REGULATORY REVIEW SUMMARY

Amendment to the Plan for Medical Assistance

I. IDENTIFICATION INFORMATION

Title of Proposed Regulation: Amount, Duration, and Scope of Services: Hospice Services

Director's Approval: April 5, 1999

Public Comment Period: July 19 – September 17, 1999

Proposed Effective Date: January 1, 2000

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II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, §32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, §32.1-324, grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act

(APA) §§9-6.14:7.1 and 9-6.14:9.1, for this agency's promulgation of proposed regulations subject to the Governor's review.

Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on January 1, 1999. The Code, at §9-6.14:4.1(C) requires the agency to file the Notice of Intended Regulatory Action within 60 days of the effective date of the emergency regulation if it intends to promulgate a permanent replacement regulation. The Notice of Intended Regulatory Action for this regulation was filed with the Virginia Register on January 26, 1999.

The Balanced Budget Act of 1997 §§4441 through 4449 modified hospice services for the Title XVIII Medicare Program. The 1998 General Assembly mandated, in Chapter 464 Item 335S of the 1998 Acts of the Assembly, that the Department revise its regulations, effective January 1, 1999, concerning the reimbursement of hospice organizations to be consistent with Medicare. The modifications affected areas of payment location, benefit periods, contracting of physicians' services, and physician service certification requirements.

Purpose: The purpose of this proposal is realign the Medicaid coverage of hospice services with those of Medicare so that individuals having terminal illnesses will have a seamless range of services available for their use to the benefit their health as well as the welfare of their supporting families.

Substance and Analysis: The sections of the State Plan affected by this action are Narrative for the Amount, Duration, and Scope of Services – Hospice Services (12 VAC 30-50-270), Standards Established and Methods Used to Assure High Quality of Care – Hospice Services (12 VAC 30-60-130), and Methods and Standards for Establishing Payment Rates-Other Types of Care – Fee-for-service providers – Hospice services payments (12 VAC 30-80-30). The state regulations affected by this regulatory action are Regulations for Hospice Services (12 VAC 30-130-480 et seq).

HISTORY

Hospice services were originally added to the Title XIX package of available services by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85) in section 9505. DMAS did not, however, begin to offer this service to its recipients until July 1, 1990. At the time of this original offer, DMAS was federally required to have its Medicaid-hospice services mirror the Medicare-hospice services, with few exceptions. This policy stemmed from the requirement that Title XIX hospice services could only be provided by hospice organizations which met the Title XVIII (Medicare)-certification requirements.

As originally covered, hospice services are a medically-directed, interdisciplinary program of palliative services for the terminally ill and their families. Hospice emphasizes pain and symptom control provided by a team of professionals, including

physicians, nurses, counselors, therapists, aides and volunteers. The majority of hospice services are delivered in the home with inpatient care available as needed. The services which are covered include: nursing care, medical social services, physician services, counseling services, short-term inpatient care, durable medical equipment and supplies, drugs and biologicals, home health aide and homemaker services, and rehabilitation services. The original program also had specified benefit periods and required physician certifications of terminal conditions for individuals' participation.

CURRENTLY

Hospice services are currently open to Medicaid recipients who have been certified by an attending physician and a hospice medical director as having 6 months or less to live. Services provided by the hospice agency include: physician, nursing, social work, counseling, personal care, and any other services necessary to carry out a plan of care related to the effects of the terminal illness.

Recipients of hospice services have four benefit periods available: there are two 90-day periods, followed by a 30-day period, followed by an indefinite period. Once the recipient has signed a hospice election form, both the hospice medical director and the attending physician must also sign it within two days or if each certifies verbally not later than two days after hospice care is initiated, then written signatures can be obtained up to eight days after such care is initiated.

Payment for these services is currently based on the location of the hospice agency that is providing the service. There are different payment rates for different areas of the State, for example Northern Virginia versus the remainder of the state. At the time of the initial availability in 1990 of this service, the payment methodology was one of the areas where the mirroring of the Medicare-hospice program was required.

The 1998 General Assembly has mandated, in Chapter 464 Item 335S, that the Department revise its regulations concerning the reimbursement of hospice organizations to be consistent with Medicare. The Balanced Budget Act of 1997 (BBA 1997) §§4441 through 4449 made the following changes to the current Medicare hospice program necessitating changes to the Virginia Medicaid Hospice Program:

Payment for hospice services shall be based on the location of the service rather than the location of the agency. This will negate the financial advantage some hospice providers may have by virtue of the physical location in a higher rate area even though the provided services may be in a lower rate area.

Hospice benefit periods are restructured to include two ninety day periods, followed by an extended period in which certifications must be made every sixty days until the recipient is no longer in the hospice program (either by demise or by electing to leave).

