



Final Regulation Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30 -80
Regulation title	Methods and Standards for Establishing Payment Rates; Other Types of Care
Action title	Ambulatory Surgery Center and Outpatient Rehabilitation Facility Reimbursement
Date this document prepared	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual*.

Brief summary

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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. Also, please include a brief description of changes to the regulation from publication of the proposed regulation to the final regulation.

This regulatory action is intended to implement reimbursement changes for Ambulatory Surgery Centers (ASCs). This action will also implement reimbursement changes for outpatient rehabilitation (rehab) facilities that are currently reimbursed on a cost basis.

This regulatory section (12VAC30-80-35) is being added to implement a new ASC reimbursement methodology. DMAS cannot continue with its current methodology because the data that it uses in support of the current method is no longer available. Medicaid currently reimburses ASCs using the Medicare methodology in effect prior to January 1, 2007. In calendar year 2007, Medicare implemented a new interim ASC reimbursement methodology but still provided information so that DMAS could assign new ASC procedure codes to one of the nine ASC groups from the old Medicare methodology. In calendar year 2008, Medicare implemented a new permanent methodology which reimburses ASCs based on Ambulatory Payment

Classification (APC) groups. This action will fully implement a new Ambulatory Patient Group (APG) methodology for Medicaid ASC reimbursement in a budget neutral manner. While similar to the new Medicare methodology, DMAS' new methodology will no longer be dependent on the Medicare methodology.

12VAC 30-80-200 is being amended to implement a statewide fee schedule methodology for outpatient rehabilitation agencies. One change was made to the final cost report requirement for outpatient rehab agencies under the old methodology being replaced by the new methodology in this final regulation. Another change was made to 12VAC 30-80-20 to conform to these changes.

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 **Ambulatory Surgery Center and Outpatient Rehabilitation Facility Reimbursement** (12VAC 30-80-35 and 12VAC 30-80-200) 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

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

Legal basis

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

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.

ASC

This final regulation is not essential to protect the health, safety, or welfare of citizens. However, it is necessary to have a reimbursement methodology for DMAS to pay ASCs that furnish services to Medicaid recipients. As a result of Medicare modifying its reimbursement methodology for ASCs, it no longer produces the data that DMAS has relied on for its current methodology. In the absence of this data, DMAS can no longer maintain its current methodology and, therefore, must develop a new methodology.

Outpatient Rehabilitation Facility Reimbursement

This final regulation is also not essential to protect the health, safety, or welfare of citizens. This final action modifies the methodology for reimbursing outpatient rehabilitation agencies. This new methodology changes reimbursement from cost-based to a statewide schedule using selected CPT codes.

There are no expected environmental benefits from these changes.

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 section of the State Plan of Medical Assistance that is affected by these changes is the Methods and Standards for Establishing Payment Rates- Other Types of Care (adding 12VAC30-80-35 and amending 12VAC30-80-200).

ASC

Medicaid currently reimburses ASCs using the Medicare methodology in effect prior to January 1, 2007, by assigning procedure codes to nine ASC groups. The rate for each group in the previous ASC grouper methodology was intended to compensate the ASC for all services performed solely based on the procedure code.

The new APG methodology defines Ambulatory Patient Groups (APGs) as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by ASCs. Each group is assigned an APG-relative weight that reflects the relative average cost for each APG compared to the relative cost for all other APGs. The base rate for ASC visits are determined by dividing total reimbursement for ASC services by the total number of visits for ASC services. The total allowable operating rate per visit is determined by multiplying the base rate times the APG relative weight.

To maintain budget neutral expenditures for ASC services and to reduce payment errors, as compared to the current Medicare-based methodology, the base rate is to be adjusted by a budget neutrality factor (BNF) determined every three years. The APG relative weights to be implemented will be the weights determined and published periodically by DMAS. The weights will be updated at least every three years in concert with calculation of the BNF for ASCs. New outpatient procedures and new relative weights are to be added as necessary between the scheduled weight and rate updates. The affected entities will be notified of these changes, as they occur, via agency guidance documents.

Outpatient Rehabilitation Facility Reimbursement

12VAC 30-80-200 is being amended to implement a prospective statewide fee schedule methodology for outpatient rehabilitation agencies based on CPT codes. The fee schedule will be developed to achieve savings totaling \$185,900 general fund dollars as required in the Governor's budget.

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.*

ASC

Implementation of APGs will align the DMAS ASC methodology more closely with other ambulatory surgery center methodologies. This change will increase the efficiency and effectiveness of payments made by DMAS to ASC providers and reduce payment errors.

