Virginia Regulatory Town Hall

Exempt Action Final Regulation
Agency Background Document

Agency Name:	Dept. of Medical Assistance Services (12 VAC 30)
VAC Chapter Number:	Chapters 10, 30, 50, 60, and 70
Regulation Title:	General Program Administration; Groups Covered and Agencies Responsible for Eligibility Determinations; Amount, Duration, and Scope of Medical and Remedial Care and Services; Standards Established and Methods Used to Assure High Quality Care; and Methods and Standards for Establishing Rates-Inpatient Hospital Care.
Action Title:	2001 Technical Amendments
Date:	

Where an agency or regulation is exempt in part or in whole from the requirements of the Administrative Process Act (§ 9-6.14:1 *et seq.* of the *Code of Virginia*) (APA), the agency may provide information pertaining to the action to be included on the Regulatory Town Hall. The agency must still comply the requirements of the Virginia Register Act (§ 9-6.18 *et seq.* of the *Code of Virginia*) and file with the Registrar and publish their regulations in a style and format conforming with the *Virginia Register Form, Style and Procedure Manual*. The agency must also comply with Executive Order Fifty-Eight (99) which requires an assessment of the regulation's impact on the institution of the family and family stability.

This agency background document may be used for actions exempt pursuant to § 9-6.14:4.1(C) at the final stage. Note that agency actions exempt pursuant to § 9-6.14:4.1(C) of the APA do not require filing with the Registrar at the proposed stage.

In addition, agency actions exempt pursuant to § 9-6.14:4.1(B) of the APA are not subject to the requirements of the Virginia Register Act (§ 9-6.18 *et seq.* of the *Code of Virginia*) and therefore are not subject to publication. Please refer to the *Virginia Register Form, Style and Procedure Manual* for more information.

Summary

Please provide a brief summary of the proposed new regulation, amendments to an existing regulation, or the regulation being repealed.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.

The changes contained in this final exempt regulatory action are discussed as follows.

The first change is to restore language concerning the enforcement of provider requirements for nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) which was inadvertently deleted from the VAC in a publishing error. This change affects 12VAC30-10-630 (State Plan for Medical Assistance preprint page 72).

The second and third regulatory changes, showing Protected SSI children as a mandatory covered group and providing for the annual increase to the Medically Needy income levels, are respectively being required by the Center for Medicare and Medicaid Services (CMS) and are necessary to correct an inadvertent omission in previously promulgated regulations. These changes affect 12VAC30-30-10 (State Plan Attachment 2.2-A) and 12 VAC 30-40-220 (State Plan Attachment 2.6-A, Supplement 1).

The fourth change, changing references to Christian Science nurses and sanitoria, are required by CMS in Program Memorandum Transmittal 01-02. This change affects: 12VAC 30-10-640 (State Plan preprint page 73); 12VAC 30-50-20 and 12VAC 30-50-30 (State Plan Attachment 3.1-A); 12 VAC 30-50-60 and 12 VAC 30-50-70 (State Plan Attachment 3.1-B).

The fifth change, moving the regulatory language providing for the reimbursement of organ transplant services, is the specific result of a CMS requirement. This change affects 12 VAC 30-50-100, 50-105, 50-140 (State Plan Attachment 3.1A&B, Supplement 1) and 12 VAC 30-70-201 (State Plan Attachment 4.19-A).

The sixth, seventh, eighth, and ninth changes, School Based Services (12 VAC 30-50-229.1), Case Management for Treatment Foster Care children (12 VAC 30-60-170), citation to nurse midwife services (12 VAC 30-50-260), and lump sum payments (12 VAC 30-70-420 and 70-435) to hospitals, resulted from federally required changes during the State Plan Amendment approval process. The Chapter 50 changes affect State Plan Attachment 3.1A&B, Supplements 1 and 2. The Chapter 70 changes affect State Plan Attachment 4.19-A.

