Virginia Regulatory Town Hall

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Fast Track Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-70-70, 70-261, 70-271, 70-500, and 12 VAC 30-90-264
Regulation title	Methods and Standards for Establishing Payment Rates – Inpatient Hospital Services, and Long Term Care
Action title	Simplify Hospital and Specialized Care Reimbursement
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 36 (2006) 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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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.

The Department intends to accomplish several reimbursement methodology changes designed to simplify provider reimbursement. The first is to simplify hospital reimbursement by eliminating recapture of hospital depreciation when a hospital is sold; this also eliminates the associated record keeping. This regulation also eliminates the hospital outlier illustration, which is outdated.

The regulation also simplifies reimbursement for specialized care nursing facilities by 1) eliminating the case mix adjustment and 2) using the same inflation method and capital rate calculation used in the regular nursing facility reimbursement methodology. After recent changes to the covered groups, there is no longer a justification for the case mix adjustment and the associated reporting. The changes would be budget neutral.

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 regulations: Methods and Standards for Establishing Payment Rates – Inpatient Hospital Services, and Long Term Care: Simplify Hospital and Specialized Care Reimbursement (12 VAC 30-70-70, 70-261, 70-271, 70-500, and 12 VAC 30-90-264) 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.

_____ _____

Date

Patrick W. Finnerty, 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 law and/or regulation, including General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the scope of 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 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.

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.

The purpose of the regulation is to simplify hospital and specialized care nursing facility reimbursement either by eliminating unnecessary hospital and specialized care nursing facility requirements or by making the specialized care nursing facility reimbursement similar to the

regular nursing facility reimbursement. Both proposals are budget neutral and the reimbursement impact on providers would be negligible. Both proposals would reduce DMAS and provider administrative costs associated with reporting and recordkeeping activities.

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 60-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 objection 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.

DMAS consulted with the Virginia Hospital and Healthcare Association and the Association (VHHA) representative indicated that the VHHA would not object to eliminating recapture of hospital depreciation. Medicare has already eliminated hospital depreciation recapture. Sometimes hospital depreciation recapture benefits DMAS and other times it benefits the provider. However, in either case the funds involved are not material and it is necessary for DMAS and the provider to review cost reports related to the original hospital depreciation, which may be many years old. Neither party considers the record keeping a good use of resources. The VHHA also agrees that it is not necessary to have the hospital outlier methodology illustration in regulation. DMAS intends to put an outlier calculation spreadsheet on its web site.

DMAS consulted with the Virginia Health Care Association and providers receiving specialized care reimbursement under the current system. DMAS presented information regarding how the proposed simplification would have effected reimbursement if the simplification had been in place. Providers agreed that simplification would reduce administrative reporting requirements and make it easier for providers to estimate reimbursement.

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.)

The sections of the State Plan for Medical Assistance that are affected by this action is Attachment 4.19-A and 4.19D. The state regulations that are affected by this action are Methods and Standards for Establishing Payment Rates for Inpatient Hospital Services (12 VAC 30-70-70, 12 VAC 30-70-261, 12 VAC 30-70-271 and 12 VAC 30-70-500) and Methods and Standards for Establishing Payment Rates for Long-Term Care (12 VAC 30-90-264).

Eliminate Recapture of Hospital Depreciation

Under current policy, DMAS must "recapture" depreciation when a hospital is sold. DMAS reimburses hospitals for depreciation based on standard depreciation schedules. When a hospital is sold, the seller may experience a windfall if the sale price exceeds the reimbursed depreciation or the seller may experience a loss if the sale price is less than the reimbursed depreciation. If the seller experiences a windfall, DMAS will recapture hospital depreciation; if the seller experiences a loss, DMAS will cover the loss. When a sale occurs, therefore, the seller and DMAS have to calculate the windfall or loss based on the original records. Hospital sales are relatively infrequent, the windfall or loss is usually not large and the net payments/recoveries for DMAS are close to zero. In many cases, this is the only reason for storing older cost reports since Medicare eliminated recapture of hospital depreciation a number of years ago. DMAS and the hospital association agree that there is little cost/benefit in continuing the recapture of hospital depreciation and therefore this regulation would eliminate it.

