Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-70-50; 30-80-200
Regulation title	Methods and Standards Used for Establishing Payment Rates: Inpatient Hospital Reimbursement; Other Type of Care
Action title	Outpatient Rehabilitation Agency and Long Stay Hospital 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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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 clarifies changes in a separate final regulatory action (Ambulatory Surgery Center and Outpatient Rehabilitation Facility Reimbursement -- Town Hall 2690/5345) that modifies the reimbursement for outpatient rehabilitation agencies and Comprehensive Outpatient Rehabilitation Facilities (CORFs), except for outpatient rehabilitation agencies operated by Community Services Boards (CSBs) or state agencies, from a cost based methodology to a new statewide fee schedule methodology.

This action also reduces reimbursement to long-stay hospitals (12VAC 30-70-50). Currently, these providers (only 2 facilities) are being reimbursed based on the methodology that was in effect for all hospitals prior to the implementation of the Diagnosis Related Groups prospective reimbursement methodology. The changes to the old methodology include the reduction of the

"incentive plan," the elimination of an additional 2% annually added to the escalator, and modification of the disproportionate share hospital (DSH) utilization threshold percentage.

There are no changes in this final stage over that which were published in the proposed stage.

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 Outpatient Rehabilitation Agency and Long Stay Hospital Reimbursement (12VAC 30-70-50, 12 VAC 30-80-20, and 12 VAC 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. I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

Gregg A. Pane, M.D., MPA, 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 and 325, 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.

Specifically, Item 306 XX and Item 306 BBB of the 2009 *Act of the Assembly* (Chapter 781) required DMAS to make these changes:

XX. Effective July 1, 2009, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to convert the current reimbursement methodology for rehabilitation agencies to a statewide prospective rate for individual and group services to achieve estimated savings of $185,909 the second year in general funds and $185,909 the second year in nongeneral funds. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act. This shall not apply to rehabilitation services furnished by the Community Services Boards.

BBB. Effective July 1, 2009, the Department of Medicaid Assistance Services shall amend the State Plan for Medical Assistance to reduce reimbursement to long-stay hospitals to achieve savings in the second year of $990,000 general fund and $990,000 non-general fund. The department shall promulgate regulations to implement this amendment no more than 280 days from the enactment of this act.

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.

Outpatient Rehabilitation Facility Reimbursement
The purpose of this regulatory action is to incorporate into 12 VAC 30-80-200 the changes made in the previous proposed regulation, with some modification. The final text here is similar to the final text in a separate final regulatory action (Ambulatory Surgery Center and Outpatient Rehabilitation Facility Reimbursement -- Town Hall 2690/5345) that also addressed 12 VAC 30-80-200 except that it has been reorganized for clarity and to make room for an additional change as a result of a separate regulatory action regarding reimbursement for early intervention services. There are no expected environmental benefits from these changes.

Long-Stay Hospital Reimbursement
The purpose of this action is to incorporate into the Virginia Administrative Code the changes to 12 VAC 30-70-50 in earlier emergency regulation and as prescribed in the proposed regulation action. This final regulatory action is not essential to protect the health safety, or welfare of the citizens of the Commonwealth. It is also not expected to have any environmental benefits. The issues addressed by this action are the reduction of payment amounts being made to these two hospitals.

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.

Outpatient Rehabilitation Agency Reimbursement
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 (amending 12VAC 30-80-200). This change implements a prospective statewide fee schedule methodology for outpatient rehabilitation agencies based on Current Procedural Terminology (CPT) codes. Rehabilitation services furnished by community services boards and state agencies will continue to be reimbursed on a cost basis. The fee schedule was developed to achieve savings totaling $185,900 general funds dollars as required in the Governor's budget.

Long-Stay Hospital Reimbursement
The section of the State Plan for Medical Assistance that is affected by this action is Methods and Standards for Establishing Payment Rates: Inpatient Hospital Services (12 VAC 30-70-50). Long-Stay Hospitals currently are reimbursed based on the methodology in effect for all hospitals prior to the implementation of the prospective reimbursement methodology based on diagnosis-related-groups effective July 1, 1996. Several aspects of the methodology are no longer appropriate, but have never been changed since there are only a few hospitals (two currently) being reimbursed using this methodology. The changes to the old methodology include the reduction of the "incentive plan", the elimination of an additional 2% annually added to the "escalator", and modification of the Disproportionate Share Hospital (DSH) utilization threshold percentage.

