Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	Dept. of Medical Assistance Services
Virginia Administrative Code (VAC) citation	12 VAC 30 Chapters 40 and 130
Regulation title	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid
Action title	Limits on Patient Pay Amounts for Non-Covered Medicaid Services
Document preparation date	Enter date this form is uploaded on the Town Hall NEED GOV APPROVAL BY 05/11/2004

This information is required for executive review (www.townhall.state.va.us/dpbpages/apaintro.htm#execreview) and the Virginia Registrar of Regulations (legis.state.va.us/codecomm/register/regindex.htm), pursuant to the Virginia Administrative Process Act (www.townhall.state.va.us/dpbpages/dpb_apa.htm), Executive Orders 21 (2002) and 58 (1999) (www.governor.state.va.us/Press_Policy/Executive_Orders/EOHome.html), and the *Virginia Register Form, Style, and Procedure Manual* (http://legis.state.va.us/codecomm/register/download/styl8_95.rtf).

Brief summary

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

Medicaid rules require that a nursing facility patient's payment for care equal the individual's total income from all sources in a month minus certain amounts that are set aside for the personal needs of the recipient, the living expenses of a spouse and minor child if those family members have little or no income of their own, and medical care and medical insurance expenses. Federal law requires that states reserve from a recipient's income a personal needs allowance. This is an amount that is considered reasonable to cover incidental expenses for items not included in the institution's basic charge, for example, clothing, hair cuts, etc. Virginia sets aside $30.00 per month as a personal needs allowance for individuals in nursing facilities.

This regulatory action proposes to limit the amount that may be deducted from the nursing facility resident's income to pay for medical services and supplies that are not other wise covered by Medicaid when the cost of the medical service or supply exceeds $500. The maximum amount that will be permitted to be deducted from the recipient's income for non-covered

medical services or supplies will be the higher of either the Medicare or Medicaid rate. In instances when an individual requires a service or device for which no Medicare or Medicaid rate exits, the agency will permit a deduction equal to the provider's usual and customary charge. Prior to this regulatory action, there was no limitation on the amount that could be deducted from an individual's income to pay for non-covered medical or remedial services. Limiting the amount of deductions from an individual's total income will preserve Medicaid funds by helping to ensure that more of the patient's income is available to be contributed to his nursing facility cost of care.

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 pages, Limits on Patient Pay Amounts for Non-Covered Medicaid Services (12 VAC 30-40-235 and 30-130-620) 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 source of legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly bill and chapter numbers, 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 and the problems the proposal is intended to solve.

Medicaid, as well as commercial health insurance companies, set maximum reimbursement amounts for services rendered by their provider networks. In the case of Medicaid, the reimbursement is usually the same as or less than the Medicare rate. Therefore, the purpose of this regulatory action is to conform this method of reimbursement to the general Medicaid reimbursement policies. This regulatory action is not expected to have any impact on the health, safety, or welfare of citizens because, even if NF residents are not able to buy the most expensive medical services available in the marketplace, they will still be able to get the medical care they need while simultaneously not overpaying for such care.

Any amounts spent by the resident for such medically indicated goods and services are deducted from the patient pay amount to be paid to the nursing facility; additional Medicaid funds are paid to the nursing facility to cover amounts that were deducted from the resident's patient pay amount used to cover those medical expenses that were not covered by Medicaid. Prior to the emergency regulations, there was no cap on the nursing facility resident's medical expenditures that could be deducted from his patient pay amount. This has resulted in Medicaid funds indirectly subsidizing higher payments made by Medicaid recipients for medically indicated, but non-covered, patient expenditures.

Prior to the emergency regulations, under 12 VAC 30-130-620, the patient pay adjustment process permitted essentially unlimited payment for non-covered, medically necessary, resident-specific, customized items or services prescribed for a Medicaid nursing facility resident thereby more quickly depleting greater amounts of residents' monthly incomes. Whatever resulting shortfall in the amount due the nursing facility from the patient pay amount is reimbursed to the NF by DMAS.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The section of the State Plan for Medical Assistance that is affected by this action is Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid (Attachment 2.6-A, Supplement 3 (12 VAC 30-40-235)). The state-only regulations that are

affected are Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid (12 VAC 30-130-620).

