Virginia Regulatory Town Hall

# Proposed Regulation
# Agency Background Document

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| **Agency Name:** | Department of Health (State Board of) |
| **VAC Chapter Number:** | 12 VAC 5-200 and 210 |
| **Regulation Title:** | Regulations Governing Eligibility Standards and Charges for Health Care Services to Individuals, and Charges and Payment Requirements By Income Levels |
| **Action Title:** | Comprehensive Revision of Eligibility and Charges |
| **Date:** | February 2003 |

This information is required pursuant to the Administrative Process Act (§ 9-6.14:9.1 *et seq.* of the *Code of Virginia*), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99), and the *Virginia Register Form,Style and Procedure Manual*. Please refer to these sources for more information and other materials required to be submitted in the regulatory review package.

## Summary

*Please provide a brief summary of the proposed new regulation, proposed amendments to an existing regulation, or the regulation proposed to be repealed. There is no need to state each provision or amendment or restate the purpose and intent of the regulation; instead give a summary of the regulatory action and alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.*

The existing Eligibility and Charges regulations govern how Virginia's local health departments determine charges paid by patients who receive health services and have not been revised in ten years. The proposed revision simplifies the charging structure by tying it to Medicaid, allows goods and purchased services to be priced at their costs, encourages patients to apply for insurance they may be eligible for, clarifies the family economic unit, and establishes for a guidance document. The sliding fee scale is not changed.

## Basis

*Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority must be provided. Please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the proposed regulation and that it comports with applicable state and/or federal law.*

Subsection A of Section 32.1-11of the Code of Virginia, provides that "[t]he [State] Board [of Health] may formulate a program of . . . preventive, curative and restorative medical care services . . . on a regional, district or local basis."

Subsection B of that section provides that

> [t]he Board shall define the income limitations within which a person shall be deemed to be medically indigent. Persons so deemed to be medically indigent shall receive the medical care services of the Department without charge. The Board may also prescribe the charges to be paid for the medical care services of the Department by persons who are not deemed to be medically indigent and may, in its discretion and within the limitations of available funds, prescribe a scale of such charges based upon ability to pay. Funds received in payment of such charges are hereby appropriated to the Board for the purpose of carrying out the provisions of this title.

Further, Subsection C of the same section provides that "[t]he Board shall review periodically the program and charges adopted pursuant to this section."

The intended regulatory action would revise and update the Board's regulations pertaining to the eligibility of persons for services rendered in local health departments across Virginia, within the scope of the law, set forth above. The authority to accomplish this action is clearly mandatory.

## Purpose

*Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the proposed regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.*

The existing regulations have not been revised in ten years and need to be updated to correct deficiencies, to adjust to changing practice and to adjust to changes in the medical environment.

## Substance

*Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement providing detail of the regulatory action's changes.*

- A distinction is made between services and goods. Services are sliding scale and goods are flat rate with a local option for sliding scale. This will allow charging the Agency's cost for lab and pharmacy services
- Charge tables are eliminated and rates are tied to Medicaid, then Medicare, and then a cost study if no Medicaid or Medicare charges are available. This will make maintenance of charges simpler.
- Applicants who do not apply for Medicaid or a children's medical insurance program within 30 days of receiving services may be assessed the established charge for the medical care and related goods and services provided. This will encourage patients to obtain appropriate funding for their care.
- Denial of services. Denial of services is clarified and restricted to better protect patients
- Flat rate charges authorized for mass encounters, but patients have the option of appearing at a different time and possible a different place for eligibility determination and possibly discounted service. This simplifies access to services such as flu shots while allowing indigent patients the right of access to discounted services.
- Establishes contracted prices. Districts will be able to establish prices for certain procedures and for a defined population by contract with a community organization. This enhances public health activities by improving access based on community need.
- Ties the list of non-chargeable STD to the Code citation for venereal diseases (§32.1-57)
- Application to Medicaid, Medicare, etc. will be required before issuing a waiver. The authority to grant waivers cannot be delegated beyond the health director. Waivers can be granted for up to 180 days. Makes this process more orderly and practical.
- Definition of a family is adjusted to reflect household economic realities. Unrelated adults living together and sharing income are in the same economic unit.
- Acknowledge that the Commissioner of Health may interpret and implement these Regulations in a Guidance Document

