**Virginia Regulatory Town Hall**

# Proposed Regulation
# Agency Background Document

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| **Agency Name:** | Dept. of Medical Assistance Services 12 VAC 30 |
| **VAC Chapter Number:** | Chapter 150 |
| **Regulation Title:** | Uninsured Medical Catastrophe Fund |
| **Action Title:** | UMCF |
| **Date:** | August 24, 2000 |

This information is required pursuant to the Administrative Process Act (§ 9-6.14:9.1 *et seq.* of the *Code of Virginia*), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99), and the *Virginia Register Form, Style and Procedure Manual*. Please refer to these sources for more information and other materials required to be submitted in the regulatory review package.

## Summary

*Please provide a brief summary of the proposed new regulation, proposed amendments to an existing regulation, or the regulation proposed to be repealed. There is no need to state each provision or amendment or restate the purpose and intent of the regulation; instead give a summary of the regulatory action and alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.*

This regulatory action creates a new Chapter 150 for DMAS in the Virginia Administrative Code for the Uninsured Medical Catastrophe Fund. This chapter contains eligibility criteria for potential applicants, covered services and other standards.

## Basis

*Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority must be provided. Please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the proposed regulation and that it comports with applicable state and/or federal law.*

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The Code of Virginia (1950) as amended, §32.1-324.3, grants to the Board of Medical Assistance Services (BMAS) the authority to publish regulations to administer the Uninsured Medical Catastrophe Fund. 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 Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) §§9-6.14:7.1 and 9-6.14:9.1, for this agency's promulgation of proposed regulations subject to the Governor's review.

## Purpose

*Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the proposed regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.*

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The purpose of this proposal is to develop rules to administer the Uninsured Medical Catastrophe Fund. In addition to criteria specified in the Code, these regulations

(i) further define an uninsured medical catastrophe as a life-threatening illness or injury requiring specialized medical treatment, hospitalization, or both;

(ii) establish procedures for distribution of moneys in the Fund to pay for the costs of treating uninsured medical catastrophes;

(iii) establish application and appeals 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.

## Substance

*Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement providing detail of the regulatory action's changes.*

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Virginia taxpayers can designate a portion of their Virginia tax refund to the Uninsured Medical Catastrophe Fund beginning with their 1999 tax returns and anyone can make a contribution to the fund at any time. Funds will first become available January 2, 2001, and, thereafter, will be available the month after tax returns are filed or after contributions are posted to the Fund. It is anticipated that funding will be limited relative to the potential need.

The Fund should have a positive impact on Virginia families by providing access to treatment for uninsured medical catastrophes. Because the UMCF regulations are designed to help uninsured Virginians receive treatment that they otherwise would not have received, the UMCF will not pay for services already rendered, including emergency services. Hospitals are already required to provide emergency services.

Regulations are necessary to develop criteria and procedures for determining who will receive funds. Due to the nature of uninsured medical catastrophes, this new Fund can make the difference between life and death. It will be very important that funds are distributed fairly. The agency will consider any alternatives suggested during the regulatory process.

There will be four criteria that must be met prior to disbursement of funds. The first criterion is that the individual meets the eligibility rules. The second criterion is that there is an approved treatment plan. The third criterion is that funds are available. The fourth criterion is that a provider can be found who is willing to accept the UMCF contract.

In addition to being a citizen or legally resident alien and a resident of Virginia, an eligible individual must have income under 300% of the Federal Poverty Level, have a life-threatening illness or injury, and be uninsured for the needed treatment.

These regulations establish an income limit above which UMCF funds will not be available. The 2000 income limits are listed below. They are to be updated annually effective July 1 following the issuance of annual figures by the federal government.

| Family Size | 300% of Poverty (Annual Income) |
|---|---|
| 1 | $25,050 |
| 2 | $33,750 |
| 3 | $42,450 |
| 4 | $51,150 |
| 5 | $59,850 |

The UMCF is not a poverty program. Most Virginians who are uninsured are so because their employers do not offer health insurance. In addition, it is generally difficult and costly to purchase individual health insurance. However, the agency feels that most uninsured Virginians with incomes over 300% of poverty should have access to affordable health insurance or have the resources to pay for treating a medical catastrophe. Given the limited funding which is expected for this program, the agency believes that it would be most beneficial to the neediest citizens to target funds to persons with incomes under 300% of the Federal Poverty Level.

