Form: TH- 10
2/22/00

Virginia
Regulatory
Town Hall

Exempt Action Final Regulation Agency Background Document

Agency Name:	Dept. of Medical Assistance Services
VAC Chapter Number:	12 VAC 30, Chapters 20, 50, 60, 110, 120, 130
Regulation Title:	State Plan for Medical Assistance Services
Action Title:	2003 Omnibus Mandatory Revisions
Date:	4/25/2003; Effective 7/1/2003

Where an agency or regulation is exempt in part or in whole from the requirements of the Administrative Process Act (§ 9-6.14:1 *et seq.* of the *Code of Virginia*) (APA), the agency may provide information pertaining to the action to be included on the Regulatory Town Hall. The agency must still comply the requirements of the Virginia Register Act (§ 9-6.18 *et seq.* of the *Code of Virginia*) and file with the Registrar and publish their regulations in a style and format conforming with the *Virginia Register Form, Style and Procedure Manual.* The agency must also comply with Executive Order Fifty-Eight (99) which requires an assessment of the regulation's impact on the institution of the family and family stability.

This agency background document may be used for actions exempt pursuant to § 9-6.14:4.1(C) at the final stage. Note that agency actions exempt pursuant to § 9-6.14:4.1(C) of the APA do not require filing with the Registrar at the proposed stage.

In addition, agency actions exempt pursuant to § 9-6.14:4.1(B) of the APA are not subject to the requirements of the Virginia Register Act (§ 9-6.18 *et seq.* of the *Code of Virginia*) and therefore are not subject to publication. Please refer to the *Virginia Register Form, Style and Procedure Manual* for more information.

Summary

Please provide a brief summary of the proposed new regulation, amendments to an existing regulation, or the regulation being repealed.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 purpose of this action is to conform the State Plan for Medical Assistance to several specific mandates required by the 2003 session of the General Assembly. Those changes are: the elimination of the QI-2 benefit; the increase of recipient co-payments for brand name drugs; the revision of service limits for home health services, outpatient psychiatric services, outpatient rehabilitation services; the repeal of Elderly Case Management; termination of Transitional

Medicaid benefits; the change in the nurse supervision visit of the personal care aide to every 30-90 days for recipients who do not have a cognitive impairment in the E&D waiver program; the provision in the Consumer Directed Personal Assistance waiver program for certain family members to supervise and direct the caregiver for the recipient and for certain family members to be reimbursed for personal assistance services provided to the recipient.

Additionally, a change is made to licensing standards required for home health agencies to conform DMAS regulations with the standards in the *Code of Virginia*.

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency .including the date the action was taken, the name of the agency taking the action, and the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages (12 VAC 30-20-80; 20-150, 20-160; -50-140; 50-150, -50-160; -50-460; 60-70; 110-1210; -120-50; -120-490, -120-500 through 550, and -130-50) and adopt the action stated therein. Because this final regulation is exempt from the public notice and comment requirements of the Administrative Process Act (Code § 2.2-4006), the Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

__________________ ______________________________________

Date Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Additional Information

Please indicate that the text of the proposed regulation, the reporting forms the agency intends to incorporate or use in administering the proposed regulation, a copy of any documents to be incorporated by reference are attached.

Please state that the Office of the Attorney General (OAG) 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. Note that the OAG's certification is not required for Marine Resources Commission regulations.

If the exemption claimed falls under § 9-6.14:4.1(C) (4)(c) of the APA *please include the federal law or regulations being relied upon for the final agency action.*

The sections of the State Plan for Medical Assistance that are affected by this action are: Coordination of Title XIX with Part A and Part B of Title XVIII (12 VAC 30-20-80); Co-payments and Deductibles for Categorically Needy/Medically Needy/QMBs (12 VAC 30-20-150 and 20-160); Amount, Duration, and Scope of Services: Home Health Services, Physician Outpatient Psychiatric Services, Outpatient Rehabilitation Services, Elderly Case Management Services (12 VAC 30-50-70, 50-140, 130-50, and 50-460 respectively). The state-only regulations affected by this action are Twelve Month Extension of Eligibility (12 VAC 30-110-1210); Elderly and Disabled Waiver (12 VAC 30-120-50); Consumer Directed PAS Waiver (12 VAC 30-120-500 through 120-550).

Elimination of Eligible Group Qualifying Individuals 2 (QI-2) (12 VAC 30-20-80)

Section 4732 of the Balanced Budget Act of 1997 established a capped allocation for each of 5 years beginning January 1998 to States for payment of Medicare Part B premiums for a mandatory eligibility group of low-income Medicare beneficiaries called Qualifying Individuals 2 (QI-2). These individuals had income from 135-175 percent of poverty and the State was required to pay a portion each month toward the Medicare Part B premiums for QI-2s. For 2002, the amount paid to each individual each month was $3.91. The source of payment of the Medicare premium for these individuals was all federal funding.

