Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-40 and 30-130
Regulation title	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid
Action title	Limits on Patient Pay Amounts for Non-Covered Medicaid Services
Document preparation date	; NEED GOV APPROVAL BY

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

Please provide a brief summary of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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. Do ***not*** *state each provision or amendment or restate the purpose and intent of the regulation.*

Presently, Medicaid recipients who are nursing facility (NF) residents are required to contribute some portion of their income (patient pay amount) to the NF care costs. NF residents are allowed to retain small personal fund amounts for their own personal use. Prior to the agency's current emergency regulations, there was no limit on the amount of money that NF residents could be charged for medical services and supplies that were not otherwise covered by Medicaid, such as eyeglasses and dentures. This regulatory action proposes to limit the amount of money that may be deducted for medically necessary medical or remedial services from the patient pay portion for nursing facility residents. Additional Medicaid funds are paid to the nursing facility to cover amounts that would be paid by the resident's patient pay amount if not otherwise used to

cover non-Medicaid covered medical services and supplies. Therefore, the more money the recipient pays, the sooner Medicaid has to start covering more of the NF costs of care.

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 Code of Virginia citation and General Assembly bill and chapter numbers, if applicable, and (2) promulgating entity, i.e., the 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 the regulation 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.

This regulatory action is not expected to have any impact on the health, safety or welfare of citizens. Medicaid, as well as commercial health insurance companies, set maximum reimbursement amounts for services rendered by their provider networks. In the case of Medicaid, the reimbursement is usually the same as or less than the Medicare rate. Therefore, the purpose of this regulatory action is to conform this method of reimbursement to the general Medicaid reimbursement policies.

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 section of the State Plan for Medical Assistance affected by this proposed action is Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid (Attachment 2.6-A, Supplement 3 (12VAC 30-40-235)). The regulations affected by this action are: Limitations on Patient Pay Amounts (12 VAC 30-130-620).

Prior to DMAS' emergency regulations, there were no limits on how much money that NF residents could be charged for necessary medical care and services that Medicaid did not pay for. This often resulted in such residents paying providers the full amount of their charges. As a result, DMAS was forced to increase its payments to the nursing facilities to cover more of the costs of Medicaid covered services because it was unable to offset these costs with any patient pay amounts, up to the difference in payment amounts. The payment differences resulted from the fact that the residents were expending large amounts on otherwise non-covered services and did not have the funds available to contribute towards the costs of their Medicaid-covered NF care.

This regulation proposes to set a maximum amount for non-covered medically necessary goods and services that can be allowed as adjustments to the patient pay for nursing facility residents. The maximum amount allowed will be the higher of either the Medicare or Medicaid rate for the same non-covered item or service. By limiting the amount of money that NF residents can expend for non-Medicaid-covered items or services, the NF residents will be able to continue to contribute more towards the costs of their Medicaid-covered NF care.

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 advantage to DMAS is that there will be a cost savings associated with this change of approximately $68,000 (GF) annually. The primary disadvantage to NF Medicaid residents is that they could be balance-billed for medical or remedial care when such care has been provided by non-enrolled providers. Medicaid enrolled providers are contractually obligated to accept Medicaid's reimbursement as payments in full and are prohibited from billing the balance of their charges to NF residents. All non-enrolled providers of services will be affected since they will no longer be receiving full reimbursement of their charges. To protect NF residents from the potential victimization that could result from this policy, DMAS is engaging in an educational effort to encourage NF residents to secure the needed non-covered services from Medicaid enrolled providers.

Financial impact

Please identify the anticipated financial impact of the proposed regulation and at a minimum provide the following information:

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 cost to the state to implement this regulation
Projected cost of the regulation on localities	There is no cost to localities to implement this regulation
Description of the individuals, businesses or other entities likely to be affected by the regulation	Nursing home residents enrolled in Medicaid and providers rendering goods and services to these clients will be affected by this regulation. The types of providers most likely to be impacted would be dentists, audiologists and durable medical equipment providers.
Agency's best estimate of the number of such entities that will be affected	Generally, a nursing home will use the same dentist and audiologist for all its residents; therefore, based on patient pay adjustments processed by the Department of Medical Assistance Services (DMAS) for fiscal year 2003, the number of dentists affected would be 84 and the number of audiologists 65. It is estimated that no more than 20 durable medical equipment companies will be affected.
Projected cost of the regulation for affected individuals, businesses, or other entities	Cost savings for DMAS was estimated at approximately $136,500 (total funds). Therefore, the cost to clients who potentially could be balance billed or providers who would no longer receive payment in full would not exceed $136,500. This cost would actually be less than this since some of the providers, especially the durable medical equipment companies, are enrolled Medicaid providers and must accept the Medicaid rate as payment in full. However, the number of providers enrolled in Medicaid who provided these services and the reimbursement to them is not available.

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.

The Agency was not permitted to consider any alternative policies due to the legislative mandate.

Public comment

Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

DMAS' emergency regulations were published in the June 30, 2003, *Virginia Register* (19:21, 3076, 6/30/2003) along with the Notice of Intended Regulatory Action (NOIRA). No comments were received on either the emergency regulations or on the NOIRA notice.

Impact on family

Please assess the impact of the proposed 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.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.

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	Current requirement	Proposed change and rationale
12VAC30-40-235	Prior to current emergency regulation, this VAC did not exist.	State Plan placement for the proposed policy as dictated by CMS. Proposed change sets out policy as discussed. Using the Medicare and Medicaid maximum reimbursement levels as the maximum amounts permissible for non-covered services has a long-standing history at DMAS.
12VAC30-130-620	Regulation currently provides that all other payment sources must be engaged before the NF	Proposed regulations add to the regulations that the maximum amount that the NF resident's patient pay amount can be reduced

	resident's patient pay amount can be reduced. Prior to the current emergency regulation, no limits existed on how much the NF-cost patient pay amount could be reduced in order for the resident to pay for other needed medical services and items.	can be no greater than the higher of either Medicare or Medicaid payments for the item or service in question.

Any amounts spent by the resident for such medically indicated goods and services are deducted from the patient pay amount to be paid to the nursing facility; additional Medicaid funds are paid to the nursing facility to cover amounts that were deducted from the resident's patient pay amount that would otherwise have been used to cover those medical expenses that were not covered by Medicaid. Prior to the emergency regulations, there is no cap on the nursing facility resident's medical expenditures. This has resulted in Medicaid funds indirectly subsidizing higher payments made by Medicaid recipients for medically indicated, but non-covered, patient expenditures.

Under 12 VAC 30-130-620, the current patient pay adjustment scheme permits essentially unlimited payment for non-covered, medically necessary, resident-specific, customized items or services prescribed for a Medicaid nursing facility resident thereby more quickly depleting greater amounts of residents' monthly incomes. Whatever resulting shortfall in the amount due the nursing facility from the patient pay amount is reimbursed by DMAS.