For each benefit period, physician signatures must be obtained at the beginning of the period.

Hospice agencies may now contract with physicians for services rather than employing them directly.

No policy alternatives were available with regard to benefit periods, location of service delivery, and the use of contracted physicians by hospices due to the mandate from the General Assembly. The agency is exercising its discretion to eliminate the redundant provisions of the state only regulations, found at 12 VAC 30-130-470 through 12 VAC 30-130-530. Those provisions that are not redundant and that affect the rights of individuals are being moved into the State Plan.

Issues: The effect of these recommended changes will be to 'catch Medicaid up' with changes made in by the BBA 1997 in Medicare. Except for the fact that Medicaid hospice criteria will be consistent with Medicare and, therefore, should be easier to comprehend, the implementation of these provisions will be transparent to the recipient and will have no impact on families. Hospice providers will have only one set of criteria to follow for Medicare and Medicaid that should increase their understanding and streamline their documentation process. These results are expected to favorably contribute to the efficient and economical operation of this important government function.

The agency projects no negative issues involved in implementing this proposed change.

Executive Order 25(98) Review: The agency determined, as a result of its earlier EO 25(98) review that the state only regulations for hospice services were redundant of the State Plan's provisions. Therefore, these regulations are proposed to be repealed by this action.

Fiscal/Budget Impact: Implementation of these changes to the Medicaid Hospice Program should have no impact on the recipients of hospice services. Hospice providers who follow the specific criteria will continue to be reimbursed for services provided to recipients who are appropriate for the hospice program. Payment at the site of service may result in a slight reduction of expenditures to the Agency.

Currently, there are 45 hospice providers enrolled in Medicaid but this number can fluctuate monthly. The total expenditures from October 1997, to October 1998, were $2,960,226. The total number of recipients who have used this service since 1994 (including those deceased and those still extant) is 2,274. The average length of stay for those deceased recipients is 70 days. The average length of stay for individuals who are still receiving services is 544 days. These very long average lengths of stay for individuals electing hospice coverage are the source of the federal law change that requires attending physicians to recertify every 60 days the need for this care.

There are no localities that are uniquely affected by these regulations as they apply statewide. The only hospice providers DMAS expects to be negatively affected by this regulatory action are those which specifically opened managerial home offices in Northern Virginia when the clients they served resided in Central or Southwest Virginia. The act of locating their home office in Northern Virginia enabled these companies to claim the high reimbursement level permitted by DMAS' previous reimbursement methodology. There are no localities that are uniquely affected by these regulations as they apply statewide.

Funding Source/Cost to Localities/Affected Entities: The Department of Medial Assistance Services is established under the authority of Title XIX of the federal *Social Security Act*, Public Law 89-97, as amended; and Title 32.1, Chapter 10, of the *Code of Virginia*. The Virginia Medicaid Program is funded with both federal and state funds. The current federal funding participation for medical assistance expenditures is 51.60%, which became effective October 1, 1998. It is estimated that this rate will increase to 51.77% on October 1, 1999. Because the federal and state fiscal years do not coincide, "blended" federal funding rates of 51.57% and 51.73% are used to estimate FY 1999 and FY 2000 expenditures respectively. The funding for hospice services in the Medicaid program for the 1998-2000 Biennium is included in Item 335 of the Appropriations Act budget program Medical Assistance Services (Medicaid)" 456. The subprogram is 45609 "Professional and Institutional Services". Any savings from this regulation will be an ongoing savings.

This regulatory action will not have any impact on local departments of social services.

Forms: The form 'Request for Hospice Benefits' has been revised and will be needed during the administration of these regulations.

Evaluation: The Department of Medical Assistance Services, routinely includes the monitoring of all Plan changes in its ongoing agency management activities. This change will become part of that ongoing process.

III. STATEMENT OF AGENCY ACTION

I hereby approve the foregoing Regulatory Review Summary and the attached amended pages to the State Plan for Medical Assistance for publication for public comment period in conformance to the public notice and comment requirements of the Administrative Process Act, Code of Virginia §9-6.14:7.1. Article 2.

04/05/1999

/s/ Dennis G. Smith
Dept. of Medical Assistance Services

JUSTIFICATION FOR PROPOSED REGULATORY CHANGE
Under Executive Order Twentyfive (98)

I. IDENTIFICATION INFORMATION

Regulation Names: Narrative for the Amount, Duration, and Scope of Services, Standards Established and Methods Used to Assure High Quality of Care, Methods and Standards for Establishing Payment Rates-Other Types of Care, and Regulations for Hospice Services

Issue Name: Hospice Services

II. JUSTIFICATION

Federal/State Mandate/Scope

These regulations are required in part by federal law. In order for DMAS to secure federal financial participation, the State Plan for Medical Assistance must delineate the coverage of hospice services, must provide for requirements for reimbursement and must provide the methodology by which reimbursement is made. Federal law does not determine the limits applicable to a service, what additional requirements a state may have or the reimbursement methodology. These recommended changes derive from the Balanced Budget Act of 1997 §§4441 through 4449 which applied to the Title XVIII Medicare program and the Chapter 464 of the 1998 Acts of the Assembly.