Outpatient Rehabilitation Facility Reimbursement Facility Reimbursement

Currently, the Virginia Administrative Code contains a cost-based methodology for computing reimbursement for outpatient rehabilitation services which is subject to a ceiling (12VAC30-80-200). For rehabilitation services, Medicare and most commercial insurers use a fee schedule. As a result, outpatient rehabilitation agencies bill differently and submit a cost report only for

Medicaid. Providers will no longer have to submit cost reports and DMAS will no longer have to settle the cost reports. Discontinuing both of these activities will result in administrative savings to both rehab providers and the Commonwealth. At this time, however, DMAS has chosen to implement this regulation using only global codes rather than all the codes that Medicare allows.

There are no disadvantages to the citizens of the Commonwealth for these changes as they are not expected to have an impact on the delivery of these services. The advantage to the citizens of the Commonwealth is the reduction in providers' and agency's costs associated with these changes.

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.

There are no changes to the ASC portion of this final regulation over those published in the proposed stage. 12VAC 30-80-200 is being amended to implement a statewide fee schedule methodology for outpatient rehabilitation agencies. One change was made to the final cost report requirement for outpatient rehab agencies under the old methodology being replaced by the new methodology in this final regulation. Another change was made to 12VAC 30-80-20 to conform to these changes.

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.

DMAS' proposed regulations were published in the July 6, 2009, *Virginia Register* for their public comment period from July 6, 2009, through September 4, 2009. Comments were received from four organizations (Virginia Physical Therapy Association, Professional Therapies of Roanoke, and Rehabilitation Associates, P.C, and Professional Rehab Associates, Inc.) A summary of the comments received and the agency's response follows.

Commenter	Comment	Agency response
Virginia Physical Therapy Assoc.	1. Requested DMAS' reconsideration of the limited Current Procedural Terminology (CPT) codes (3) available to physical therapists to bill. Such a limited number of procedure codes with which to bill for services does not adequately reflect the standards of practice and is inconsistent with	DMAS has made no changes to the final regulations in response to these comments. The number of billing codes allowed by DMAS is a policy decision and is not mandated by the regulation. Allowing more billing codes, however, would require DMAS to modify the prior authorization requirements in 12VAC30-50-150. DMAS has met with providers and may consider possible changes in future

	<p>billing practices of other insurers, including Medicare. Such a limited choice of available codes with which to bill does not comport with current professional standards of practice. This commenter provided the professional standards of practice developed by the American Physical Therapy Association (APTA).</p>	<p>regulatory actions, but not in this current action. DMAS acknowledges that, in implementing this regulation, it is only allowing a limited number of codes and that this differs from the practice of most payers. DMAS, however, can define its own unique billing requirements. While providers must adapt their billing practices, especially in cases where there is third party coverage, there should be no additional cost after this initial adaptation. DMAS has established rates that are consistent with the expenditures authorized in the Appropriation Act.</p>
<p>Professional Therapies of Roanoke</p>	<p>This commenter believes that DMAS' proposed regulations permit their billing for only 8 out of 76 published CPT codes. This commenter believes that being forced to code its varied and very complex services with one of the 8 approved codes would create fraudulent billing situations in violation of the federal Correct Coding Initiatives and Uniform Coding requirements. Being restricted by Medicaid to billing such a limited number of codes would require manual modifications to their business billing systems. This commenter stated that certain statements in the Agency Background document were not true: (i) the new reimbursement methodology of outpatient services would more closely align to the Medicare's and commercial insurers' methodologies; (ii) providers would experience little to no administrative costs as the claim reporting requirements are not affected; (iii) providers will save approximately \$2,000 annually since they will no longer have to file cost reports. This commenter stated that the new system will create administrative and billing nightmares with significant increases in the cost of billing and collections while reducing payments. This commenter summarized with the request to be able to use all the CPT codes that correctly reflect what services therapists are actually performing and are mandated for them.</p>	<p>DMAS has made no changes to the final regulations in response to these comments. The number of billing codes allowed by DMAS is a policy decision and is not mandated by the regulation. Allowing more billing codes, however, would require DMAS to modify the prior authorization requirements in 12VAC30-50-150. DMAS has met with providers and may consider possible changes in future regulatory actions, but not in this current action. DMAS acknowledges that in implementing this regulation, it is only allowing a limited number of codes and that this differs from the practice of most payers. DMAS, however, can define its own unique billing requirements. While providers must adapt their billing practices, especially in cases where there is third party coverage, there should be no additional cost after this initial adaptation. DMAS has established rates that are consistent with the expenditures authorized in the Appropriation Act.</p>

