



# COMMONWEALTH of VIRGINIA

Office of the Attorney General

Mark R. Herring  
Attorney General

202 North Ninth Street  
Richmond, Virginia 23219  
804-786-2071  
Fax 804-786-1991  
Virginia Relay Services  
800-828-1120  
7-1-1

## MEMORANDUM

**TO:** EMILY MCCLELLAN  
Regulatory Supervisor  
Department of Medical Assistance Services

**FROM:** ELIZABETH M. GUGGENHEIM *EMG*  
Assistant Attorney General

**DATE:** July 12, 2018

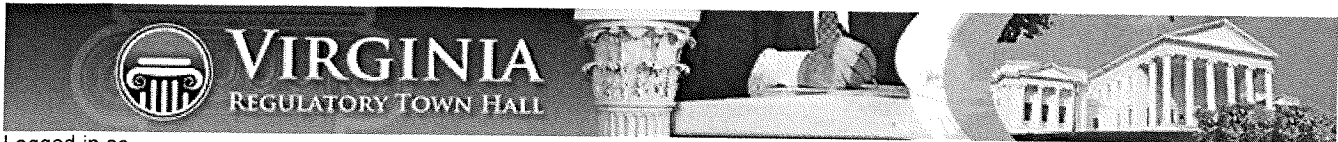
**SUBJECT:** Exempt final regulations regarding reduction in inpatient cost sharing to comply with federal regulations, 12 VAC 30-20-150, 30-120-160

I have reviewed the final exempt regulations that would decrease the cost sharing amount charged per inpatient hospitalization from \$100 to \$75. You have asked the Office of the Attorney General to review the proposed regulations to determine if DMAS has the legal authority to promulgate the amended regulations as final exempt and if they would comport with state and federal law. Based on that review, it is this Office's view that DMAS has the authority, subject to compliance with the provisions of Article 2 of the Administrative Process Act (APA), and has not exceeded that authority.

The amended regulation is required by 42 C.F.R. § 447.52(b)(2). It is my view that the promulgation of this amended regulation is exempt from the procedures of Article 2 of the Administrative Process Act pursuant to Virginia Code § 2.2-4006(A)(4)(c).

If you have any questions, please feel free to contact me at 786-2071.

cc: Kim F. Piner  
Senior Assistant Attorney General



Logged in as

Elizabeth Guggenheim

## Final Text

**Action:** Reduction in Inpatient Cost Sharing to Comply with Federal ...**Stage:** Final

7/6/18 9:46 AM [latest] ▼

Part III

Recipient Cost Sharing

**12VAC30-20-150. Copayments and deductibles for categorically needy and QMBs for services other than under 42 CFR 447.53.**

A. The following charges are imposed on the categorically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR 447.53.

Service*	Type Charge			Amount and Basis for Determination
	Deduct	Coins	Copay	
Inpatient Hospital	<del>\$100.00</del> -0-	-0-	<del>-0-</del> \$75.00	State's average daily payment of \$594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	\$3.00	State's average payment of \$136 is used as basis.
Clinic Visit	-0-	-0-	\$1.00	State's average payment of \$29 is used as basis.
Physician Office Visit	-0-	-0-	\$1.00	State's average payment of \$23 is used as basis.
Eye Examination	-0-	-0-	\$1.00	State's payment of \$30 is used as basis.
Prescriptions:				
--Generic	-0-	-0-	\$1.00	State's average per generic script of \$25 is used as payment basis.
--Brand Name	-0-	-0-	\$3.00	State's average per brand-name script of \$97 is used as payment basis.
Home Health Visit	-0-	-0-	\$3.00	State's average payment of \$56 is used as basis.
Other Physician Services	-0-	-0-	\$3.00	State's average payment of \$56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	\$3.00	State's average payment \$78 is used as basis.

\*NOTE: The applicability of copays to emergency services is discussed further in this section.

B. The method used to collect cost sharing charges for categorically needy individuals requires that providers be responsible for collecting the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he or she is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing changes.

E. State policy does not provide for cumulative maximums on charges.

F. Emergency Services. No recipient copayment shall be collected for the following services:

1. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

- a. Placing the patient's health in serious jeopardy;
- b. Serious impairment to bodily functions; or
- c. Serious dysfunction of any bodily organ or part; and

2. All services delivered in emergency rooms.

**12VAC30-20-160. Copayments and deductibles for medically needy and QMBs for services other than under 42 CFR 447.53.**

A. The following charges are imposed on the medically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR 447.53.

Service*	Type Charge			Amount and Basis for Determination
	Deduct	Coins	Copay	
Inpatient Hospital	\$400.00	-0-	-0-	State's average daily payment of \$594 is used as basis.
	-0-		\$75.00	

Outpatient Hospital Clinic	-0-	-0-	\$3.00	State's average payment of \$136 is used as basis.
Clinic Visit	-0-	-0-	\$1.00	State's average payment of \$29 is used as basis.
Physician Office Visit	-0-	-0-	\$1.00	State's average payment of \$23 is used as basis.
Eye Examination	-0-	-0-	\$1.00	State's payment of \$30 is used as basis.
Prescriptions:				
--Generic	-0-	-0-	\$1.00	State's average per generic script of \$25 is used as payment basis.
--Brand Name	-0-	-0-	\$3.00	State's average per brand-name script of \$97 is used as payment basis.
Home Health Visit	-0-	-0-	\$3.00	State's average payment of \$56 is used as basis.
Other Physician Services	-0-	-0-	\$3.00	State's average payment of \$56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	\$3.00	State's average payment \$78 is used as basis.

\*NOTE: The applicability of copays to emergency services is discussed further in this section.

B. The method used to collect cost sharing charges for medically needy individuals requires that providers be responsible for collecting the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he or she is unable to pay the required copayment.

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- a. Placing the patient's health in serious jeopardy;
  - b. Serious impairment to bodily functions; or
  - c. Serious dysfunction of any bodily organ or part; and
2. All services delivered in emergency rooms.