Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30 -80
Regulation title	Methods and Standards for Establishing Payment Rates; Other Types of Care
Action title	Ambulatory Surgery Center and Outpatient Rehabilitation Facility 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

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

This regulatory action is intended to implement reimbursement changes for Ambulatory Surgery Centers (ASCs). This action will also implement reimbursement changes for outpatient rehabilitation (rehab) facilities that are currently reimbursed on a cost basis.

This regulatory change (12VAC30-80-35) is being added to implement a new ASC reimbursement methodology. DMAS cannot continue with its current methodology because the data that it uses in support of the current method is no longer available. Medicaid currently reimburses ASCs using the Medicare methodology in effect prior to January 1, 2007. In calendar year 2007, Medicare implemented a new interim ASC reimbursement methodology but still provided information so that DMAS could assign new ASC procedure codes to one of the nine ASC groups from the old Medicare methodology. In calendar year 2008, Medicare implemented a new permanent methodology which reimburses ASCs based on Ambulatory Payment Classification (APC) groups. This action will fully implement a new Ambulatory Patient Group (APG) methodology for Medicaid ASC reimbursement in a budget neutral manner. While similar

to the new Medicare methodology, DMAS' new methodology will no longer be dependent on the Medicare methodology.

12VAC 30-80-200 is being amended to implement a statewide fee schedule methodology for outpatient rehabilitation agencies.

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 Code of Virginia citation and General Assembly chapter number(s), 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 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 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, the environmental benefits, and the problems the proposal is intended to solve.

ASC

This proposed regulation is not essential to protect the health, safety, or welfare of citizens. However, it is necessary to have a reimbursement methodology for DMAS to pay ASCs that furnish services to Medicaid recipients. As a result of Medicare modifying its reimbursement methodology for ASCs, it no longer produces the data that DMAS has relied on for its current methodology. In the absence of this data, DMAS can no longer maintain its current methodology and, therefore, must develop a new methodology.

Outpatient Rehabilitation Facility Reimbursement

This proposed regulation is also not essential to protect the health, safety, or welfare of citizens. This proposed action modifies the methodology for reimbursing outpatient rehabilitation agencies. This new methodology is similar to the methodology used by Medicare and commercial insurers including Medicaid MCOs.

There are no expected environmental benefits from these changes.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (More detail about these changes is requested in the "Detail of changes" section.)

The section of the State Plan of Medical Assistance that is affected by these changes is the Methods and Standards for Establishing Payment Rates- Other Types of Care (adding 12VAC30-80-35 and amending12VAC30-80-200).

ASC

Medicaid currently reimburses ASCs using the Medicare methodology in effect prior to January 1, 2007, by assigning procedure codes to nine ASC groups. The rate for each group in the previous ASC grouper methodology was intended to compensate the ASC for all services performed solely based on the procedure code.

The new APG methodology defines Ambulatory Patient Groups (APGs) as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by ASCs. Each group is assigned an APG-relative weight that reflects the relative average cost for each APG compared to the relative cost for all other APGs. The base rate for ASC visits are determined by dividing total reimbursement for ASC services by the total number of visits for ASC services. The total allowable operating rate per visit is determined by multiplying the base rate times the APG relative weight.

To maintain budget neutral expenditures for ASC services and to reduce payment errors, as compared to the current Medicare-based methodology, the base rate is to be adjusted by a budget neutrality factor (BNF) determined every three years. The APG relative weights to be implemented will be the weights determined and published periodically by DMAS. The weights will be updated at least every three years in concert with calculation of the BNF for ASCs. New outpatient procedures and new relative weights are to be added as necessary between the scheduled weight and rate updates. The affected entities will be notified of these changes, as they occur, via agency guidance documents.

Outpatient Rehabilitation Facility Reimbursement

12VAC 30-80-200 is being amended to implement a prospective statewide fee schedule methodology for outpatient rehabilitation agencies based on CPT codes. Rehabilitation services furnished by community services boards and state agencies will continue to be reimbursed on a cost basis. The fee schedule will be developed to achieve savings totaling $185,900 general fund dollars as required in the Governor's budget.

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.

ASC

Implementation of APGs will align the DMAS ASC methodology more closely with other ambulatory payment methodologies. This change will increase the efficiency and effectiveness of payments made by DMAS to ASC providers and reduce payment errors.

Outpatient Rehabilitation Facility Reimbursement Facility Reimbursement

Currently, the Virginia Administrative Code contains a cost-based methodology for computing reimbursement for outpatient rehabilitation services which is subject to a ceiling (12VAC30-80-200). For rehabilitation services, Medicare and most commercial insurers use a fee schedule. As a result, outpatient rehabilitation agencies bill differently and submit a cost report only for Medicaid. Implementation of a fee schedule methodology will align the DMAS reimbursement methodology for outpatient rehabilitation services more closely to the Medicare methodology and other reimbursement methodologies used by commercial insurers, including Medicaid's enrolled Managed Care Organizations (MCOs). Providers will no longer have to submit cost reports and DMAS will no longer have to settle the cost reports. Discontinuing both of these activities will result in administrative savings to both rehab providers and the Commonwealth.