Essential Nature of Regulation

The effect of these recommended changes will be to 'catch Medicaid up' with changes made by the BBA 1997 in Medicare. Except for the fact that Medicaid hospice criteria will be consistent with Medicare and, therefore, should be easier to comprehend, the implementation of these provisions will be transparent to the recipient and will have no impact on families. Hospice providers will have only one set of criteria to follow for Medicare and Medicaid that should increase their understanding and streamline their documentation process. These results are expected to favorably contribute to the efficient and economical operation of this important government function.

Agency Consideration of Alternatives

The agency's ability to consider alternatives was negated by the mandate from the 1998 General Assembly in the 1998 Acts of the Assembly, Chapter 464, Item 335 S.

Family Impact Assessment (Code of Virginia §2.1-7.2)

This proposed change is unlikely to have any affect on families.

Regulation Review Schedule

The regular review of this regulation will occur in conjunction with the review of all agency regulations according to the schedule approved by the Secretary of Health and Human Resources under Executive Order Twentyfive (98).

REGULATORY REVIEW CHECKLIST

To accompany Regulatory Review Package

Agency Department of Medical Assistance Services

Regulation title Amount, Duration, and Scope of Services, Standards Established and Methods Used to Assure High Quality of Care, Methods and Standards for Establishing Payment Rates-Other Types of Care.

Purpose of the regulation To promulgate changes to the permanent hospice services regulations to conform the program to changes in the Balanced Budget Act of 1997.

Summary of items attached:

☒ **Item 1:** A copy of the proposed new regulation or revision to existing regulation.

☒ **Item 2:** A copy of the proposed regulation submission package required by the Virginia Administrative Process Act (Virginia Code Section 9-6.14:7.I.G [redesignated Section 9-6.14:7. I.H after January 1, 1995]). These requirements are:

- ☒ (i) the basis of the regulation, defined as the statutory authority for promulgating the regulations, including the identification of the section number and a brief statement relating the content of the statutory authority to the specific regulation proposed.
- ☒ (ii) the purpose of the regulation, defined as the rationale or justification for the new provisions of the regulation, from the standpoint of the public's health, safety and welfare.
- ☒ (iii) the substance of the regulation, defined as the identification and explanation of the key provisions of the regulation that make changes to the current status of the law.
- ☒ (iv) the issues of the regulation, defined as the primary advantages and disadvantages for the public, and as applicable for the agency or the state, of implementing the new regulatory provisions.
- ☒ (v) the estimated impact, defined as the projected number of persons affected, the projected costs, expressed as a dollar figure or range, for the implementation and compliance thereof, and the identity of any localities particularly affected by that regulation.

☒ **Item 3:** A statement from the Attorney General that the agency possesses, and has not exceeded, its statutory authority to promulgate the proposed regulation.

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☒ **Item 4:** A statement disclosing whether the contemplated regulation is mandated by state law or federal law or regulation, and, if mandated in whole or in part, a succinct statement of the source (including legal citation) and scope of the mandate, together **with an attached copy of all cited legal provisions.**

☒ **Item 5:** For any proposed regulation that exceeds the specific minimum requirements of a legally binding state or federal mandate, a specific rather than conclusory statement setting forth the reasoning by which the agency has concluded that the proposed regulation is essential to protect the health, safety or welfare of citizens or for the efficient and economical performance of an important governmental function.

☒ **Item 6:** For any proposed regulation that exceeds the specific minimum requirements of a legally binding state or federal mandate, a specific rather than conclusory statement describing the process by which the agency has considered less burdensome and less intrusive alternatives for achieving the essential purpose, the alternatives considered, and the reasoning by which the agency has rejected such alternatives.

☒ **Item 7:** A schedule setting forth when, no later than three (3) years after the proposed regulation is effective, the agency will initiate a review and reevaluation of the regulation to determine if it should be continued, amended, or terminated. Include a description of the specific and measurable goals the proposed regulation is intended to achieve, if practical.

☒ **Item 8:** A detailed fiscal impact analysis prepared in coordination with DPB that includes: (a) the projected cost to the state to implement and enforce the proposed regulation and (b) the source of funds to meet this projected cost.

____________________________________ ____________________

Signature of Agency head Date

Date forwarded to
DPB & Secretary