Eliminate Hospital Outlier Illustration

12 VAC 30-70-261 are the regulations for the hospital outlier methodology. The section to be eliminated is only an illustration that is now more than 10 years out of date. DMAS intends to publish annual hospital outlier calculation worksheets on the DMAS web site and therefore it makes more sense to eliminate this regulation than to revise it.

Simplify Reimbursement of Specialized Care Nursing Facility Services

The goals of the planned regulatory action are to reduce unnecessary complexity and reduce administrative burden associated with the method used to determine nursing facility payment rates for Adult and Pediatric Specialized Care.

The current specialized care payment rate calculation method uses the Resource Utilization Group System (RUGS III) nursing only index to calculate each facility's average normalized case mix index (NCMI), which is the measure of each facility's average patient severity level normalized by the average of all specialized care patients in the state. Ceilings and payment rates are adjusted by the NCMI, in order to avoid overpayments to facilities with a less severe patient population and to ensure adequate payments to facilities that have a more severe patient population, relative to the state average. When this reimbursement methodology was developed there were approximately 40 adult specialized care providers serving recipients with ventilator, rehabilitation and complex care needs. Since 2003, however, adult specialized care serves only ventilator patients. As a result, there are less than 10 adult specialized care providers with a much more homogenous patient population. Pediatric specialized care still covers all categories, but the patients in the two pediatric specialized care facilities have very similar resource needs. In both the adult and pediatric specialized care facilities, specialized care facility NCMI scores are very close to 1.0 (the same as the state average) and application of the NCMI adjustment has a negligible effect on payment rates and is unnecessary.

Based on the provider and patient changes, there is no longer a compelling reason to continue adjusting rates and ceilings by the NCMI, especially given the extra work this requires and other disadvantages. DMAS uses the services of an outside accounting firm to calculate specialized care NCMI scores and rate adjustments. Specialized care facilities are required to send in additional MDS data on a monthly basis and the calculations cannot be completed until all

facilities have sent in this data. Providers have indicated to DMAS that the additional work is a burden and the lack of timeliness in finalizing rates is frustrating.

Along with eliminating the NCMI, DMAS is proposing two additional changes to further simplify the methodology by conforming the inflation adjustment and occupancy requirements to the methodology used in regular nursing facility reimbursement.

The current inflation methodology for specialized care reimbursement was also used for regular nursing facility reimbursement until July 1, 2002. This methodology involves a combination of historical and anticipated inflation, annual revisions and quarterly inflation updates. The new, simpler inflation methodology adopted effective July 1, 2002 for regular nursing facility reimbursement updates inflation annually using a single inflation factor. The inflation methodology used for specialized care reimbursement, however, was not changed. This regulation would require that the specialized care reimbursement use the simpler inflation methodology utilized for regular nursing facility reimbursement.

Additionally, this regulatory action will require adult specialized care reimbursement to use the same 90% occupancy requirement used in the regular nursing facility reimbursement. Under current regulations the occupancy requirement only applies to regular nursing facilities not to adult specialized care even though occupancy is already calculated by using total facility paid days, including specialized care days, as a percent of total available days. DMAS does not anticipate that capital reimbursement for specialized care facilities would be frequently affected by this change, but, in any event, the special consideration is not justified. The lower 70% occupancy requirement for pediatric specialized care would not change.

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.

The changes do not have a fiscal impact and they eliminate unnecessary administrative burdens on both DMAS and providers. The advantage to both the hospital and nursing facility providers of this change is the reduction of paperwork that is required by the policies being changed by this action. The advantage to DMAS with this change will be the simplification of both the inpatient hospital and nursing facility cost settlement process. There are no disadvantages to the Commonwealth for this action.