The Code of Virginia indicates that an uninsured medical catastrophe shall include a life-threatening illness or injury requiring specialized medical treatment, hospitalization, or both. This regulation further defines life-threatening as an illness or injury that, if left untreated, would more than likely result directly in death. The agency intends to cover only acute illnesses or injuries or acute phases of chronic illnesses.

The regulation clarifies that an eligible individual may be insured in general, but may be uninsured for the particular needed medical treatment. For example, someone may have health insurance that does not cover organ transplants. Such an individual could apply for UMCF payment for an organ transplant, if the failure to receive a transplant would be life-threatening, and the other stated criteria were met.

The UMCF, in general, will pay for services needed to treat acute illnesses or injuries or the acute phases of chronic illnesses. The services must be part of an approved treatment plan. The proposed treatment plan must be for a course of treatment to remediate, cure, or ameliorate the life threatening illness or injury. The treatment plan must not be open-ended. The UMCF will not be responsible for long-term maintenance medications or additional treatments beyond the course of treatment approved by DMAS. The UMCF will not pay for custodial care, for transportation, or for mental health services.

Coverage will be limited to medical or surgical services that are not considered to be experimental or investigational by the medical community. The proposed treatment plan should reflect the medical community's standard of practice for treating the particular life threatening illness.

In addition, the UMCF will only cover certain organ and tissue transplants. Transplants are some of the most expensive treatments that could be covered by the UMCF. There can be waiting lists for organs and the transplant procedures vary in effectiveness. Because of the concern about limited funding, the agency proposes to limit coverage of transplants. This will avoid tying up UMCF funds to assist individuals on transplant waiting lists to receive transplants when the procedure has demonstrated limited effectiveness for the diseases being treated. These regulations propose that the UMCF cover only cornea, liver, kidney, and bone marrow/stem cell transplants. Livers, kidneys, and bone marrow/stem cell transplants are generally available and generally very effective. Kidney transplants on average cost less than $10,000. Autologous bone marrow/stem cell transplants can cost $80,000 and allogeneic bone marrow/stem cell transplants can cost $120,000. Liver transplants are the most expensive of the three transplants

and can cost $155,000. The actual costs of these transplants (except for kidney) could be more as the amounts shown are what DMAS pays as an all-inclusive rate.

Even if an applicant is determined eligible and the treatment plan is approved, expenditures will be limited to available funding. The UMCF is not an entitlement program . The agency anticipates that funding will be limited relative to the need. These regulations establish objective criteria for determining who gets available funds. Funds will be disbursed on a first-come, first-served basis based on the date the original application is received by DMAS or its agent. The agency will also develop a waiting list, if necessary.

Finally, the agency cannot disburse these designated funds unless there is a provider willing to contract with DMAS. The agency intends to establish a global fee to cover the costs of the proposed treatment plan. The global fee will be based on the Medicaid reimbursement methodology to cover the services in the approved treatment plan. This is similar to the process the agency uses to pay for transplant procedures under Medicaid. The agency will work with applicants to find a willing provider but the responsibility for identifying a willing provider will ultimately rest with the applicant.

On the basis of the individual's contract, funds will be fully committed from the UMCF and unavailable to other applicants. This will insure that the UMCF will cover treatment in full once a commitment has been made. Funds will be available for up to one year after the contract is signed. Any unused funds at the end of the contracted course of treatment will be returned to the UMCF.

These regulations also establish application and appeals procedures. Funds will be committed on behalf of eligible individuals on a first-come, first-served basis based on the date and time the original signed application is received by DMAS or its agent. This date and time will also determine ranking on a waiting list, if necessary. DMAS will determine eligibility and approval of the treatment plan within 60 days of the application date.

