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	12VAC30-150-40 - 12VAC30-150-100
Regulation title	Uninsured Medical Catastrophe Fund
Action title	UMCF Program Changes
Document preparation date	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 21 (2002) 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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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.

In 1999 the General Assembly created the Uninsured Medical Catastrophe Fund ("UMCF" or "the Fund") under Code of Virginia § 32.1-324.3. The General Assembly authorized the Department of Medical Assistance ("DMAS") to oversee the Fund and to promulgate regulations to administer the UMCF. DMAS has made no changes to the UMCF regulations since the establishment of the Fund. DMAS has determined that the Fund is hindered by regulatory requirements that impede the efficient operation of the program. The UMCF is a fund-limited program that places much of the responsibility for medical care on Fund applicants. Applicants are required to locate a provider willing to accept structured Fund payments for medical services. Because the Fund does not reimburse providers in the usual manner that medical claims are paid, Fund applicants must quickly master the complicated UMCF requirements and be able to explain these complex requirements to potential providers. The changes proposed in this regulatory action seek to address these burdens on Fund recipients, providers, and on DMAS staff, and will help ensure greater simplicity and efficiency of administration.

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 Agency Background Document with the attached amended regulations Uninsured Medical Catastrophe Fund Program Changes (12 VAC 30-150-40 through 12 VAC 30-150-90) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012.1, of the Administrative Process Act and is full, true, and correctly dated.

_____ _____

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 Medicaid authority as established by §1902(a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services. The *Code of Virginia* (1950) as amended, §§ 32.1-325 and 32.1-351, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and the Title XXI Plan (FAMIS), respectively. 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 *Code of Virginia* (1950) amended, § 32.1-324.3, established the Uninsured Medical Catastrophe Fund on the books of the Comptroller and authorized the Board of Medical Assistance to promulgate regulations that (i) further define an uninsured medical catastrophe, (ii) establish procedures for distribution of moneys in the Fund to pay for the costs of treating uninsured medical catastrophes, (iii) establish application procedures, and (iv) establish criteria for eligibility for assistance from the Fund and the prioritization and allocation of available moneys among applicants for assistance from the Fund.

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 this regulatory action is to streamline the application approval process and fund disbursement to providers. This regulatory action will lessen the burden placed on the applicant and provide more efficient payment disbursements to providers. Currently the applicant must obtain a signed Agreement from one provider willing to accept payment for all services rendered that are identified on the Treatment Plan and disburse funds to other medical providers rendering services on the approved Treatment Plan. The proposed changes will allow the UMCF to disburse payment to more than 1 provider who rendered services on an approved Treatment Plan. The changes also provide more efficient administration of the fund by DMAS and allow more citizens to be served.

The current UMCF regulations, while well-intended, do not take into consideration the applicant's medical condition, the complexity of the Fund's program requirements, and the ability for potential applicants to communicate those program requirements to providers with sufficient detail to secure services and obtain a signed Agreement.

Rationale for using fast track process

Please explain the rationale for using the fast track process in promulgating this regulation. 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.

This action is being taken to simplify and streamline the application process and program operation for applicants to receive funds through the UMCF to pay for treatment for life threatening injury or illness of the uninsured. These changes will not allow more individuals to become eligible who would not otherwise be approved, but only allow a more efficient process. The Fast Track process allows the most expedient implementation of these regulations, which will ease the burdens on Fund applicants and potential providers alike. DMAS does not expect any opposition to or controversy concerning this action.

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 regulations affected by these suggested changes are 12 VAC 30-150-40 (Eligibility criteria), 30-150-50 (Treatment plan), 30-150-70 (Contracts with providers), 30-150-80 (Payments), and 30-150-90 (Application procedures and waiting list). The major changes proposed for the program are: to allow funds to be disbursed to more than 1 provider for services approved on the treatment plan, to allow funds to be disbursed for services provided as of the date the application is approved, and to decrease the application processing time period from 45 to 30 days for applicants to provide information to determine eligibility. The details of the proposed changes are described in the chart below.

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 primary advantage of this action is to simplify and streamline the application process and program operation for Fund applicants to have their medical providers paid through the UMCF**.** There are no disadvantages to the public, the Department, or the Commonwealth in the implementation of these suggested changes. The Department has worked closely with the Fund originators and the provider community and anticipates no negative response concerning these proposed changes.

Economic impact

There is no anticipated economic impact of the proposed regulations.

