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 Chapter 80
Regulation title	Methods and Standards for Establishing Payment Rates-Other Types of Care: Hospital Outpatient Reimbursement and Rehab Agencies Reimbursement
Action title	Limit Outpatient Hospital Payment to 80% of Allowable Cost; Establish Prospective Reimbursement for Rehab Agencies
Document preparation date	Date by which Governor's signature needed: 05/11/04

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

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

This regulatory action amends the reimbursement of Type Two hospitals for outpatient services providing that cost reimbursement shall be limited to 80 percent of allowable costs. Type One teaching hospitals are excluded from this change. In addition, this action establishes a prospective reimbursement methodology for rehabilitation agencies other than those operated by Community Service Boards (CSBs). Rehabilitation agencies operated by CSBs will continue to be reimbursed on an allowable cost basis.

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 (Limit Outpatient Hospital Payment to 80% of Allowable Cost; Establish Prospective Reimbursement for Rehab Agencies 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.

__02/26/04_____ __/s/__Patrick W. Finnerty_____

Date Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Legal 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 the Department of Medical Assistance Services (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. This regulatory action is a response to a change in the 2003 Virginia Appropriations Act (Item 325 KKK and Item 325 NNN).

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing 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 equal to 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 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.

The section of the Virginia Administrative Code that is affected by this action is 12 VAC 30-80-20 -- Methods and Standards for Establishing Payment Rates -- Other Types of Care -- Hospital Outpatient Services. In addition, a new section is added, 12 VAC 30-80-200, establishing prospective reimbursement for all rehabilitation agencies except those operated by Community Service Boards.

Outpatient Hospital Allowable Cost Limit

Regulations at 12 VAC 30-80-20 identify services that are reimbursed on the basis of allowable costs and describe any special provisions related to specific services or provider categories. Outpatient hospital services are currently listed in this section, and are subject only to the limits related to Medicare principles of reimbursement. These limits provide that outpatient-operating costs are reimbursed at 94.2% of cost, and capital costs at 90% of cost. This final regulation provides for reimbursement of all outpatient costs at 80% of allowable cost.

Prospective Reimbursement for Rehab Agencies

Regulations at 12 VAC 30-80-20 also currently list rehabilitation agency services that are reimbursed at their actual allowable costs, subject only to the limits related to Medicare principles of reimbursement. This final regulation provides that rehabilitation agencies operated by Community Services Boards (CSBs) continue to be paid based on allowable costs, and this amendment also includes a new subsection (12 VAC 30-80-200), describing a prospective reimbursement methodology applicable to rehabilitation agencies other than those operated by CSBs. Each provider's prospective rate would be the lesser of its own historical cost per visit, or 112% of the weighted median cost per visit of all providers.

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 the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

The advantage of these regulations to DMAS is that there will be a cost savings associated with this change of approximately $8.5 million ($4.25 million GF; $4.25 million NGF) annually. For the change to a prospective payment system for outpatient rehabilitation agencies, a savings to the Medicaid program of $3.0 million ($1.5 million GF; $1.5 million NGF) is expected. The primary disadvantage to affected hospitals and rehabilitation agencies is a concomitant reduction in reimbursement for these services.

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 these final regulations over the proposed regulations that were published for public comment.

Public comment

Please summarize all comment received during the public comment period following the publication of the proposed stage, and provide the agency response. If no public comment was received, please so indicate.

DMAS' proposed regulations were published in the November 17. 2003, 2003, *Virginia Register* (VR 20:5) for their public comment period from November 17 through January 16, 2004. 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	Current requirement	Proposed change and rationale
12VAC30-80-20	Prior to the current emergency regulation, this VAC section prescribed reimbursement on a reasonable cost basis for inpatient and outpatient hospitals.	The final regulation limits Type Two hospitals to 80% of their allowable costs, while continuing Type One hospital reimbursement levels at 94.2% of operating costs and 90% of capital costs.
12VAC30-80-200	This is a new regulation section. Prior to the current emergency regulations addressing reimbursement for	These regulations add a new section to the reimbursement regulations to implement the new prospective

	rehabilitation agencies, such agencies were reimbursed on an allowable cost basis.	reimbursement method for all rehabilitation agencies except for those operated by Community Service Boards.

Family impact

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

This regulation has no impact on recipients or their families. These changes do not strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 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; strengthen or erode the marital commitment; or increase or decrease disposable family income.

This regulation affects the reimbursement rates paid to hospitals and rehab agencies serving Medicaid recipients. This change alone would not be expected to affect recipients or their families in any appreciable way.