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TO: **Emily McClellan**
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FROM: **Elizabeth M. Guggenheim**
Assistant Attorney General
Office of the Attorney General

DATE: **November 12, 2019**

SUBJECT: **Final Exempt Regulations: 2019 Provider Reimbursement Changes (12 VAC 30-70-271, 331 and 341; 12 VAC 30-80-36 and 190)**

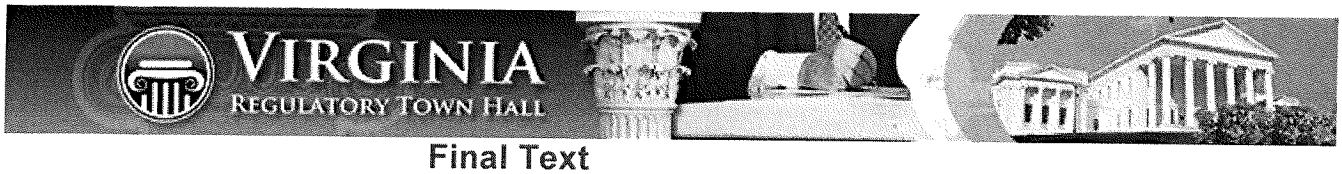
I am in receipt of the attached regulations that would make changes to provider reimbursement. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services (DMAS) has the statutory authority to promulgate these regulations and if they comport with applicable state law.

Virginia Code § 32.1-325 authorizes the Board of Medical Assistance Services to promulgate regulations as may be necessary to carry out the provisions of the state plan. Virginia Code § 32.1-324 authorizes the Director of DMAS with the Board's authority when it is not in session. It is this Office's view that the Director has the authority to promulgate these final exempt regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA") and Executive Order 14 (Revised)(2018), and has not exceeded that authority.

Based on the foregoing, it is my view that the amendments to these regulations are exempt from the procedures of Article 2 of the APA under Virginia Code §§ 2.2-4006(A)(4)(a). If you have any questions or need additional information about these regulations, please contact me at 786-7363.

cc: Kim F. Piner, Esq.
Attachment

Virginia.gov Agencies | Governor



Final Text

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Action: 2019 Provider Reimbursement Changes
Stage: Final

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12VAC30-70-271. Payment for capital costs.

A. Inpatient capital costs shall be determined on an allowable cost basis and settled at the hospital's fiscal year end. Allowable cost shall be determined following the methodology described in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

B. For hospitals with fiscal years that are in progress and do not begin on July 1, inpatient capital costs for the fiscal year in progress shall be apportioned in accordance with subdivisions 1 through 6 of this subsection.

1. Inpatient capital costs apportioned before July 1, 2003, shall be settled at 100% of allowable cost.

2. Effective July 1, 2003, through June 30, 2009, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals shall be settled at 80% of allowable cost.

3. Effective July 1, 2009, through June 30, 2010, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

4. Effective July 1, 2010, through September 30, 2010, inpatient capital costs of Type One hospitals shall be settled at 97% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 72% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 77% of allowable cost.

5. Effective October 1, 2010, through June 30, 2011, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

6. Effective July 1, 2011, inpatient capital costs of Type One hospitals shall be settled at 96% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 71% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 76% of allowable cost.

7. Effective July 1, 2019, inpatient capital rates for critical access hospitals shall be increased to a percent of cost reimbursement of 100%.

C. The exception to the policy in subsection A of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12VAC30-70-321 B, shall be an all-inclusive payment for operating and capital costs. The capital rate per day determined in 12VAC30-70-321 will be multiplied by the same percentage of allowable cost specified in subsection B of this section.

12VAC30-70-281. Payment for direct medical education costs of nursing schools, paramedical programs, and graduate medical education for interns and residents.

A. Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

1. Payments for these direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

2. Final payment for these direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

B. Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis, subject to cost settlement as outlined in this subsection except that on or after April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs as outlined in subsection C of this section.

1. The methodology provides for the determination of a hospital-specific base period per-resident amount to initially be calculated from cost reports with fiscal years ending in state fiscal year 1998 or as may be rebased in the future and provided to the public in an agency guidance document. The per-resident amount for new qualifying facilities shall be calculated from the most recently settled cost report. This per-resident amount shall be calculated by dividing a hospital's Medicaid allowable direct GME costs for the base period by its number of interns and residents in the base period yielding the base amount.

2. The base amount shall be updated annually by the moving average values in the Virginia-Specific Hospital Input Price Index as described in 12VAC30-70-351. The updated per-resident base amount will then be multiplied by the weighted number of full-time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTEs reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

C. Effective April 1, 2012, Type One hospitals shall be reimbursed 100% of Medicaid allowable fee-for-service (FFS) and managed care organization (MCO) GME costs for interns and residents.

1. Type One hospitals shall submit annually separate FFS and MCO GME cost schedules, approved by the agency, using GME per diems and GME ratios of cost to charges (RCCs) from the Medicare and Medicaid cost reports and FFS and MCO days and charges. Type One hospitals shall provide information on managed care days and charges in a format similar to FFS.