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency .including the date the action was taken, the name of the agency taking the action, and the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages and adopt the action stated therein. Because this final regulation is exempt from the public notice and comment requirements of the Administrative Process Act (Code 2.2-4006), the Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

_____ _____

Date Eric S. Bell, Director

Department of Medical Assistance Services

Additional Information

Please indicate that the text of the proposed regulation, the reporting forms the agency intends to incorporate or use in administering the proposed regulation, a copy of any documents to be incorporated by reference are attached.

Please state that the Office of the Attorney General (OAG) 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. Note that the OAG's certification is not required for Marine Resources Commission regulations.

If the exemption claimed falls under § 9-6.14:4.1(C) (4)(c) of the APA *please include the federal law or regulations being relied upon for the final agency action.*

This exempt final action affects multiple areas of the Virginia Administrative Code and the State Plan for Medical Assistance. Each regulatory change is examined separately below:

12 VAC 30-10-631. Provider requirements applicable to nursing facilities and Intermediate Care Facilities for the Mentally Retarded.

The first change is to restore language concerning the enforcement of provider requirements for nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) which was inadvertently deleted from the VAC in a 1995 publishing error.

12 VAC 30-30-10. Mandatory coverage. Categorically needy and other required special groups.

The second part of this regulatory action concerns the addition of language indicating coverage of this group of eligibles. CMS has not yet issued a preprinted page with language providing for this group. But since DMAS continues to claim federal matching dollars in order to cover services for this federally mandated group, it must be reflected in the State Plan for Medical Assistance.

The Balanced Budget Act, enacted on August 5, 1997, created mandatory coverage for disabled children who were being paid Social Security Income (SSI) payments on August 22, 1996, but who lost their SSI payments because the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed the definition of childhood disability. If this definition had not been changed, these children would have continued to receive SSI payments and thus be eligible for Medicaid. This mandatory coverage group protects the Medicaid eligibility for those children who were affected by this change in the SSI definition of childhood disability. Without this protection, these children may not be able to access needed medical coverage.

12 VAC 30-40-220. Income eligibility levels.

This third part of this regulatory package concerns the Medically Needy income eligibility levels. The 2000 Acts of Assembly, Chapter 1073, Item 319, 3c mandated the increase to the Medically Needy income eligibility levels. This mandate also provided for the annual automatic change, consistent with the Consumer Price Index (CPI). Reference to this automatic change consistent with the CPI was inadvertently omitted from DMAS' previously promulgated final regulations. The Medically Needy Income Levels (MNILs) are tied by Social Security Act § 1903 (f) to the Standards of Assistance (subitem A.1). Thus, when the MNILs are increased by CPI increases, the Standards of Assistance must also be increased. This ensures that the MNILs are no more than 133 1/3 % of the Standards of Assistance. This action corrects previous omissions.

12 VAC 30-10-640, 12 VAC 30-50-20, 12 VAC 30-50-30, 12 VAC 30-50-60, 12 VAC 30-50-70. Christian Science nurses and sanitoria services.

CMS issues certain preprinted pages for the State Plan for Medical Assistance, including Attachment 3.1-A and Attachment 3.1-B. In June 2001, CMS issued Program Memorandum (attached) 01-02 conveying revised preprinted pages Attachment 3.1-A page 9 and Attachment 3.1-B page 8. The changes were the removal of Christian Science nurses as a permitted service (but one which DMAS never elected to cover) and revising references to Christian Science sanitoria to Religious Non-medical Health Care Institutions (which DMAS has always covered with no limitations). Because these preprinted language changes are federally issued, DMAS has no choice but to incorporate them into the Virginia Title XIX State Plan. No changes are being made in the covered services.

12 VAC 30-50-100, 12 VAC 30-50-105, 12 VAC 30-50-140, and 12 VAC 30-70-201. Organ transplant reimbursement.

The fifth part of this regulatory action involves moving the organ transplant reimbursement language from the Amount, Duration, and Scope of Medical and Remedial Care and Services chapter (12 VAC 30-50) to Methods and Standards for Establishing Payment Rates; in-Patient Hospital care chapter (12 VAC 30-70). This change was requested by CMS during informal discussions with the Department. Reimbursement language is being removed from 12 VAC 30-50-100, 12 VAC 30-50-105, and 12 VAC 30-50-140 (Supplement 1 to Attachment 3.1 A&B) and being added to 12 VAC 30-70-201 (Attachment 4.19-A). No changes have been made to the substance of the current regulations regarding organ transplant reimbursement.