The incentive plan currently pays a hospital up to 25% of the difference between the ceiling and its cost per day. As a result of the incentive plan, hospitals can be reimbursed more than their costs. The regulatory change reduces the maximum incentive plan to up to 10.5% of the difference between the ceiling and its cost per day. The escalator, which is currently inflation plus 2%, is used to increase the ceilings and the operating cost per day. The regulation will change the escalator to just inflation. Currently, DSH is calculated by multiplying the difference between the Medicaid utilization percentage and the Medicaid utilization threshold of 8% times the prospective cost per day. The regulation will increase the utilization threshold from 8% to 10.5%. The regulatory changes were projected to save $1.98 million (total funds) in FY10.

Please Note: DMAS implemented the Outpatient Rehabilitation Agency Reimbursement changes through a non-emergency regulatory process initiated in 2008. DMAS published a NOIRA (Town Hall 2690/4671 on 9/24/08 (VAR 25:3) and had a proposed regulation (Town Hall 2690/4933) which addressed this element of the Outpatient Rehabilitation package. The final regulation made these changes permanent on March 3, 2010 (Ambulatory Surgery Center and Outpatient Rehabilitation Facility Reimbursement--Town Hall 2690/5345, published VAR 26:11). The 2009 budget required DMAS to implement the Outpatient Rehabilitation Agency Reimbursement changes prior to its originally scheduled implementation date via an emergency regulation. While the Agency has finalized the outpatient rehabilitation reimbursement in the previously cited action, DMAS has included the same section in this proposed regulation. By doing so the Agency had the opportunity to consider provider feedback to the new reimbursement methodology. In the end, this final regulatory action makes no substantive changes to the proposed regulations.

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.

Outpatient Rehabilitation Facility Reimbursement
Prior to the change in the final regulatory action (Ambulatory Surgery Center and Outpatient Rehabilitation Facility Reimbursement -- Town Hall 2690/5345), the Virginia Administrative Code contained a cost-based methodology for computing reimbursement for outpatient rehabilitation services which is subject to a ceiling (12VAC 30-80-200). 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.

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. Some providers objected to the manner in which the agency implemented the new methodology. In the end, DMAS determined it was not necessary to make any substantive changes to the current regulations.

Long-Stay Hospitals Reimbursement
This regulatory action poses no disadvantages to the public or the Commonwealth. If the change in reimbursement is not implemented, it will mean ongoing expenditures to two hospitals will continue contrary to the General Assembly's directive. The primary advantage to the Commonwealth will be the reduction in payment amounts to these two enrolled Medicaid providers.

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 in this final stage over that which were published in the proposed stage.

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 January 17, 2011, *Virginia Register* for their public comment period from December 27, 2010, through March 18, 2011. No comments were received.

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.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-80-200	N/A	Describes the fee schedule use to reimburse most outpatient rehabilitation agencies	Reorganizes for clarity and makes room for additional changes as a result of separate regulatory action regarding reimbursement for early intervention services.
12 VAC 30-80-20	N/A	Describes rehabilitation services reimbursed on a cost basis.	Reorganizes for clarity and makes room for additional changes as a result of separate regulatory action regarding reimbursement for early intervention services.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-70-50(E)	N/A	Contains an incentive plan percentage that hospitals are to be paid between the allowable operating costs and per diem group ceiling when the allowable operating costs are lower than the ceiling.	Reduces the incentive plan percentage from 25% to 10.5%. This is needed to achieve the cost savings directed by the GA in its mandate.
12VAC30-70-50 (B)7		The statement regarding two percentage points was not in the previous permanent regulations.	Sentence being removed for internal consistency for Item 7.
12VAC30-70-50(F)	N/A	DSH methodology contains a Medicaid inpatient utilization percentage of 8%	Increases DSH percentage to 10.5% as the new standard that must be met in order to qualify for the additional DSH payment.

		as the level required to be met in order to qualify for the additional payment.	

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.

Outpatient Rehabilitation Facility Reimbursement

An alternative to this regulatory action was to convert the outpatient rehabilitation methodology to a time-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.

Long-Stay Hospital Reimbursement

The proposed changes have no effect on the reporting requirements or performance standards for small businesses. There is no compliance or operational changes that will be required for small businesses as a consequence of this regulatory action.

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.