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	$ 0
Projected cost of the regulation on localities	$ 0
Description of the individuals, businesses or other entities likely to be affected by the regulation	Individuals with a life threatening injury and illness, as well as hospital, clinics, physicians, and other medical service providers involved in the treatment and resolution of catastrophic medical conditions.

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.	No economic impact is anticipated on any providers or small businesses.
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.	$ 0

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.

There are no viable alternatives without regulatory changes to improve the administration of the UMCF. The program would exist within the current regulatory requirements.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability.

This regulatory action has the potential to serve more individuals with a life threatening injury or illness. It will not increase or decrease disposable family income or erode the marital commitment. It will have no negative effects on the institution of the family or family stability. It will not increase or decrease disposable family income of erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, or the assumption of family responsibilities.

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.

Currently the UMCF program requires an evaluation of the treatment plan submitted by a treating physician for an applicant and the establishment of a global fee for the course of treatment identified. The treatment plan may involve a variety of medical services and multiple providers, however, the current regulations require that one provider must sign the Fund agreement for the global fee established and the designated provider must disburse all funds to other medical providers who render services. Some providers are not able to accommodate this requirement, resulting in an otherwise eligible applicant being denied approval because of difficulties associated with the required disbursement methodology. Changing the requirement to allow multiple disbursements will benefit Fund applicants and providers greatly, while having only minimal impact DMAS fiscal staff.

The change to allow UMCF funds to be disbursed as of the date the application is approved instead of the date that the Agreement is signed will provide greater operational efficiency. Currently the UMCF cannot commit funds for services prior to the date the Fund agreement is actually signed. With the proposed change providers could be reimbursed for services based upon the date the application was approved, regardless of the date the Agreement was actually signed. Without the change, unreimbursed services may be rendered in the gap between approval and execution of the Fund agreement. Under current practice it takes time to establish a working understanding of the Fund program with the primary provider. Previous experience shows that applicants do not delay necessary treatment pending the DMAS determination of their UMCF application. Providers typically do not delay necessary services to patients; most applicants who receive services without insurance are self-pay; permitting reimbursement based upon the date the Fund application was approved decreases the financial liability of the applicant, and is a more equitable result for providers.

Decreasing the application processing time period from 45 days to 30 days will have minimal adverse impact, if any, on application processing. Since the program began taking applications in September of 2002, the only applicants denied for failing to provide information within 45 days were those who did not respond in any manner to eligibility information requests. No applicant has been denied for providing information after the 45th day. The 30 day time limit is sufficient to provide required information (income, insurability and the treatment plan); if DMAS determines that the applicant is unable to provide the necessary documentation within this timeframe, additional time may be permitted. The program processes applications on a first come, first served basis. Because the Fund cannot disburse payment before an application is approved and the Agreement is signed, it is imperative that action on the application be taken as quickly as possible in order to facilitate payment for those individuals with pending applications who have a life threatening injury or illness.

The current regulations require that an individual be uninsured on the date of application, however they do not address the possibility that an individual may become insured during the course of treatment. This eventuality is addressed in this action. Language is being added to provided that if an individual becomes insured after the date of application, the UMCF will only pay for services not otherwise covered by subsequent insurance. The UMCF should not pay for services identified on a treatment plan if the provider can receive payment from an insurance carrier.