Prior to the agency's current emergency regulations, there was no limit on the amount of money that NF residents could have deducted from income to pay for medical services and supplies that were not otherwise covered by Medicaid, such as eyeglasses and dentures. This regulatory action proposes to limit the amount of money that may be deducted for medically necessary medical or remedial services, exceeding $500, from the patient pay portion for nursing facility residents. The maximum amount that will be permitted will be the higher of either the Medicare or the Medicaid rate. In the few instances when a resident requires a service or device for which no Medicare or Medicaid rate exists, then the agency will permit the patient pay adjustment to be up to the maximum of the provider's usual and customary charge. In situations when additional Medicaid funds are paid to the nursing facility to cover amounts that would have been paid by the resident's patient pay amount, then this represents additional expenditures for the agency. Using the existing Medicare or Medicaid rate structure for the maximum permissible deductible amount will encourage NF residents to seek services from Medicaid-enrolled providers.

This regulation proposes to set a maximum amount for non-covered medically necessary goods and services that can be allowed as adjustments to the patient pay for nursing facility residents. The maximum amount allowed will be the higher of either the Medicare or Medicaid rate for the same non-covered item or service. By limiting the amount of money that NF residents can expend for non-Medicaid-covered items or services, the NF residents will be able to continue to contribute more towards the costs of their Medicaid-covered NF care.

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.

The advantage to DMAS is that there will be a cost savings associated with this change of approximately $68,000 (GF) annually. Providers of services will be affected since DMAS will no longer automatically authorize providers' full charges to be deducted from the patient pay amount. This policy will give NF residents information on the amount that Medicaid would allow for the medical or remedial service. A disadvantage to NF residents is that they could be balance billed the difference between Medicaid's allowed amount and the provider's usual and customary charge. An advantage to NF residents is that this may conserve some of their patient pay amount to be used towards other needed, non-covered services.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

The changes made in this final regulation were required by the Centers for Medicare and Medicaid Services during its review of the State Plan amendment companion to DMAS' original emergency regulations. CMS required the addition of the provision providing that should there not be any Medicare or Medicaid pricing information for the particular needed service or device, then DMAS is to permit the deduction of the provider's full charge from the NF resident's income.

Public comment

Please summarize all comment received during the public comment period following the publication of the proposed stage, and provide the agency response. If no public comment was received, please so indicate.

DMAS published its proposed regulations on November 17, 2003, in the *Virginia Register* (VR 20:5, page 429, 11/17/03) for comment period from November 17 through January 16, 2004. The same comments were received from both the Virginia Health Care Association (VHCA) and the Virginia Poverty Law Center (VPLC). Comments were also received from the Office of the State Long-Term Care Ombudsman. A summary of the VHCA/VPLC's and Ombudsman's comments follow. The agency's responses are below.

1. Caseworkers with the local departments of social services (dss) are presently allowed, by policy, to adjust the patient pay portion (the amount the patient contributes to his cost of nursing facility care) when the cost of the non-covered service is less than $500 or is considered an 'old bill'. Expenses that do not exceed $500 do not require specific approval from DMAS. The regulation should incorporate this threshold amount and recognize the special treatment of 'old bills'. The regulations should be limited to medical items referred to as 'big ticket' items. Examples of 'big ticket' items would include dentures, expensive eyeglasses, and special wheelchairs. The regulation should be limited to such 'big ticket' items that are acquired after Medicaid eligibility begins. The commenters further noted that quick turnaround of approval decisions by local dss caseworkers is very important to maintain the delivery of needed medical services to NF residents.

   Agency response: The wording in the budget bill did not specify a minimum amount that would apply. Since the only requests for patient pay adjustments that require DMAS approval are those over $500, DMAS is only applying these regulations to those medical bills that are over $500. To change the wording of the regulation would be contrary to the language in the budget bill.

DMAS' existing policy for "old bills" defines them as unpaid medical, dental, or remedial care expenses which: (i) were incurred prior to the Medicaid application month and the application's retroactive period, (ii) were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and (iii) remain a liability to the individual. Old bills are already deducted from patient pay as non-covered expenses. Old bills do not require approval from DMAS in order to be deducted in the patient pay calculation, even when its amounts exceed $500. Since this issue is already addressed in DMAS policy and this proposed regulation makes no changes, no further action is recommended for this regulation.

