrative burden of home health providers as they render services to recipients. This action modifies home health physician certification and re-certification requirements as contained in 12 VAC 30-60-70. This reduces administrative oversight that home health providers currently provide for recipients of home health services. Home health providers have indicated that the additional oversight was burdensome and did not necessarily improve patient care and outcomes.

This regulatory action is expected to help protect the health, safety, and welfare of recipients receiving home health services by enabling them to live successfully in their homes and communities.

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.

Without compromising on quality of care, this action decreases the administrative burden of home health providers as they render services to recipients so objections by providers and their advocacy groups are not anticipated. These regulatory changes were shared with an advisory group of providers and advocates and they had no substantive comments about the changes but supported them. The agency is using the fast-track process in order to complete the needed regulatory changes as soon as possible so as to decrease the administrative burden to providers.

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 section of the State Plan for Medical Assistance Services that is affected by this action is Standards Established and Methods Used to Assure High Quality of Care (Attachment 3.1-C (12 VAC 30-60-70)).

The current requirements, implemented in 1996, for the coverage of home health services include that the attending physician sign and date the recipient certification (of the need for the home health care) within 21 days of the start of care and sign and date the re-certifications (of the need for continuing care) within 60 days of the renewal date. Based on the existing knowledge and experience in 1996, these standards were reasonable and duly promulgated. Since the implementation of these regulations, DMAS has held the home health agencies responsible for ensuring that the physician sign and date the certifications within 21 days and the re-certifications within 60 days. This was put into place to ensure that the attending physician approved the plan of care before services began or continued. If the attending physician did not comply with these requirements, DMAS has held the home health agency responsible and retracted reimbursement on utilization review for services already provided.

In 1999, the Centers for Medicare and Medicaid Services (CMS) implemented the Outcome and Assessment Information Set (OASIS) for Medicare beneficiaries and changed its conditions of participation for home health agencies. Since the Medicaid program was not required to comply with these requirements, DMAS did not change its 1996 requirements. In light of the Medicare change and DMAS' retention of its then-current policies, this left the home health agencies in the position of complying with different sets of requirements for Medicare and for Medicaid. Such differences between these two major health care programs created, for home health agencies, considerable administrative and management burdens. Furthermore, the Medicare conditions of participation did not just apply for Medicare beneficiaries but to all clients of home health agencies.

Recently, DMAS determined that the quality of care rendered to home health recipients is not compromised if Medicare requirements, regarding physician review of the home health certifications and re-certifications, are adopted for Medicaid recipients. In the spring of 2004, DMAS convened an advisory group, comprised of DMAS staff, provider agencies, and provider advocacy groups, to assist with issues concerning the home health program. The provider-members of the advisory group advised DMAS that its restrictive administrative requirements were causing some home health providers to consider reducing the number of Medicaid recipients in their caseloads.

With the implementation of this regulatory change, home health providers will not be held to the current stringent physician requirements. This new regulation outlines the requirements for physician oversight of home health services that home health agencies must follow in order to receive reimbursement from DMAS. These changes do not conflict with home health regulations from the Virginia Department of Health.

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 primary advantage for the Commonwealth with these changes is that home health providers are more likely to continue providing services to Medicaid recipients thereby enabling recipients remain their in homes and averting institutional costs of care. The advantage of these changes to Medicaid recipients in need of home health care is that their access to such care, across the Commonwealth, will be preserved. The advantage to home health agencies afforded by these changes is the reduction of administrative and management duties required by DMAS' current requirements.

The disadvantage to the Commonwealth, Medicaid recipients, and home health providers of not instituting these changes could be the reduction in the availability of these services as providers relinquish their Medicaid provider agreements.

There are no disadvantages to the Commonwealth or Medicaid recipients in implementing these changes.

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	There is no increase in the cost to the Commonwealth to remove the selected physician requirements.
Projected cost of the regulation on localities	There is no projected cost of the regulation on localities.
Description of the individuals, businesses or other entities likely to be affected by the regulation	Affected businesses include home health providers since they will have fewer conflicting requirements to comply with.
Agency's best estimate of the number of such entities that will be affected	As of 6/28/04, there were 176 home health agencies enrolled with DMAS. WVMI, the DMAS preauthorization contractor, will continue to perform preauthorization on home health services. DMAS already has existing staff who will continue to perform utilization review on home health services. No new staff will be required by either WVMI or DMAS for the prior authorization or utilization review of home health services.
Projected cost of the regulation for affected individuals, businesses, or other entities	None.

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.

There are no other alternatives that DMAS has considered, in response to the request for changes to the physician requirements for home health services as the regulated industry the change of Medicaid policies to conform to Medicare requirements.

Family impact

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

This regulatory action will not have any negative effects on the institution of the family or family stability. It will not increase nor decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, or the assumption of family responsibilities.

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
60 B	N/A	Requires physician to review, sign and date the written plan of care at least every 60 days.	Language changed to require the physician to only review the written plan of care at least every 60 days to conform to Medicare conditions of participation standards. (B)
60 D	N/A	Provision sets out general conditions that apply to the provision of home health services.	Added new requirement about a start of care comprehensive assessment being completed no later than 5 days after the beginning of care. Language added: (i) the initial plan of care is the certification and it must be signed by the physician before the home health agency is permitted to bill DMAS; (ii) physician re-certification shall be performed within the last five days of each current 60-day certification period, i.e., between and including days 56-60. Deleted language that required additional physician certifications for various covered therapies.