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Exempt Action: Final Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 30-70-221, 12 VAC 30-70-231, 12 VAC 30-80-30, 12 VAC 30-80-36
VAC Chapter title(s)	General; Operating payment for DRG cases; Fee-for-service providers; Fee-for-service providers: outpatient hospitals
Action title	Hospital Readmissions and Emergency Room Visits
Final agency action date	9/11/2020
Date this document prepared	9/11/2020

Although a regulatory action may be exempt from executive branch review pursuant to § 2.2-4002 or § 2.2-4006 of the *Code of Virginia*, the agency is still encouraged to provide information to the public on the Regulatory Town Hall using this form. However, the agency may still be required to comply with the Virginia Register Act, Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

This regulatory action implements two mandates from the 2020 General Assembly. These relate to hospital readmissions and emergency room visits.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, internal staff review, petition for rulemaking, periodic review, or board decision). "Mandate" is defined as "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

DMAS is implementing these changes through a Final Exempt regulation pursuant to §2.2-4006 A 4 a, as a regulations that is "necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved."

The 2020 Appropriations Act, Item 313.AAAAA requires DMAS to allow the pending, reviewing and the reducing of fees for avoidable emergency room claims for codes 99282, 99283 and 99284, both physician and facility. The department shall utilize the avoidable emergency room diagnosis code list currently used for Managed Care Organization clinical efficiency rate adjustments. If the emergency room claim is identified as a preventable emergency room diagnosis, the department shall direct the Managed Care Organizations to default to the payment amount for code 99281, commensurate with the acuity of the visit.

As a result, this regulatory package contains the following changes to 12 VAC 30-80-30 and 12 VAC 30-80-36:

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public) except that emergency room services 99282-99284 with a principal diagnosis on the Preventable Emergency Room Diagnosis List shall be reimbursed the rate for 99281. The Preventable Emergency Room Diagnosis List shall be based on the list used for Managed Care Organization clinical efficiency rate adjustments.

d. Effective July 1, 2020, reimbursement for claims with procedure codes 99281-99284 and a principal diagnosis code on the Preventable Emergency Room Diagnosis List shall be based on an all inclusive EAPG payment weight for claims with CPT 99281 and a principal diagnosis code on the Preventable Emergency Room Listing**.** All other procedures on the outpatient hospital claim shall be packaged in the all inclusive payment for 99281-99284. DMAS shall calculate the all-inclusive payment weight for claims with 99281 using data from the most recent rebasing. The Preventable Emergency Room Diagnosis List shall be based on the list used for Managed Care Organization clinical efficiency rate adjustments.

The 2020 Appropriations Act, Item 313.BBBBB requires DMAS to modify the definition of readmissions to include cases when patients are readmitted to a hospital for the same or a similar diagnosis within 30 days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the patient was originally discharged against medical advice. If the patient is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases shall be paid at 50 percent of the normal rate, except that a readmission within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits.

As a result, this regulatory change contains the following changes to 12 VAC 30-70-221 and 12 VAC 30-70-231:

"Readmissions" means when patients are readmitted to the same hospital for the same or a similar diagnosis ~~within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as new cases.~~ Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits.

2. Readmissions within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case.
3. Effective July 1, 2020, readmissions within six to thirty days of discharge shall be paid at fifty percent of the normal rate unless it is a planned readmission, an obstetrical readmission, an admission to critical access hospitals, or in any case where the patient was originally discharged against medical advice.

Statement of Final Agency Action

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.

DMAS has submitted Final Exempt changes to 12 VAC 30-70-221, “General”; 12 VAC 30-70-231, “Operating Rate for DRG Cases”; 12 VAC 30-80-30, “Fee-for-Service Providers”; and 12 VAC 30-80-36, “Fee-for-service providers: outpatient hospitals” in order to meet the 2020 General Assembly mandates.