## Issues

*Please provide a statement identifying the issues associated with the proposed regulatory action. The term "issues" means: 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 include a sentence to that effect.*

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The proposed regulation poses two main advantages to the public and the agency:

1. Patients are encouraged to apply for Medicaid and state-sponsored children's health insurance and, if enrolled, they will have substantially increased access to medical care services. Waivers are made more likely to be granted so those with financial hardships will not incur additional charges. Some patients may receive higher charges, but some may receive lower charges. The discounted fee schedule (sliding scale) is not changed.

2. These changes provide for administrative simplifications and clarifications. They allow for charges to be more rational, to adjust more rapidly to Medicaid reimbursement levels, and encourage application for Medicaid and state-sponsored children's health insurance which will increase agency revenue.

There are no known disadvantages to the public, the agency or the Commonwealth associated with the proposed regulation.

## Fiscal Impact

*Please identify the anticipated fiscal impacts and at a minimum include: (a) the projected cost to the state to implement and enforce the proposed regulation, including (i) fund source / fund detail, (ii) budget activity with a cross-reference to program and subprogram, and (iii) a delineation of one-time versus on-going expenditures; (b) the projected cost of the regulation on localities; (c) a description of the individuals, businesses or other entities that are likely to be affected by the regulation; (d) the agency's best estimate of the number of such entities that will be affected; and e) the projected cost of the regulation for affected individuals, businesses, or other entities.*

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No changes in funding will be required to enact these regulations. Numerous changes to patient charges will occur, but they will tend to be modest, consist of both increases and decreases, and no overall net change is expected on the basis of fee changes. Notably, the agency expects to incur the benefit of administrative efficiencies and cost savings as the new regime created by the proposed regulations becomes implemented.

## Detail of Changes

*Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or cross-walk - of changes implemented by the proposed regulatory action. Where applicable, include citations to the specific sections of an existing regulation being amended and explain the consequences of the proposed changes.*

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12VAC5-200-10. Definitions.

Where the phrase "health care services" appears it is replaced by "medical care services" as part of the distinction between services provided by the, and goods and services purchased on behalf of patients. Also "medical care services" are defined as "clinical medical, dental, and nursing services provided to patients by physicians, dentists, nurses, and other health care providers employed by health districts or contracted by health districts to provide these services. It does not include laboratory tests, pharmaceutical and biological products, radiological or other imaging studies, other goods or products, or other medical services that a health district does not provide."

The definition of a "child" is clarified

The definition of "extraordinary financial hardship" is added

The definition of "family" or "family unit" is changed to focus on economic realities instead of simply relying on biological or legal relationships

The "flat rate charges" definition is clarified by adding "goods or services" as a qualifier

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) checks; and educational assistantships when provided to pay for, or in the form of, tuition, fees, other direct educational expenses, housing, or meals are additional exclusions from gross income.

12VAC5-200-40. Administration of chapter.

Acknowledges that the commissioner may issue a Guidance Document to interpret these regulations and to provides guidance for their implementation.

Defines how charges are to be set stating, "Whenever possible, charges for services shall use the most appropriate current Medicaid charges (and matching Medicaid codes). If there is no Medicaid code for a particular service, the most appropriate current Medicare charge (and matching code). If both Medicaid and Medicare charges (and codes) exist for the same service, the Medicaid charge (and code) will be used. If neither a Medicaid nor a Medicare code exists for a particular service, the commissioner, or a designee, shall determine an appropriate charge and develop a matching code. The Guidance Document shall include procedures for determining the costs and establishing the charges for medical care and related goods and services when any of these are not otherwise addressed in these regulations or the Code of Virginia."