Authority for benefits for these persons expired on December 31, 2002. Therefore, effective January 1, 2003, the QI-2 benefit is no longer federally authorized.

This change will have no impact on providers since the QI-2 benefit was paid directly to the Medicare beneficiary as a reimbursement for a portion of their Medicare Part B premium. There will be a minimal fiscal impact on Medicare recipients who qualified as QI-2 since the only assistance that they received from the Medicaid program was a payment of $3.91 a month or a maximum of $46.92 for calendar year 2002 if they were enrolled during the entire year. This has no fiscal impact on DMAS, as the funding for this group was all federal money.

Increase Recipient Co-payments for brand Name Prescription Drugs (12 VAC 30-20-150, 20-160)

Federal Medicaid regulations permit State plans to impose "nominal" cost sharing on certain recipients. Federal regulations also protect special groups of Title XIX eligibles from being required to pay copays: children, pregnant women, institutionalized individuals, persons receiving emergency and family planning services, and individuals enrolled in health maintenance organizations (42 CFR § 447.53). For non-institutional services, such as pharmacy services, the maximum amount of the co-payment varies with the cost of the service. 42 CFR § 447.54 provides:

State payment for the service	Maximum copayment
$10 or less	$0.50
$10.01 to $25	$1.00

$25.01 to $50	$2.00
$50.01 or more	$3.00

The State Plan currently imposes a co-payment for different services for the Categorically and Medically Needy recipients and Qualified Medicare Beneficiaries (QMBs) subject t0 federally specified exclusions.

The 2003 Appropriations Act mandated (in Item 325 AAA) that DMAS increase its recipient co-payments for brand-name prescription drugs to $3.00.

Limit Outpatient Psychiatric Services (12 VAC 30-50-140, 50-150)

Historically, DMAS has allowed a service limit of 26 outpatient psychiatric sessions per enrollee, in the first year of treatment, without authorization. The 27th session and all subsequent sessions must be prior authorized. The 2003 Appropriations Act (Item 325 DDD (2)) mandated that DMAS make the necessary regulatory and system changes to implement the following planned changes.

The new policy for outpatient psychiatric services does not in any way limit access to treatment. It does, however, require the treating provider to evaluate the recipient's medical necessity, develop a comprehensive treatment plan, and obtain authorization for additional treatment sessions after an initial 5 sessions. Prior authorization of all additional outpatient psychiatric services beyond the initial five in the first year of treatment and in all subsequent years is now required. The assurance that the requested on-going outpatient psychiatric services are medically necessary, that they address stated treatment goals, and that the expected progress is occurring can only benefit the recipients of this service. The only impact to DMAS' outpatient psychiatric providers is that they must seek authorization from DMAS for recipients prior to the 6th session, instead of prior to the 27th session. There is no change for subsequent years of psychiatric services, as all subsequent sessions must be prior authorized.

Increase of Home Health Service Limits (12 VAC 30-50-160)

Pursuant to Item 325 DDD (1)-(2) of the 2003 Appropriations Act, DMAS is mandated to implement prior authorization requirements in the home health program for rehabilitative and nurse services after the fifth visit. Currently, prior authorization is not required until the 25th and 32nd visit, respectively. This change will affect home health providers who will now have to request prior authorization earlier than they otherwise would have. This change is a cost-savings measure.

Repeal Elderly Case Management (ECM) (12 VAC 30-50-460)

Pursuant to Item 325 QQ of the 2003 Appropriations Act, DMAS has been directed to remove coverage of the ECM Program as an optional Medicaid State Plan service. DMAS has been

reimbursing the Area Agencies on Aging (AAAs) for this program. These funds will instead be shifted to cover the costs of the new Chronic Care Conditions Waiver, through the AAAs, that DMAS is developing. DMAS is deleting the regulations for the ECM Program which are no longer necessary. This change is cost-neutral.

Certification/Licensure of Home Health Agencies and Occupational Therapists (12 VAC 30-60-70).

As a result of a review by the Office of the Attorney General, DMAS is revising the licensing and certification references in this regulation to conform to the standards provided for in the Code of Virginia § 32.1-162.8. This is a technical modification to the regulations and does not represent a policy change.

Termination of Transitional Medicaid Benefits (12 VAC 30-110-1210)

In 1999, the General Assembly enacted legislation to implement the Virginia Independence Program (VIP), a statewide welfare reform program. As part of this effort, §63.2-611 et seq. of the *Code of Virginia* required that transitional Medicaid assistance be provided to individuals who received cash assistance payments under the AFDC/TANF program but who lost their cash assistance and their Medicaid eligibility for reasons other than increased earnings from employment. In order to implement VIP, federal waivers of rules for the AFDC and Medicaid Programs were required. The waivers were approved and authorized to begin on July 1, 1995, and run for a period of eight years. The waivers expire on June 30, 2003, and are not renewable. The 2003 Appropriations Act Item 325 PPP directs DMAS to amend all appropriate regulations to eliminate transitional Medicaid coverage offered as part of the VIP waiver.

