Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	Department of Health (State Board of)
Virginia Administrative Code (VAC) citation	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
Document preparation date	May 19, 2004

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 21 (2002) 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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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.

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 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.

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.

On April 26, 2004, the State Board of Health in a general meeting specifically authorized the State Health Commissioner, who is vested with the Board's authority when it is not in session, to adopt the regulations 15 days after close of the public comment period, in accordance with Section 2.2-4013 of the Code of Virginia. On May 18, 2004, the State Health Commissioner acted on his special and statutory authority by adopting the regulations as final.

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.

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 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.

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. The adopted, final regulations reflect such an effort.

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.

- A distinction is made between services and goods. Services are generally 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 first to Medicaid, then Medicare if no Medicaid rate exists, 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 are 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 or low income 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 when they contract with a community organization. This enhances public health activities by improving access based on community need.
- Ties the list of non-chargeable sexually transmitted diseases 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 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.

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.

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.

NONE

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.

NONE

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.

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.

The sliding fee scale is modified by the addition of a discount of 5% for those between 200 and 250% (233.3 and 283.3% for Northern Virginia) of the federal poverty level. Full fee becomes above 250% (283.3% for Northern Virginia).

12VAC5-200-40. Administration of chapter.

Acknowledges that the commissioner may issue a Guidance Document to interpret these regulations and to provide 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).

Family impact

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

No longer required by executive order.