2. The commenters stated that whenever the needed service is not covered by Medicaid (the example of dentures for adults was provided) or Medicare (therefore there is no existing price structure), then the actual full cost of the service should be deductible from the patient pay amount.

   Agency response: DMAS covers dentures for children younger than 21 years of age. Therefore, DMAS does have an allowed amount for this service. DMAS does not, however, cover most routine dental services for adults but instead provides only emergency dental services. The maximum allowable for dental services would be determined by the either the Medicaid allowable amount, should one exist for the needed service, or the provider's invoice or usual and customary charges, should there not be an existing Medicaid rate.

3. The commenters expressed concern that when a service is not covered by Medicare, that the regulation proposes to use the Medicaid reimbursement level. The commenters described the Medicaid reimbursement as far lower than the actual and reasonable cost of care and stated such a situation leaves nursing home residents without the ability to pay for legitimate medical expenses.

   Agency response: DMAS notes the commenter's dissatisfaction with the Medicaid reimbursement levels in general. However, this regulation will apply the higher of the Medicare or Medicaid rates, or if no rate is established by either, then the provider's usual and customary charge will be paid. In general, Medicare or Medicaid has a rate established for the majority of services affected by this regulation. DMAS does not believe that this regulation would limit a recipient's access to medical care since most services are already covered by Medicaid and would be paid in full. Furthermore, the modification of providers' reimbursement rates is outside the purview of this regulatory issue to amend.

4. The commenters expressed concern that there could be unintended and undesirable consequences from this regulation. The commenters provided this example: if a NF resident has a dental bill for $600, he might only get a patient pay deduction for $200 (representing the maximum Medicaid reimbursement for the service received). How could the resident pay the dentist the remaining $400 with only $30 per month income and limited resources? What if the NF resident pays the dentist the full amount billed and then cannot meet his patient pay obligations to the NF? The commenters stated that the

NF resident could then be subject to discharge from the NF. This would be a highly undesirable consequence. The commenters felt that the agency's suggestion in the preamble discussion document that the resident's family would pay the excess dental bill is not realistic for many NF residents.

Agency response: It currently is not possible for the NF resident to be discharged from the NF in the circumstances described in the comment. The patient pay adjustment process requires that if the dental service exceeds $500, it must be pre-approved by DMAS. This precludes and protects the patient from paying in advance and; consequently, the resident is informed of the amount DMAS authorizes, prior to receiving the service.

5. Also the commenters questioned if the Department intended to require an enrolled dentist to accept just $200 for an adult Medicaid recipient who is not entitled to Medicaid dental care. *[Note: Medicaid only covers dental care for adults in conjunction with a medical condition in which the patient's health could be compromised (i.e., removal of a tumor in the mouth, abscessed tooth complicating management of a medical condition such as diabetes. Ambulatory dental care in Medicaid is only covered for children younger than 21 years of age*.] The commenters further stated that it did not make sense to deny the dentist reasonable compensation from the resident. To do so could only result in a further decline in dentists' affiliation with Virginia's Medicaid program. Where there is not a comparable Medicare service, DMAS should use typical payment rates paid by private insurers as the measure for an appropriate patient pay deduction.

   Agency response: If there is no rate in either Medicare or Medicaid for the requested service, DMAS uses the provider's usual and customary charges. The suggestion to pay the provider the highest reimbursement paid by a private insurer is beyond the purview of this regulatory action as no additional funding was legislatively appropriated in conjunction with this mandatory action.

6. The commenters suggested that instead of the broadly drafted regulation, DMAS should instead select specific 'big ticket' non-covered services for which it will limit patient pay deductions. DMAS should also, on an annual basis, select the maximum deduction allowed and should publish, for use by all affected providers, NF residents and their families, its list of maximum deduction amounts tied to specific services. The commenters stated that the maximum should be no lower than the higher of Medicaid/Medicare reimbursement and in the absence of either of these two payment standards, should consider private insurer reimbursement rates. The commenters indicated that where Medicaid rates are inadequate, that private rates should also be considered.

   The purpose of publishing the list of reimbursement rates for specific services would be to adequately notify NF residents and their families, as well as providers, of the permitted patient pay deduction amounts ***before*** (emphasis added) the services are received.