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 that exceed applicable 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 are no localities particularly affected by the proposed regulation.

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 was undertaken specifically to simplify the reimbursement and to eliminate unnecessary administrative activity on the part of DMAS and providers.

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

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	The state would annually save some administrative funds, probably less than $50,000.
Projected cost of the regulation on localities	None
Description of the individuals, businesses or other entities likely to be affected by the regulation	Providers of specialized care and hospital services.
Agency's best estimate of the number of such entities that will be affected. Please include an	There are currently 8 providers of specialized

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.	care and approximately 95 hospital providers. DMAS does not believe that any of the providers meet the small business criteria.
All projected costs of the regulation for affected individuals, businesses, or other entities. Please be specific. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses.	This regulation would have a negligible reimbursement impact on providers. However, it should save providers administrative costs related to reporting and recordkeeping. DMAS cannot estimate the savings to providers.

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.

The changes made in this action were selected to simplify the reimbursement and to eliminate unnecessary administrative activity on the part of DMAS and providers.

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; 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.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.

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

The section of the State Plan for Medical Assistance that will be affected by this intended action is the revaluation of hospital assets (12 VAC 30-70-70), the payment for hospital capital costs (12 VAC 30-70-271) and reimbursement for specialized care services (12 VAC 30-90-264).

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12 VAC 30-70-70 and 12 VAC 30-70-271		Requires hospital depreciation recapture.	Eliminates hospital depreciation recapture.
12 VAC 30-70-261 and 12 VAC 30-70-500		12 VAC 30-70-500 is a hospital outlier illustration and 12 VAC 30-70-261 refers to this section.	Eliminates the regulation with the illustration and deletes the reference to it elsewhere.
12VAC30-90-264, Subsection 4		Defines the statewide routine operating ceiling and the use of NCMI when calculating a Facility-specific prospective routine operating ceiling for specialized care.	Rebases the statewide routine operating ceiling for adult Specialized Care and eliminates the use of NCMIs in the calculation of a facility-specific prospective routine operating ceiling.
12VAC30-90-264, Subsection 5		Defines NCMI.	Eliminates this subsection and renumbers subsequent subsections. NCMIs are no longer necessary in the revised specialized care reimbursement methodology.
12VAC30-90-264, Subsection 6		Describes how the inflation adjustment and NCMI are used in calculating the facility-specific prospective routine operating base cost per day.	References the inflation methodology in 12VAC30-90-41 to be used in inflating specialized care costs and eliminates the case mix adjustment.
12VAC30-90-264, Subsection 7		Describes how interim rates are calculated.	Eliminates reference to use of the Minimum Data Set since it is no longer necessary to calculate a case mix adjustment.
12VAC30-90-264, Subsection 8		Describes reimbursement coverage for ancillary costs, including the method for inflating the ancillary cost ceiling.	References the inflation methodology in 12VAC30-90-41 to be used in inflating the specialized care ancillary cost ceiling.
12VAC30-90-264, Subsection 10		Exempts Specialized Care facilities from a 90% occupancy requirement when calculating Specialized Care capital costs.	Eliminates the exemption from the occupancy requirement.
12VAC30-90-264, Subsection 12		Describes how the pediatric routine operating ceiling and cost rate is calculated mirroring provisions in subsections 3-5.	Rebases the statewide routine operating ceiling for pediatric Specialized Care and eliminates the reference to subsection 5, which has been eliminated because the NCMI is no longer used.
12VAC30-90-264, Subsections 14 and 15		Describes procedures for submitting supplemental MDS data and calculating the initial case mix measures.	Eliminates these subsections and renumbers subsequent subsections. By eliminating the use of an NCMI, it is no longer necessary to submit supplemental MDS data.

12 VAC 30-90-264, Subsection 16		Describes cost reporting procedures.	There are no exceptions for specialized care providers to the requirements listed in 12 VAC 30-90-70 and 12 VAC 30-90-80.