Virginia Regulatory Town Hall

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Fast Track Proposed Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation	12 VAC 30-90-20; 12 VAC 30-90-70; 12 VAC 30-90-257
Regulation title	Methods and Standards for Establishing Payment Rates—Long Term Care Services
Action title	ICF/IID Ceiling; Cost Report Submission; Credit Balance Reporting
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 14 (2010) 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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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.

These changes modify the Nursing Facility (NF) reimbursement methodology in three areas: (i) updates the calculation of the per diem ceilings reimbursements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to account for state facilities' closures; (ii) makes a technical correction to an incorporation by reference included in nursing facility (NF) cost reporting requirements, and; (iii) updates NF credit balance reporting requirements to reflect more current Medicaid policies.

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 Regulatory Review Summary with the attached amended State Plan pages (12 VAC 30-90-20; 12 VAC 30-90-70, and; 12 VAC 30-90-257) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012.1, of the Administrative Process Act.

_____ _____

Date

Cynthia B. Jones, 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 citations to the Code of Virginia or General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority.

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.

Title 42 of the *Code of Federal Regulations* § 430.10 et seq. requires the states to modify their Title XIX State Plans whenever there are material changes in state policies for the Medicaid program. The Title XIX State Plan is the Commonwealth's comprehensive written statement which describes the nature and scope of the Virginia Medicaid program and is the basis upon which the Commonwealth claims its federal financial participation.

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 action modifies three sections in the NF reimbursement methodology to reflect updated policies resulting from the closure of state operated ICF/IIDs and more current policies for NFs reporting and resolution of credit balances. The third change is a technical correction of an incorrect internal citation that has been incorporated.

None of these changes has any affect on the health, safety or welfare of either citizens of the Commonwealth or Medicaid individuals. The calculation of the ICF/IID per diem reimbursement is not affected because none of these types of facilities are being paid their potential ceiling amounts. The changes to NF credit balance reporting may affect enrolled nursing facility providers. The technical correction affects neither individuals nor providers.

Rationale for using fast track process

Please explain the rationale for using the fast track process in promulgating this regulation. Why do you expect this rulemaking to be noncontroversial?

Please note: If an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall (i) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

This regulatory action is noncontroversial because it has no affect on Medicaid individuals. The changes to the ICF/IID rate setting and the credit balance reporting are expected to be well received by providers as they facilitate their processes as providers.

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.) Please be sure to define any acronyms.

The sections of the State Plan for Medical Assistance that will be affected by this action are the Nursing Home Payment System (12 VAC 30-90-20 et seq.), specifically 12 VAC 30-90-20, Nursing home payment system, generally; 12 VAC 30-90-70, Cost report submission, and; 12 VAC 30-90-257, Credit balance reporting.

12 VAC 30-90-20. Nursing home payment system; generally.

CURRENT POLICY

This section establishes the payment methodology that DMAS uses for nursing facilities. It includes three separate cost components: plant or capital costs, operating costs (direct patient care costs), and; nurse aide training/competency evaluation and competency evaluation (NATCEPs) costs.

Subsection D provides for the separate treatment of state-owned (the Department of Behavioral Health and Developmental Services) or federal government-owned (Department of Veterans Services) nursing facilities. All of these types of nursing facilities are exempt from the prospective payment system (as set out in Articles 1, 3, 4, 6, and 8) and instead are reimbursed retrospectively on the basis of reasonable costs in accordance with the Medicare principles of reimbursement. These institutions are limited to the highest rate paid to a state ICF/IID institution as determined each July 1 by DMAS.

ISSUES

The need for the changes to 12 VAC 30-90-20 derives from the Department of Justice suit against the Department of Behavioral Health and Developmental Services which is resulting in the closure of the state's training centers. Most of the individuals who have been residing in these facilities are being transitioned into community settings to be cared for by one of the Medicaid home and community based care waiver programs. This transition to communities is set out in the settlement agreement between the Commonwealth and DOJ.

As the training centers' individual populations are declining, the centers' operating and overhead costs are increasing. These centers' operating and overhead costs include: (i) utility payments; (ii) staff salaries and health/welfare benefits, and; (iii) administrative costs. As the individual populations decline, they generate fewer and fewer patient care days for which these facilities can bill DMAS. At the same time that declining patient care days are generating fewer billable days, these centers are experiencing increasing overhead costs from employees who are retiring or are eligible for severance pay.

This extreme imbalance of rapidly declining billable patient care days with rapidly increasing operating costs is causing the ratio between these two items to drive higher and higher per day costs. Since DMAS uses this per day cost from these state centers to set the reimbursement rates for both public and private Intermediate Care Facilities for Individuals with Intellectual Disabilities, this rate setting methodology must be changed.

RECOMMENDATIONS

DMAS recommends that the current methodology be replaced with one that uses a benchmark amount (from SFY 2012) which is then slightly increased by the annual nursing facility inflation factor that is based on the percentage of change in the moving average of a nursing facility's market basket of routine service costs. This revised methodology will be appropriate in the long term for the declining number of state-owned ICF/IIDs and the increasing number of private ICF/IIDs.

12 VAC 30-90-70. Cost report submission.

This section is included here due to the need to modify an incorrect internal regulatory citation. Currently, A 6 refers to 12 VAC 30-90-37; it should be 12 VAC 30-90-38.