Agency response: DMAS' final regulation addresses conditions where there is no Medicare or Medicaid rate. DMAS limits its ***prior authorization*** *process (before the service is rendered) to those services and supplies which exceed $500. The requesting recipient and his family are always informed about the maximum amount that DMAS will approve for the needed medical service and supplies. DMAS notes the commenter's dissatisfaction with the Medicaid reimbursement levels in general.*

Ombudsman comments:

This Office expressed concern that the proposed regulations or policies had the potential to adversely affect long-term care residents. The concern was that the proposed regulations could significantly impede a nursing home resident's access to medical services and supplies that are central to both quality of care and quality of life. This Office questioned if it is DMAS' intent that it review and approve every adjustment to the Medicaid patient pay amount. The concern was that requiring that all such adjustments be approved through DMAS would seriously encumber DMAS and would create unnecessary delays in getting patient pay amounts fairly adjusted. This commenter pointed out that current policy, which allows DSS caseworkers to make these adjustments, has created an efficient and effective system.

Concern was also expressed over the proposed policy of using 'the maximum allowable costs under Medicare or Medicaid'. The commenter stated that this was not a useful standard because the Medicaid rate for items or services is unrealistically low and Medicare's coverage is often narrowly circumscribed as to lend no meaningful standard. The commenter predicted the result of applying such a standard would be that either the patient/resident would not get the needed care or therapeutic items, or would be expected to pay off the balance above the allowable rate out of his $30 per month allowance.

Should a resident choose to allocate his moneys to pay balances, thereby leaving insufficient funds to cover the NF patient pay amount, he could end up facing involuntary discharge for failure to meet payments to the NF. 'To the extent that there is an expectation that family members will step in to pay off such balances, that is simply not a viable expectation for many residents with very limited resources'.

The commenter stated that setting an allowable rate unrealistically low could impede NF residents' access to items and services that are critical to their quality of care and life. Impeding access to services and care can have hidden costs. The commenter generally referenced much existing data that shows the importance of maintaining the general functional abilities in the elderly. The lack of such care, such as well-fitting dentures, can result in decreased appetite, compromised ability to eat, poor nutrition, dehydration, skin breakdown (causing decubiti), and dementia. Similarly, delays and barriers to receiving eyeglasses and hearing aids, which compensate for sensory losses, put NF residents at risk of falls, undetected illnesses, social isolation, and dementia.

This commenter recognized that the state had a legitimate interest in managing programs in a cost effective way. The commenter suggested that the state scrutinize 'big ticket' items to

optimize the use of limited resources but did not feel that the regulation, as proposed, accomplished this goal. The proposed changes would lead to diminished quality of care and life for long-term care recipients and ultimately to higher health care costs.

Agency response: DMAS is not modifying its current policy of requiring items/services exceeding $500 to be reviewed and prior authorized directly by DMAS before services are rendered. DMAS is also not modifying its current policy of permitting local departments of social services to continue handling all items/ services costing less than $500. DMAS is only requiring that those items/services that it reviews and approves not cost more nor be lower than the higher of either the Medicare or Medicaid rates for the same non-covered service. The initiating legislation (Chapter 1042 of the 2003 Acts of Assembly, Item 325 BBB) required that DMAS use the maximum amounts allowed by either Medicare or Medicaid. The selection of these two existing rate structures as applicable to this policy was made by legislative action. In spite of the earlier referenced general provider dissatisfaction with reimbursement rates, DMAS does not believe that its rates are set unrealistically.

All changes made in this regulatory action

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

Current section number	Current requirement	Proposed change and rationale
12 VAC 30-40-235	Prior to current emergency regulation, this VAC did not exist.	State Plan placement for the proposed policy as dictated by CMS. Proposed change sets out policy as discussed. Using the Medicare and Medicaid maximum reimbursement levels as the maximum amounts permissible for non-covered services has a long-standing history at DMAS.
12VAC30-130-620	Regulation currently provides that all other payment sources must be engaged before the NF resident's patient pay amount can be reduced. Prior to the current emergency regulation, no limits existed on how much the NF-cost patient pay amount could be reduced in order for the resident to pay for other needed medical services and items.	Proposed regulations add to the regulations that the maximum amount that the NF resident's patient pay amount can be reduced can be no greater than the higher of either Medicare or Medicaid payments for the item or service in question.

Family impact

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

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, but may increase disposable family income depending upon which provider the recipient chooses for the item or service prescribed.