12VAC5-200-70 is deleted.

12VAC5-200-80. Application process.

Added is, "Individuals who have failed to make any payment within the past 90 days for medical care services, or other goods or services, they have received may have their medical care services terminated. The district director may terminate services only following notice to the individual that such services will be terminated and only after determining that terminating services would not be detrimental to the individual's health. Medical care services cannot be terminated for individuals receiving ongoing care without making a good faith effort to secure alternative care." This clarifies and restricts the ability to deny services.

12VAC5-200-90. Charges for services.

Allows for charges to be rounded to a convenient amount for selected items to make charging simpler in high volume events such as flu clinics. Also clarifies in those high volume events where everyone is charged a flat rate, that an individual can request an eligibility determination be performed and the service discounted. The individual may have to receive this discounted service at another time or place to keep from disrupting patient flow.

12VAC5-200-100. Flat rate charges.

This section is clarified and allows the commissioner to delegate his authority to allow flat rate fees.

Contracted charges is moved to this section and the section is clarified.

12VAC5-200-120. Automatic eligibility.

Encourages application for insurance by allowing full charges when insurance eligible patients do not apply for insurance within 60 days of receiving services.

12VAC5-200-160. Immunization services.

Limits free services to "appropriate" individuals during an epidemic or when declared necessary by the commissioner. Extends this authority to the district health director.

12VAC5-200-170. Other health care services.

Wording is changed as above to "appropriate" citizens and extends the authority to the commissioner, or district health director.

12VAC5-200-190. Limitations

Eliminates program directors from this authority.

12VAC5-200-210. Deleted

12VAC5-200-220. Waivers, General.

Simplifies the qualification for a waiver to "financial hardship" and increases the waiver period from 90 to 180 days.

12VAC5-200-230. Waivers

A. Removes the authority of district directors to delegate this authority and eliminates the program director authority. Defines "unusually serious health problems" as those that exceed a certain percentage of the gross income. The percentage is to be determined by the commissioner and included in the Guidance Document (it is currently set at 5%)

D. Requires those thought to be eligible for Medicaid or any state-sponsored children's medical insurance program, to apply to those programs in order to be eligible for a waiver.

12VAC5-200-270. Rights.

B. Program director is deleted.

C. Operations director is deleted. Allows the commissioner to delegate his authority in this section.

D. Deleted.

12VAC5-200-280. Fraud.

Program director is deleted.

12VAC5-210-10. Charges and payment requirements

The Charts 1 and 2 are eliminated and charges are stated to be available for public inspection at the headquarters, district, and local health department offices of the department (Charges are set in 12VAC5-200-90).

## Alternatives

*Please describe the specific 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.*

The alternative is to leave the regulations unchanged and continue with deficiencies in both eligibility determination and charging for medical care. This alternative is clearly unwarranted.

## Public Comment

*Please summarize all public comment received during the NOIRA comment period and provide the agency response.*

None was received.

## Clarity of the Regulation

*Please provide a statement indicating that the agency, through examination of the regulation and relevant public comments, has determined that the regulation is clearly written and easily understandable by the individuals and entities affected.*

The Virginia Department of Health has determined through extensive involvement of the persons who will be applying these regulations that they are clear, concise, and unambiguous.

## Periodic Review

*Please supply a schedule setting forth when the agency will initiate a review and re-evaluation to determine if the regulation should be continued, amended, or terminated. The specific and measurable regulatory goals should be outlined with this schedule. The review shall take place no later than three years after the proposed regulation is expected to be effective.*

The Virginia Department of Health will review these regulations within three years of adoption. The measurable goal will be a survey of the local health departments applying these regulations to determine if they are effective.

## Family Impact Statement

*Please provide an analysis of the proposed regulatory action that assesses the potential impact on the institution of the family and family stability including the extent to which 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.*

No longer required by executive order.