Current section number	New section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-150-40. Eligibility criteria.		5. Is uninsured for the needed treatment on the date of application and is not eligible for coverage for the needed treatment through private insurance or federal, state, or local government medical assistance programs.	5. Is uninsured for the needed treatment on the date of application and is not eligible for coverage for the needed treatment through private insurance or federal, state, or local government medical assistance programs. If an individual becomes insured for the needed treatment after the date of application, the UMCF will only pay for services not otherwise covered by the existing insurance. **Rationale**: The current regulations do not address the possibility that a person could become insured after an application has been submitted. The UMCF should only pay for services not otherwise covered under other insurance.
12VAC30-150-50. Treatment plan.		D. DMAS may approve the treatment plan as submitted, modify the treatment plan, or deny the treatment plan. DMAS may review and revise treatment plan decisions based on additional information up until the time a contract is signed. A treatment plan may only be altered if, during the course of treatment approved, the medical condition of the person substantially changes and renders the original course of treatment no longer appropriate, as determined by the contracting health provider. Any alteration cannot exceed either the established total dollar amount or the one-year time frame from initial authorization. F. The UMCF will not commit funds or pay for services provided prior to the date the contract is signed between DMAS and the contracting provider	D. DMAS may approve the treatment plan as submitted, modify the treatment plan, or deny the treatment plan. DMAS may review and revise treatment plan decisions based on additional information up until the time a contract is signed. A treatment plan may only be altered if, during the course of treatment approved, the medical condition of the person substantially changes and renders the original course of treatment no longer appropriate, as determined by the contracting health provider. If any alteration increases the established dollar amount, additional funds can be approved if available. Any alternation cannot exceed the one-year time frame from initial authorization. **Rationale:** Because the treatment plan is approved prior to services being rendered, there needs to be capability to allow payment for additional medical services identified as a result of initial treatment. Additional funds would only be committed if funds were available at the point in time that additional services were identified. F. The UMCF will not commit funds or pay for services provided prior to the date the application is approved ~~and a contract is signed between DMAS and the contracting provider~~. **Rationale:** Currently because the provider can date the Agreement as of the date the application is approved, this change has no substantive impact other than operational efficiency.

12VAC30-150-70. Contracts with providers		B. Reimbursement for covered services shall be a global fee based on existing Medicaid rates or Medicaid reimbursement methodology to cover all services in the approved treatment plan. The global fee will cover: procurement costs for transplants; any hospital costs from admission to discharge; total physician costs for all physicians providing services during the course of treatment; and any other medical or drug costs associated with the treatment plan approved by DMAS.	B. Reimbursement for covered services shall be a global fee based on existing Medicaid or Medicare rates (whichever is higher) or Medicaid reimbursement methodology to cover all services in the approved treatment plan. The global fee will cover: procurement costs for transplants; any hospital costs from admission to discharge; total physician costs for all physicians providing services during the course of treatment; and any other medical or drug costs associated with the treatment plan approved by DMAS. **Rationale:** The Medicaid rate is a lower reimbursement rate than the Medicare program rate. The UMCF is not the Medicaid program and feedback has been received from providers that they would be more agreeable to signing an Agreement if the reimbursement rate was comparable to the Medicare rate.
12VAC30-150-80. Payments		B. Payments are based on a global fee as provided for in 12VAC30-150-70. DMAS may establish a schedule of payments in the contract consistent with phases of the treatment plan. Payments will be made to contracting providers upon the completion of the treatment or phases of the treatment as specified in the contract.	B. Payments are based on a global fee as provided for in 12VAC30-150-70. Payments may be made to more than one provider if it is determined that one global payment cannot be made due to a provider's limitation to disburse funds. An individual provider's payments shall be based upon that provider's component of the global fee DMAS may establish a schedule of payments in the contract consistent with phases of the treatment plan. Payments will be made to contracting providers upon the completion of the treatment or phases of the treatment as specified in the contract. **Rationale:** Some providers are not able to accommodate this requirement because they are a small practice, resulting in an otherwise eligible applicant being denied due to the required disbursement methodology.
12VAC30-150-90. Application procedures and waiting list		C. It is the responsibility of the applicant to provide financial and medical information necessary to determine eligibility and approve the treatment plan. Failure to complete the application, submit the items in subsection B of this section, or provide requested information within 45 days of the date of the original signed application is grounds for denial.	C. It is the responsibility of the applicant to provide financial and medical information necessary to determine eligibility and approve the treatment plan. Failure to complete the application, submit the items in subsection B of this section, or provide requested information within 30 days of the date of the original signed application is grounds for denial

		D. Eligibility for Uninsured Medical Catastrophe Funds and approval of the treatment plan shall be determined by DMAS within 60 days of the date the original signed application was received. DMAS will not fully evaluate an application if it has determined that there is at least one cause for disqualification. DMAS shall advise in writing all applicants within 60 days of its determination about their applications.	D. Eligibility for Uninsured Medical Catastrophe Funds and approval of the treatment plan shall be determined by DMAS within 45 days of the date the original signed application was received. DMAS will not fully evaluate an application if it has determined that there is at least one cause for disqualification. DMAS shall advise in writing all applicants within 45 days of its determination about their applications. **Rationale:** 30 days is sufficient time to allow applicants to provide information for an eligibility determination. Allowance of additional time will be authorized if it is determined that it is beyond the applicant's ability to obtain documentation required and has demonstrated effort to obtain the necessary information.