12 VAC 30-50-229.1. School health services.

The VAC section affected by this action is 12 VAC 50-229.1 (Attachment 3.1 A&B). This regulatory action deletes language regarding the payment of physical therapists, occupational therapists, speech pathology providers, skilled nursing providers, and psychiatric providers for participation in meetings for the development, evaluation, or reevaluation of the Individualized Education Program (IEP) for specific children. This change was required by CMS during its process of approving State Plan Amendment transmittal 00-12.

The Department submitted a State Plan Amendment (SPA) 00-12 to CMS for review and approval. During the review of this SPA, CMS determined that previously approved language relating to payments to certain providers (physical therapists, occupational therapists, speech pathology providers, skilled nursing providers, and psychiatric providers) for consultations for the development, evaluation and reevaluation of the IEP was in conflict with Section 1903(c) of the *Social Security Act*. Section 1903 (c) of the *Act* authorizes Medicaid payment for "medical assistance for covered services" included in a child's IEP. CMS stated that consultations between providers and meetings to discuss patients are not separately billable services under Medicaid, but may be incorporated into the rate paid for services provided directly to the child. This action deletes language allowing payment of these consultation services.

Upon learning of CMS' position that these consultations are not considered separately covered and therefore not Medicaid reimbursable services, the Virginia Department of Education (DOE) agreed to forego seeking such reimbursement. It was the Virginia DOE that sought the original General Assembly directive to DMAS to pursue securing the federal matching funds for this service coverage.

12 VAC 30-50-480, 12 VAC 30-60-170. Case management services for children in treatment foster care.

This regulatory action affects 12 VAC 30-50-260 (Attachment 3.1 A&B), and 12 VAC 30-60-170 (Attachment 3.1 C). This regulatory action identifies case manager qualifications and clarifies covered services provided by case managers.

This action incorporates CMS required changes to Attachment 3.1 C (12 VAC 30-60-170). These changes added language regarding the assurance of quality in the care provided by a case manager. CMS also required language to be added to indicate that reimbursement is not provided to case managers for permanency planning. Additional language was added to ensure that case managers assessed the potential for reunification with the child's family.

12 VAC 30-50-260. Nurse midwife services.

This technical amendment affects 12 VAC 30-50-260 (Supplement 1, Attachment 3.1 A&B), Nurse midwife services. This action changes a citation concerning the licensure requirements for nurse midwives from the *Social Security Act* to the Code of Federal Regulations (CFR).

12 VAC 30-70-420, 12 VAC 30-70-435. Inpatient hospital services Diagnosis Related Groups.

After completing the Administrative Process Act's Article 2 process for the final regulations for Diagnosis Related Groups (DRGs), DMAS filed a State Plan Amendment (SPA 00-07) with the CMS in order to obtain federal approval of the final regulations' changes and secure federal matching funds. While this SPA was under review, CMS requested additional information from

the Department regarding these proposed reimbursement changes contained in the SPA package. The first change dealt with the effective date for payment of services to non-cost reporting hospitals based on DRGs. The initial SPA had an effective date of January 1, 2000. This effective date did not fall within the calendar quarter for the implementation of this change by the Commonwealth. In order to comply with CMS's policy that effective dates must be within the calendar quarter of implementation, the effective date was changed to July 1, 2000.

Additionally, CMS required the Department to modify its language regarding lump sum payments to participating hospitals for inpatient services. CMS stated that DMAS could calculate these special payments using data from earlier time periods but the actual payments must be for Medicaid covered services provided on or after July 1, 2000.

In response to this directive, the Department submitted clarifying language that CMS subsequently approved for both the effective date and the clarification of lump sum payments. This regulatory action adds this clarifying language so that DMAS' VAC section mirrors the federally approved State Plan language.

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the 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.

This regulatory action will not have any negative or positive affects on the institution of the family or family stability since it does not make any difference in covered services, reimbursement or eligibility. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, nor the assumption of family responsibilities.