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TO: **BRIAN MCCORMICK**
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FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **July 31, 2015**

SUBJECT: **Fast Track Regulations Regarding Type One Physician Supplemental Payments (4360/7222)**

I am in receipt of the attached regulations to adjust the supplemental payments to physicians at Type One hospitals. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate these regulations and if they comport with state and federal law.

Based on that review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and -325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority; and these regulations comport with the authorization granted under Item 301.B.4 of the 2015 *Acts of the Assembly*.

Pursuant to Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

These regulations require approval by CMS as they will amend the State Plan. It is my understanding the CMS has approved these regulations. If you have any questions or need additional information about these regulations, please contact me at 786-6005.

cc: Kim F. Piner, Esquire

Attachment

Project 4376 - Fast-Track

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Type One Physician Supplemental Payments

12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public). The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this subdivision 1 shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services rendered in emergency departments that DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.

2. Dentists' services.

3. Mental health services including: (i) community mental health services, (ii) services of a licensed clinical psychologist, or (iii) mental health services provided by a physician.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME) and supplies.

Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"DMERC" means the Durable Medical Equipment Regional Carrier rate as published by the Centers for Medicare and Medicaid Services at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

"HCPCS" means the Healthcare Common Procedure Coding System, Medicare's National Level II Codes, HCPCS 2006 (Eighteenth edition), as published by Ingenix, as may be periodically updated.

a. Obtaining prior authorization shall not guarantee Medicaid reimbursement for DME.

b. The following shall be the reimbursement method used for DME services:

(1) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10%. For dates of service on or after July 1, 2014, DME items subject to the Medicare competitive bidding program shall be reimbursed the lower of:

(a) The current DMERC rate minus 10% or

(b) The average of the Medicare competitive bid rates in Virginia markets.

(2) For DME items with no DMERC rate, the agency shall use the agency fee schedule amount. The reimbursement rates for DME and supplies shall be listed in the DMAS Medicaid Durable Medical Equipment (DME) and Supplies Listing and

updated periodically. The agency fee schedule shall be available on the agency website at www.dmas.virginia.gov.

(3) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, less shipping and handling, plus 30%. The manufacturer's net charge to the provider shall be the cost to the provider minus all available discounts to the provider. Additional information specific to how DME providers, including manufacturers who are enrolled as providers, establish and document their cost or costs for DME codes that do not have established rates can be found in the relevant agency guidance document.

c. DMAS shall have the authority to amend the agency fee schedule as it deems appropriate and with notice to providers. DMAS shall have the authority to determine alternate pricing, based on agency research, for any code that does not have a rate.

d. The reimbursement for incontinence supplies shall be by selective contract. Pursuant to § 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d), the Commonwealth assures that adequate services/devices shall be available under such arrangements.

e. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the

ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled

agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services.

8. Laboratory services (other than inpatient hospital). The agency's rates for clinical laboratory services were set as of July 1, 2014, and are effective for services on or after that date.

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-ray services.

11. Optometry services.

12. Medical supplies and equipment.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

16. Supplemental payments for services provided by Type I physicians.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group, organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a

hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 2, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for Type I physician services and Medicare rates. Effective August 13, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 143% of Medicare rates. Effective January 3, 2012, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 181% of Medicare rates. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

c. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter.

d. Effective April 8, 2014, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 201% of Medicare rates.

17. Supplemental payments for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital

physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 143% of Medicare rates as defined in the supplemental payment calculation for Type I physician services subject to the following reduction. Final payments shall be reduced on a prorated basis so that total payments for freestanding children's hospital physician services are $400,000 less annually than would be calculated based on the formula in the previous sentence. Payments shall be made on the same schedule as Type I physicians.

18. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical

professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 18 d of this subsection and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 18 b (1) of this subsection for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision 18 b (2) of this subsection by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3) of this subsection, Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B 2) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim

payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

19. Personal assistance services (PAS) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the DMAS website at http://www.dmas.virginia.gov.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

12VAC30-80-300. Medicare equivalent of average commercial rate.

Physician supplemental payment amounts shall be calculated using the Medicare equivalent of the average commercial rate (ACR) methodology prescribed by CMS. The following methodology describes the calculation of the supplemental payment. To compute the ACR by commercial payers, calculate the average amount reimbursed for each procedure code (e.g., CPT or HCPCS) by the top five commercial payers for a specified base period. Data from Medicare, Workers' Compensation, and other noncommercial payers and codes not reimbursed by Medicaid are excluded.

(Payer 1 + Payer 2 + Payer 3 + Payer 4 + Payer 5) / (5) = Average Commercial Reimbursement

To compute the reimbursement ceiling, multiply the average reimbursement rate as determined by the number of claims recorded in Medicaid Management Information System

(MMIS) for each procedure code that was rendered to Medicaid members by eligible physicians during the base period. Add the product for all procedure codes. This total represents the total reimbursement ceiling.

(Average Commercial Reimbursement) X (Medicaid Count) = Total Reimbursement Ceiling for each Procedure Code

Sum of Total Reimbursement Ceiling for each Procedure Code = Total Reimbursement Ceiling

To determine the Medicare equivalent to the reimbursement ceiling, for each of the billing codes used to determine the reimbursement ceiling, multiply the Medicare rate by the number of claims recorded in MMIS for each procedure code that was rendered to Medicaid members during the base period. Add the product for all procedure codes. This sum represents the total Medicare reimbursement that would have been received. Divide the reimbursement ceiling (commercial payment) by Medicare reimbursement. This ratio expresses the ACR as a percentage of Medicare.

(Medicare Rate) X (Medicaid Count) = Total Medicare Reimbursement for each Procedure Code

Sum of Total Medicare Reimbursement for each Procedure Code = Total Medicare Reimbursement

(Total Reimbursement Ceiling) / (Total Medicare Reimbursement) = Medicare equivalent of the ACR

This single ratio is applied to the Medicare rates for reimbursable Medicaid practitioner services to determine the total allowable Medicaid payment, including both the regular base payment and supplemental payment.

(Medicare equivalent of the ACR) X (Medicare rate per CPT Code for all applicable CPT Codes) = Total Allowable Medicaid Payment

Total Allowable Medicaid Payment – Medicaid Base Payment = Maximum Supplemental Payment

The Medicare equivalent of the ACR demonstration shall be updated every three years. Only the professional component of radiology services and clinical laboratory services is included in the ACR calculation. Claims with a technical component were excluded from the demonstration.