If funds are not available for all applicants, applicants who have been determined eligible and whose treatment plans have been approved will be placed on a waiting list on a first-come, first-served basis based on the date and time their original, signed applications are received by DMAS or its agent. DMAS may review the eligibility and treatment plan decisions if more that 60 days have elapsed between the date that DMAS initially determines an applicant eligible and approves the treatment plan, and the date that funds become available to assist the highest ranking individual on the waiting list. The approved treatment plan takes into account applicants' health status at the time the treatments are approved. If applicants' health status deteriorates while they are on the waiting list, the treatment plan may no longer be appropriate and can be revised.

Applicants have the right to appeal adverse determinations regarding eligibility and their treatment plans. Every effort will be made to make determinations before funds become available. Applicants will have an expedited appeal process that will protect their place on the waiting list for available funds. An applicant will lose his position on the waiting list during a normal appeal or if the appeal decision is unfavorable and the applicant sues in circuit court. If an applicant subsequently receives a favorable decision, he or she is restored to the waiting list

with the ranking based on the date and time the original signed application was received by DMAS or its agent.

## Issues

*Please provide a statement identifying the issues associated with the proposed regulatory action. The term "issues" means: 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 include a sentence to that effect.*

The primary advantage of this regulation is that some uninsured Virginians will be able to receive medical treatments for medically catastrophic illnesses that they otherwise would not have been able to because they could not pay for it.

The primary disadvantage is expected to be the limited source of funding. As a result, the Fund may be able to serve only a few uninsured Virginians who have medical catastrophes. In particular, the UMCF will not help uninsured Virginians to pay for expensive treatments that they have already received.

## Fiscal Impact

*Please identify the anticipated fiscal impacts and at a minimum include: (a) the projected cost to the state to implement and enforce the proposed regulation, including (i) fund source / fund detail, (ii) budget activity with a cross-reference to program and subprogram, and (iii) a delineation of one-time versus on-going expenditures; (b) the projected cost of the regulation on localities; (c) a description of the individuals, businesses or other entities that are likely to be affected by the regulation; (d) the agency's best estimate of the number of such entities that will be affected; and e) the projected cost of the regulation for affected individuals, businesses, or other entities.*

No General Funds are required. Funding is limited to contributions, primarily designated contributions from individual income tax refunds. The agency estimates annual contributions between $50,000 and $200,000. Administrative costs will be minimal and can be absorbed by the DMAS' administrative budget. There are no localities that are uniquely affected by these regulations as they will apply statewide.

Funding Source/Cost to Localities/Affected Entities: Virginia taxpayers can designate a portion of their Virginia income tax refund to the Uninsured Medical Catastrophe Fund. Designated tax refunds and voluntary contributions are the sole sources of funding for this program.

This program would have a minimal impact on local departments of social services. The local departments of social services would have information and applications for the Uninsured Medical Catastrophe Fund and could receive applications to be forwarded to DMAS.

## Detail of Changes

*Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or cross-walk - of changes implemented by the proposed regulatory action. Where applicable, include citations to the specific sections of an existing regulation being amended and explain the consequences of the proposed changes.*

This entire regulation is new.

## Alternatives

*Please describe the specific 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.*

Policy alternatives were evaluated by the workgroup convened on this issue and are discussed in the Summary section.

## Public Comment

*Please summarize all public comment received during the NOIRA comment period and provide the agency response.*

No comments were received during the NOIRA comment period.

## Clarity of the Regulation

*Please provide a statement indicating that the agency, through examination of the regulation and relevant public comments, has determined that the regulation is clearly written and easily understandable by the individuals and entities affected.*

DMAS has examined these regulations and, in so far as is possible, has ensured that they are clearly written and easily understandable by the individuals and entities affected.

## Periodic Review

*Please supply a schedule setting forth when the agency will initiate a review and re-evaluation to determine if the regulation should be continued, amended, or terminated. The specific and measurable regulatory goals should be outlined with this schedule. The review shall take place no later than three years after the proposed regulation is expected to be effective.*

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These regulations will be evaluated after this program has operated for several years.

## Family Impact Statement

*Please provide an analysis of the proposed regulatory action that assesses the potential impact on the institution of the family and family stability including the extent to which 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 program will not have any negative impacts on families in the Commonwealth. By providing a funding source for a medical crisis, this program may enable an eligible individual to remain with his family longer than would otherwise be possible.