12 VAC 30-90-257. Credit balance reporting.

CURRENT POLICY

No later than 30 days after the close of every quarter, nursing facilities (NFs) are required to report credit balances to DMAS. Then either the NF issues a check for the credit amount to DMAS or submits claim adjustments to rectify the credit balance. In the absence of either of these two repayment options, DMAS retracts the credit amount owed from future payments owed to the NF. DMAS is also permitted to impose penalties for NF failures to report and repay such Medicaid credit balances.

ISSUES

Beginning in 2003, CMS required that all state Medicaid agencies conduct this activity for hospitals. At that time, DMAS promulgated these regulations which follow the Medicare model for hospitals of reporting and recovery. For several reasons, this approach has been found to be unworkable.

There are differences in how Medicare covers NF services as compared to Medicaid. Medicare covers only relatively short lengths of NF stays for its beneficiaries whereas Medicaid's lengths of NF stays can range over years. Medicare patients are responsible for annual deductible and coinsurance amounts determined at discharge. Medicaid patients have patient pay requirements (individuals are required to contribute towards the costs of their NF care) that reduces allowable costs by individuals' financial means including Social Security payments since Medicaid is a payer of last resort.

Furthermore, there are 262 nursing facilities that are currently enrolled in Virginia Medicaid. To continue to require NFs to make quarterly reports to DMAS would generate annually 1048 reports that would require manual review and adjudication. This manual review/adjudication process would require an additional 2-3 more full time staff at salaries and fringe benefit costs exceeding $150,000.

A recently completed audit by the HHS Office of the Inspector General (OIG) determined that NFs owe only a small amount, at any one time, of overpayments (less than $25,000) back to DMAS.

RECOMMENDATIONS

DMAS proposes to regularly remind NF providers, via their weekly remittance advice documents (computer generated reports that explain the resolution of submitted claims), that they

are expected to review their account ledgers, at least quarterly, to determine if they have any credit balances with DMAS. If providers do identify credit balances, they are able to easily adjust such amounts through the claims processing system by filing claim adjustments.

DMAS also proposes to follow up, during site visits at NFs for audits of Personal Fund Accounts, to ensure that this activity has been occurring and that the NFs' account books are balanced.

DMAS believes that combining this credit balance look-behind with Personal Fund Audits with nursing facilities is the most efficient and least cumbersome way to ensure that NFs are not inappropriately retaining large amounts of tax dollars.

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.

There are no advantages or disadvantages to citizens in any of these actions. The primary advantages to the agency and the Commonwealth for the recommended changes to 12 VAC 30-90-20 and 12 VAC 30-90-257 will be the judicious use of tax dollars with the more appropriate reimbursement levels for ICF/IID services and improved collections associated with NF credit balance reporting. Businesses may not like not being able to keep Medicaid payments for longer periods of time but are expected to appreciate the reduced penalties.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements more restrictive than related federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

There will be no localities that are more affected than others as these requirements will apply statewide.

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.

This regulatory action is not expected to affect small businesses as it does not impose compliance or reporting requirements, nor deadlines for reporting, nor does it establish performance standards to replace design or operational standards.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

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	$0
Projected cost of the *new regulations or changes to existing regulations* on localities.	$0
Description of the individuals, businesses or other entities likely to be affected by the *new regulations or changes to existing regulations*.	Nursing facilities (262) and Intermediate Care Facilities for Individuals with Intellectual Disabilities
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	All nursing facilities will be affected by the reduced credit balance reporting requirements.
All projected costs of the *new regulations or changes to existing regulations* for affected individuals, businesses, or other entities. Please be specific and include all costs. Be sure to include the projected reporting,	DMAS does not anticipate that these changes will create new costs for the affected providers.

recordkeeping, and other administrative costs required for compliance by small businesses. Specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.	
Beneficial impact the regulation is designed to produce.	Modify the rate setting methodology for state facilities; simplify the credit balance process for providers. The technical change has no impact.

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. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

These recommendations do not impose any new reporting requirements on businesses and are the least costly and intrusive alternatives.

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; nor 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 list all changes that are being proposed and the consequences of the proposed changes. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action.

*If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all differences between the **pre**-emergency regulation and this proposed regulation, and (2) only changes made since the publication of the emergency regulation.*

For changes to existing regulation(s), use this chart:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12 VAC 30-90-20 D		Requires that the rate for ICF/MRs be limited by applying the highest rate paid to a state ICF/Mr.	Use a benchmark rate (the highest state ICF/MR rate paid in 2012) and adjust it annually by applying the NF inflation factor.
12 VAC 30-90-70		Internal reference to 12 VAC 30-90-37	Internal reference changed to 12 VAC 30-90-38.
12 VAC 30-90-257		NFs are required to make quarterly reports of Medicaid credit balances and promptly issue repayments. Penalties are imposed if such payments are not forthcoming.	NF providers are still required to conduct quarterly reviews of their accounts to determine if they have Medicaid credit balances. They are no longer required to file reports with DMAS. They are expected to return identified balances to DMAS via the claims processing system by filing claim adjustments. DMAS will follow-up with NF providers on this issue when it conducts its site visits for purposes of verifying Personal Fund Account balances.