Medicaid currently provides up to 12 months of extended coverage for individuals: (i) who received Medicaid in three of the previous six months and, (ii) who lose coverage as a result of increased income. While this policy continues to apply for the general Medicaid population, the waiver allowed DMAS to eliminate the required reasons for the loss of coverage and the three of six months requirement in the work component of VIP. Under the regulations being repealed, individuals, required to participate in the welfare reform work component but chose not to, are dropped from the TANF program. Such individuals continued as Medicaid eligible under this transitional benefit even if they had not received Medicaid for at least three of the last six months.

The repeal of these regulations will only affect those individuals in the welfare reform work component of VIP who lose their Medicaid due to increased earnings and have not received Medicaid in three of the last six months. Individuals who have received Medicaid for three of the previous six months will not be affected as they will continue to receive Medicaid coverage under a twelve month extended program which is not affected by these regulations.

The federal Medicaid waiver allowed the Commonwealth to receive federal funds for the provision of transitional medical assistance for participants in the work component of VIP. Effective July 1, 2003, federal funds for the provision of transitional medical assistance is no

longer available. If the State elected to pay for transitional medical assistance for former TANF recipients who do not otherwise qualify for Medicaid, it is estimated that it would cost approximately $2.1 million dollars each year in General Funds.

The repeal of these regulations will primarily affect adults, as any children in the household will continue to be eligible to receive coverage under either the Medicaid or FAMIS programs.

Revise Elderly and Disabled Waiver (E&D) (12 VAC 30-120-50)

DMAS recently completed the final regulatory process for the E&D Waiver regulations, which became effective February 1, 2003. One of the changes incorporated in the final E&D waiver regulations addressed supervision of the personal care (PC) aide by the supervisory registered nurse (RN) every 30 days. DMAS and the workgroup agreed that DMAS, during the proposed regulation process, would amend this requirement so that the PC aide could be supervised by the RN every 30 to 90 days for recipients who do not have a cognitive impairment.

Based on inaccurate information from the licensing agency, DMAS adopted a maximum of 60 days in its final regulations. Subsequent to the completion of these final regulations, DMAS identified the problem and is hereby correcting the time period to be every 30 to 90 days as originally agreed in the workgroup meetings. This technical change, pursuant to the *Code* § 2.2-4006(A)(3), is cost-neutral.

DMAS has amended the waiver application for this change and has obtained federal approval.

Revise Consumer-Directed Personal Attendant Services (C-D PAS) Waiver (12 VAC 30-120-490 through 120-550)

Senate Bill 1008, requires DMAS to prepare and seek approval of a revision of the C-D PAS Waiver to allow spouses, parents, adult children, and guardians to direct care on behalf of the waiver recipient, when such recipient is incapable of directing his own care. Currently, the regulations state that individuals who receive these waiver services must be mentally alert, have no cognitive impairments, be able to manage their own affairs without help from another individual, not have a guardian or committee, and have the ability to hire and train personal attendants and supervise attendants' performance. This change will allow recipients to have more choices for their care. Currently, individuals who meet the criteria for the waiver, but who are not able to manage their own affairs, would receive care through the E&D Waiver. With this change, the recipient would have the option of having a caregiver manage his care through the C-D PAS Waiver. This change is cost-neutral.

With this renewal, DMAS made the following change: "Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse." DMAS has secured federal approval of this C-D PAS Waiver change.

Reduce Outpatient Rehabilitation Services (12 VAC 30-130-50).

Currently, up to 24 outpatient rehabilitation visits (physician therapy, occupational therapy, and speech/language pathology services) are covered before prior authorization is required. Item 325 DDD.1 of the Appropriation Act mandates that the State Plan for Medical Assistance be amended to limit the number of such visits to 5 without prior authorization. Acute and rehabilitation hospitals, rehabilitation agencies, and home health agencies that provide physical therapy, occupational therapy, and speech-language pathology services in outpatient settings will have to ensure that Medicaid recipients have the proper authorization for more than 5 visits. School based rehabilitation services were excluded, in the mandate, from these prior authorization requirements and will no longer be subject to prior authorization. The implementation of these new prior authorization requirements are expected to produce some cost savings for the DMAS.

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the 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.

This final exempt regulatory action will not have any direct impact on the institution of the family and the stability of the family. It will not strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; it will not encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, or one's children and/or elderly parents; nor will it strengthen or erode the marital commitment.