REGULATORY REVIEW CHECKLIST

To accompany Preliminary Determination Package

Agency Department of Medical Assistance Services

Regulation title Amount, Duration, and Scope of Services and Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services: Coverage of Inpatient Hospital Services Out-of-State

Purpose of the regulation To clarify and expand upon limits to be placed upon coverage of inpatient hospital services by providers who are located outside the borders of the Commonwealth.

Summary of items attached:

☒ **Item 1:** An explanation of the specific reason for the proposed regulation.

☒ **Item 2:** A statement identifying the source of the agency legal authority to promulgate the contemplated regulations and a statement as to 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. **(Be sure to attach a copy of all cited legal provisions).**

☒ **Item 3:** A statement setting forth the reasoning by which the agency has concluded that the contemplated 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 4:** A statement describing the process by which the agency has considered, or will consider, less burdensome and less intrusive alternatives for achieving the essential purpose, the alternatives considered or to be considered (to the extent known), and the reasoning by which the agency has rejected any of the alternatives considered.

/s/ Dennis G. Smith	7/19/99	VPS 7/20/99
Signature of Agency Head	Date	Date forwarded to DPB & Secretary

PRELIMINARY JUSTIFICATION FOR REGULATORY ACTION
UNDER EXECUTIVE ORDER TWENTYFIVE (98)

I. IDENTIFICATION INFORMATION

Regulation Name: Amount, Duration, and Scope of Services; Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services

Issue Name: Coverage of Out-of-State Inpatient Hospital Services

VAC Numbers: **12 VAC 30-50-100; 12 VAC 30-50-105; 12 VAC 30-50-140; 12 VAC 30-60-09; 12 VAC 30-70-120; 12 VAC 30-70-420**

Registrar's Filing Deadline: _____

II. LEGAL AUTHORITY

Agency Legal Authority: Code of Virginia §§32.1-324 and 32.1-325; 42 U.S.C. §1396.

Director Approval of Action: /s/ Dennis G. Smith 7/19/99
Dennis G. Smith Date

III. JUSTIFICATION

1. Statement of Reason for Regulation

The reason for this recommended action to amend the State Plan for Medical Assistance is to specify the circumstances for the coverage of out-of-state inpatient hospital services to include additional limitations on payment as allowed by Federal regulations. These recommendations are consistent with other states' Medicaid programs as set out in 42 CFR § 431.52. Currently, DMAS places no geographic limits on out-of-state hospital providers.

DMAS proposes to limit general access to out-of-state general acute care hospitals to within 50 miles of the border when the service is medically necessary. When the hospital is outside of the 50-mile border, then one of the following reasons must exist in order for the hospital's claim to be paid. The physician who is referring the patient to the out-of-state hospital will be required to obtain any needed authorizations.

The reasons for the recipient's need for out-of-state services must be one of the following: (i) a medical or surgical emergency exists; (ii) inpatient hospital services are needed and the

recipient's health would be endangered if he were required to travel back to the Commonwealth to obtain medical care; (iii) the Commonwealth determines, on the basis of medical advice, that the needed inpatient hospital services, or necessary supplementary resources, are more readily available in another state; (iv) it is the general practice for recipients in a particular locality to use inpatient hospital resources in another state. DMAS would recognize exceptional circumstances based on the medical needs of the patient.

Use of out-of-state general acute care hospital services in circumstances other than those listed above will be denied.

2. Federal/State Mandate and Scope

The legal authority of the Agency to administer the Medicaid Program is as stated above (II.). The regulation is mandated by federal law in that State Plans must indicate provision of out-of-state coverage of services. These recommended restrictions to the existing policy are not mandated but must be incorporated into the Plan in order for DMAS to have the authority to require prior authorization.

3. Essential Nature of Regulation

This regulatory action is intended to minimize travel outside of the Commonwealth's borders for the receipt of routine inpatient hospital care. DMAS anticipates somewhat of a reduction in transportation expenditures. DMAS' claims processing system does not capture information about out-of-state travel so precisely identifying transportation savings as a result of this regulatory action will not be possible. Although DMAS has not identified the amount of funds that out-of-state providers would still receive under the new proposed policy, DMAS estimates that up to $12 M in care may now be provided by Virginia facilities.

This regulatory action will have no impact on local departments of social services.

Setting additional limits, while still permitting access to out-of-state services when necessary, for payment of out-of-state routine inpatient hospital services, as permitted by Federal regulations, is intended to encourage use of in-state hospital facilities and reduce the cost of providing services out-of-state thereby keeping the Virginia taxpayers' money within the Commonwealth.

4. Agency Consideration of Alternatives

The current State Plan language does not place specifically-stated geographic restrictions on obtaining hospital services out-of-state. All providers rendering services to a Virginia Medicaid recipient must enroll with DMAS in order to receive reimbursement. Out-of-state hospitals that regularly treat Virginia residents are required to enroll with DMAS as participating providers. Out-of-state hospitals that treat Virginia residents on a non-routine basis enroll as non-participating providers.

Participating providers are currently paid per diem rates and at their fiscal year end, participating hospitals' costs are settled at the appropriate Diagnosis Related Grouping (DRG) rate. Non-participating providers are paid the lesser of either: the average in-state per diem OR a percent of their charges. The percentage of charge is based on the in-state

ratio of reimbursement to charges. Before DMAS can begin limiting reimbursement for out-of-state services, the State Plan must be changed. Out-of-state providers may see a reduction in reimbursement from Virginia Medicaid. DMAS is proposing the adoption of a policy similar to that of the border states of North Carolina, West Virginia and Tennessee. The Agency will consider any alternatives identified through the public comment process.

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

Families who live close to the borders of the Commonwealth will still be allowed to access out-of-state hospital providers if it is the general practice for recipients in that locality to use medical resources in the other state. In addition, coverage will be provided when medical services are needed in the case of a medical emergency; when medical services are needed and the recipient's health would be endangered if required to return to Virginia; and the needed medical services are more readily available in another state. There may be some impact if Virginia physicians commonly refer out of state rather than using in-state facilities as this types of referrals will not be authorized for payment.