	<p>This commenter also submitted a form letter from 28 therapists that stated: (i) DMAS has initiated a drastic reduction in payment for speech therapy services; (ii) the use of a very limited number of procedure codes will prevent therapists from billing correctly for services actually rendered to patients in violation of federal regulations. This would create administrative nightmares by causing problems with billing systems and other costly billing problems.</p>	
<p>Rehabilitation Associates, P.C.</p>	<p>This provider submitted the same form letter from an additional 23 therapists that stated: (i) DMAS has initiated a drastic reduction in payment for speech therapy services; (ii) the use of a very limited number of procedure codes will prevent therapists from billing correctly for services actually rendered to patients in violation of federal regulations. This would create administrative nightmares by causing problems with billing systems and other costly billing problems.</p>	<p>DMAS has made no changes to the final regulations in response to these comments. The number of billing codes allowed by DMAS is a policy decision and is not mandated by the regulation. Allowing more billing codes, however, would require DMAS to modify the prior authorization requirements in 12VAC30-50-150. DMAS has met with providers and may consider possible changes in future regulatory actions, but not in this current action. DMAS acknowledges that in implementing this regulation, it is only allowing a limited number of codes and that this differs from the practice of most payers. DMAS, however, can define its own unique billing requirements. While providers must adapt their billing practices, especially in cases where there is third party coverage, there should be no additional cost after this initial adaptation. DMAS has established rates that are consistent with the expenditures authorized in the Appropriation Act. Adjusting the speech therapy rates upwards would require adjusting other rates downward.</p>
<p>Professional Rehab Associates, Inc.</p>	<p>This provider submitted the same form letter from as additional four therapist that stated: (i) DMAS has initiated a drastic reduction in payment for speech therapy services;(ii) the use of a very limited number of procedure codes will prevent therapists from billing correctly for services actually rendered to patients in violation of federal regulations. This would create administrative nightmares by causing problems with billing systems and other costly billing problems.</p>	<p>DMAS has made no changes to the final regulations in response to these comments. The number of billing codes allowed by DMS is a policy decision and is not mandated by the regulation. Allowing more billing codes, however, would require DMAS to modify the prior authorization requirements in 12VAC30-50-150. DMAS has met with providers and is considering possible changes in future regulatory actions, but not in this current action. DMAS acknowledges that in implementing this regulation, it is only allowing a limited number of codes and that this differs from the practice of most payers. DMAS, however, can define its own unique billing requirements. While</p>

		<p>providers must adapt their billing practices, especially in cases where there is third party coverage, there should be no additional cost after this initial adaptation. DMAS has established rates that are consistent with the expenditures authorized in the Appropriation Act. Adjusting the speech therapy rates upwards would require adjusting other rates downward.</p>
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DMAS received more than 25 requests for a public meeting and met with outpatient rehab providers on October 8, 2009. If necessary, DMAS will address in a forthcoming regulatory package (Outpatient Rehabilitation Agency and Long Stay Hospital Reimbursement) any unresolved issues associated with this regulatory change.

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.

ASC

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
	12VAC30-80-35	N/A	Implements APG methodology for ASC reimbursement in a budget neutral manner.

Outpatient Rehabilitation Facility Reimbursement

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-80-20		Comprehensive outpatient rehabilitation facilities are listed as a provider group that is subject to the cost based reimbursement method.	Removes this provider group from the applicability of this reimbursement method.
12VAC30-80-200	N/A	Reimburses a prospective rate for outpatient rehabilitation services equal to the lesser of an agency's cost per visit for each type of service (physical, occupational, or speech therapy) or statewide	Modifies this methodology to begin reimbursing outpatient rehabilitation services according to a statewide fee schedule. Changes were made to the final cost report requirements under the old methodology.

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Regulatory flexibility analysis

Please describe the agency’s analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

ASC

This regulatory action is based on the inability to maintain the existing reimbursement methodology for ASCs. DMAS considered several alternatives and requested feedback from the public and providers through the regulatory process. Individual providers would experience little to no impact as the claim reporting requirements are not affected by this change.

Outpatient Rehabilitation Facility Reimbursement

An alternative to this regulatory action is to convert the outpatient rehabilitation methodology to a timed-unit based methodology, paying the same rate for all rehabilitation services in 15 minute increments. Since the cost to prepare a cost report does not vary significantly by size of business, it’s more burdensome on small businesses. Either proposal would eliminate the requirement to prepare and submit a cost report. However, the proposed reimbursement methodology is the least burdensome because it is the most similar to the methodology used by other payers, including Medicaid HMOs. In implementing this regulation, DMAS has chosen to use only selected global codes, which is different than other payers. Using all the codes allowed by other payers would have required prior authorization changes for 12VAC 30-50-150.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) 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; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

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.