Virginia Regulatory Town Hall

# Notice of Intended Regulatory Action
# Agency Background Document

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| **Agency Name:** | Dept. of Medical Assistance Services 12 VAC 30 |
| **VAC Chapter Number:** | Chapter 90 |
| **Regulation Title:** | Methods and Standards for Establishing Payment Rates-Long Term Care, Nursing Home Payment System |
| **Action Title:** | NF Credit Balance Reporting |
| **Date:** | November 20, 2001 |

This information is required prior to the submission to the Registrar of Regulations of a Notice of Intended Regulatory Action (NOIRA) pursuant to the Administrative Process Act § 9-6.14:7.1 (B). Please refer to Executive Order Twenty-Five (98) and Executive Order Fifty-Eight (99) for more information.

## Purpose

*Please describe the subject matter and intent of the planned regulation. This description should include a brief explanation of the need for and the goals of the new or amended regulation.*

The purpose of this regulatory action is to add a new requirement to the Nursing Home Payment System that each nursing facility submit a quarterly report of Medicaid credit balances. A credit balance would be defined as an improper or excess payment made to a provider as a result of patient billing or claims processing errors. Therefore, for each credit balance the nursing facility would also be required to either submit to the Department of Medical Assistance Services the payment of the credit balance or an adjustment claim to correct any billing or claims processing errors.

## Basis

*Please identify the state and/or federal source of legal authority to promulgate the contemplated regulation. The discussion of this authority should include a description of its scope and the extent to which the authority is mandatory or discretionary. The correlation between the*

*proposed regulatory action and the legal authority identified above should be explained. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority must be provided.*

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The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistant in lieu of Board action pursuant to the Board's requirements. The *Code* also provides, in the Administrative Process Act (APA) §§ 2.2-4007, 4012, and 4013, for this agency's promulgation of proposed regulations subject to the Governor's review.

Title 42 of the *Code of Federal Regulations* Part 447, Payment for Services, prescribes State Plan requirements, Federal Financial Participation limitations and procedures concerning payments made by State Medicaid agencies for Medicaid services. States must provide sufficient detail in their plans about their reimbursement methodologies in order that the Centers for Medicare and Medicaid Services (CMS (formerly the Health Care Financing Administration)) may determine if the methodologies conform to existing federal law and regulations and are therefore approvable for Federal Financial Participation.

## Substance

*Please detail any changes that would be implemented: this discussion should include a summary of the proposed regulatory action where a new regulation is being promulgated; where existing provisions of a regulation are being amended, the statement should explain how the existing regulation will be changed. The statement should set forth the specific reasons the agency has determined that the proposed regulatory action would be essential to protect the health, safety or welfare of citizens. In addition, a statement delineating any potential issues that may need to be addressed as the regulation is developed shall be supplied.*

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The section of the State Plan for Medical Assistance affected by this action is Methods and Standards for Establishing Payment Rates-Long term Care (12 VAC 30 Chapter 90, Section 257).

Currently, DMAS does not require NFs to report credit balances. Consequently, those NFs who are overpaid (due to various reasons such as payments from third party payers and claims processing errors) retain these tax dollars until biannual audits can be conducted.

This regulatory action is necessary to implement a reporting requirement for nursing facilities which will make it possible for DMAS to more timely identify, collect, and correct claims for Medicaid overpayments. Such overpayments may exist for paid claims from providers for services rendered to recipients.

## Alternatives

*Please describe, to the extent known, the specific alternatives to the proposal that have been considered or will be considered to meet the essential purpose of the action.*

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The alternative to this proposal is to continue the current process of identifying these overpayments only every two to three years during periodic routine audits of providers' claims. The current process does not permit the timely identification and collection of Medicaid overpayments which have been made to providers on claims for services to recipients.

## Family Impact Statement

*Please provide a preliminary analysis of the potential 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.*

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This proposed regulatory action should have no impact on the institution of the family. This proposal deals with identifying, collecting and correcting Medicaid overpayments received by nursing facilities as a result of payments received from third party payers and or erroneous claims being submitted by the nursing facility provider.