There are no disadvantages to the citizens of the Commonwealth for these changes as they are not expected to have an impact on the delivery of these services. The advantage to the citizens of the Commonwealth is the reduction in providers' and agency's costs associated with these changes.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which are 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 applicable federal requirements, but DMAS must have a methodology to pay ASCs and outpatient rehabilitation agencies for services furnished to Medicaid recipients.

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 that would be particularly affected by this regulatory action as it will be applied statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, DMAS is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, DMAS is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments may do so by mail, email or fax to Carla Russell, Manager, Div. of Provider Reimbursement, DMAS, 600 E. Broad Street, Suite 1300, Richmond VA 23219 (804/225-4586; fax 804/371-8892) (**Carla.Russell@dmas.virginia.gov**) **.** Written comments must include the name and address of the commenter. In order to be considered comments must be received by the last date of the public comment period. Written comments may also be submitted via the Virginia Regulatory Town Hall website (www.townhall.virginia.gov).

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

ASC

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 implementation of APGs will be budget neutral. DMAS will use its current funding for MMIS changes to implement this methodology. A commercial vendor furnishes the grouper to be used free of charge.
Projected cost of the regulation on localities	There are no projected costs on localities.
Description of the individuals, businesses or other entities likely to be affected by the regulation	ASC providers enrolled in the Virginia Medicaid Program.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently	Approximately 86. DMAS has no information relative to whether these enrolled providers would meet the definition of small businesses.

owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	
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 is intended to be budget neutral in the aggregate for all ASCs. However, some individual providers may receive reduced reimbursement and others may gain. Individual providers would experience little to no administrative costs as the claim reporting requirements are not to be affected. It is not necessary for providers to purchase the grouper, but some ASC providers may wish to do so to estimate reimbursement. The Managed Care Organizations (MCOs) may incur administrative costs if the MCOs decided to make system changes to mirror the DMAS methodology; however, MCOs already have flexibility to determine how to pay providers.

Outpatient Rehabilitation Facility Reimbursement

This reimbursement methodology change is expected to achieve a total savings of $371,800 ($185,900 non-general funds; 185,900 in general funds).

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 implementation of the new reimbursement methodology will achieve savings of $185,900 GF. DMAS will use its current funding for MMIS changes to implement this methodology. DMAS will annually save $48,500 GF since it will no longer audit and settle cost reports.
Projected cost of the regulation on localities	There are no projected costs on localities.
Description of the individuals, businesses or other entities likely to be affected by the regulation	Outpatient rehabilitation agencies enrolled in the Virginia Medicaid Program excluding community service boards and state agencies.
Agency's best estimate of the number of such entities that will be affected. Please include an 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.	Approximately 100.
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 is intended to achieve savings for the Commonwealth but the impact will vary by provider. Some individual providers may receive reduced reimbursement and others may gain. Individual providers would experience little to no administrative costs as the claim reporting requirements are not affected. Providers will each save approximately $2000 annually since they will no longer have to prepare cost reports.

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.

ASC

The need for this regulatory action is based on the inability to maintain the existing reimbursement methodology for ASCs. DMAS considered several alternatives and requested feedback from the public and providers through the regulatory process. Other alternatives were less effective and would have been more costly to maintain.

Outpatient Rehabilitation Facility Reimbursement

An alternative to this regulatory action is to convert the outpatient rehabilitation methodology to a timed-unit base methodology, paying the same rate for all rehabilitation services in 15-minute increments. Since the cost to prepare a cost report does not vary significantly by size of business, it's more burdensome on small businesses. Either proposal would eliminate the requirement to prepare and submit a cost report. However, the proposed reimbursement methodology is the least burdensome because it is the most similar to the methodology used by other payers, including Medicaid MCOs.

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.

ASC

This regulatory action is based on the inability to maintain the existing reimbursement methodology for ASCs. DMAS considered several alternatives and requested feedback from the public and providers through the regulatory process. Individual providers would experience little to no impact as the claim reporting requirements are not affected by this change.

Outpatient Rehabilitation Facility Reimbursement

An alternative to this regulatory action is to convert the outpatient rehabilitation methodology to a timed-unit based methodology, paying the same rate for all rehabilitation services in 15 minute

increments. Since the cost to prepare a cost report does not vary significantly by size of business, it's more burdensome on small businesses. Either proposal would eliminate the requirement to prepare and submit a cost report. However, the proposed reimbursement methodology is the least burdensome because it is the most similar to the methodology used by other payers, including Medicaid HMOs.

Public comment

Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.

DMAS' Notice of Intended Regulatory Action was published in the September 15, 2008, *Virginia Register of Regulations* (VR 25:1) for its public comment period from September 15, 2008 to October 15, 2008. No public comments were received.

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; or 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. It does not strengthen or erode the marital commitment.

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.

ASC

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
	12VAC30-80-	N/A	Implements APG methodology for ASC

	35		reimbursement in a budget neutral manner.

Outpatient Rehabilitation Facility Reimbursement

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-80-200	N/A	Reimburses a prospective rate for outpatient rehabilitation services equal to the lesser of an agency's cost per visit for each type of service (physical, occupational, or speech therapy) or statewide ceiling	Modifies this methodology to begin reimbursing outpatient rehabilitation services according to a statewide fee schedule similar to the reimbursement methodology used by Medicare and commercial payers, including Medicaid MCOs.