2. Interim lump sum GME payments for interns and residents shall be made quarterly based on the total cost from the most recently audited cost report divided by four and will be final settled in the audited cost report for the fiscal year end in which the payments are made.

D. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

~~E. Effective July 1, 2017, the Department of Medical Assistance Services (DMAS) shall make supplemental payments to the following hospitals sponsoring institutions for the specified number of primary care residencies: Sentara Norfolk General (two residencies), Carilion Medical Center (six residencies), Centra Lynchburg General Hospital (one residency), Riverside Regional Medical Center (two residencies), and Bon Secours St. Francis Medical Center (two residencies). DMAS shall make supplemental payments to Carilion Medical Center for two psychiatric residencies. The supplemental payment for each residency shall be $100,000 annually minus any Medicare residency payment for which the hospital is eligible. Supplemental payments shall be made for up to four years for each new qualifying resident. A hospital will be eligible for the supplemental payments as long as the hospital maintains the number of residency slots in total and by category. Payments shall be made quarterly following the same schedule for other medical education payments. Subsequent to the new award of a supplemental payment, the hospital must provide documentation annually by August 1, 2017, that it continues to meet the criteria for the supplemental payments and must report any changes during the year to the number of residents.~~

E. DMAS will make supplemental payments to hospitals for qualified graduate medical residencies. Residency programs (along with their hospital partners) will submit applications for this funding each year. (Applications are available on the DMAS website.) The applications will be scored and the top applicants will receive funding. The supplemental payment for each new qualifying residency slot will be $100,000 annually and shall be made for up to four (4) years. Payments to hospitals will be made quarterly. Additional criteria include:

1. Sponsoring institutions or the primary clinical site must be:

a. Physically located in Virginia;

b. An enrolled hospital provider in Virginia Medicaid and continue as a Medicaid-enrolled provider for the duration of the funding;

c. Not subject to a limit on Medicaid payments by the Centers for Medicare and Medicaid Services; and

d. Accredited through either the American Osteopathic Association (AOA) or the American Council for Graduate Medical Education (ACGME).

2. Applications must:

a. Be complete and submitted by the posted deadline;

b. Request funding for primary care (care (General Pediatrics, General Internal Medicine, or Family Practice) or high-need specialty residencies; and

c. Provide substantiation of the need for the requested primary care or specialty residency.

3. Programs that are awarded funding in the fall must attest (by June 1) that the resident(s) have been hired for the start of the academic year and have continued employment with the program each year thereafter.

12VAC30-70-331. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12VAC30-70-361, times the inflation values specified in 12VAC30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals:

1. For Type One hospitals the adjustment factor shall be a calculated percentage that causes the Type One hospital statewide operating rate per case to equal the Type Two hospital statewide operating rate per case;

2. For Type Two hospitals the adjustment factor shall be:

a. 0.7800 effective July 1, 2006, through June 30, 2010.

b. 0.7500 effective July 1, 2010, through September 30, 2010.

c. 0.7800 effective October 1, 2010.

C. For critical access hospitals, the operating rate shall be increased by using an adjustment factor to 1.0, effective July 1, 2019.

12VAC30-70-341. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12VAC30-70-371, times the inflation values specified in 12VAC30-70-351 times the adjustment factor specified in subsection B or C of this section.

B. The adjustment factor for acute care rehabilitation cases shall be the one specified in subsection B of 12VAC30-70-331.

C. The adjustment factor for acute care psychiatric cases for:

1. Type One hospitals shall be the one specified in subdivision B 1 of 12VAC30-70-331 times the factor in subdivision 2 this subsection divided by the factor in subdivision B 2 of 12VAC30-70-331.

2. Type Two hospitals shall be:

a. 0.7800 effective July 1, 2006, through June 30, 2007.

b. 0.8400 effective July 1, 2007, through June 30, 2010.

c. 0.8100 effective July 1, 2010, through September 30, 2010.

d. 0.8400 effective October 1, 2010.

3. Effective July 1, 2019, for critical access hospitals, the inpatient operating rate per day shall be increased using an adjustment factor or percent of cost reimbursement equal to 100%.

D. Effective July 1, 2009, for freestanding psychiatric facilities, the adjustment factor shall be 1.0000.

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). Except as otherwise noted in this section, state developed fee schedule rates are the same for both governmental and private individual practitioners. The state agency fee schedule is published on the DMAS website at **http://www.dmas.virginia.gov/#/searchcptcodes**.

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).

2. Dentists' services. Dental services, dental provider qualifications, and dental service limits are identified in 12VAC30-50-190. Dental services are paid based on procedure codes, which are listed in the agency's fee schedule. Except as otherwise noted, state-developed fee schedule rates are the same for both governmental and private individual practitioners.

3. Mental health services.

a. Professional services furnished by nonphysicians as described in 12VAC30-50-150. These services are reimbursed using current procedural technology (CPT) codes. The agency's fee schedule rate is based on the methodology as described in subsection A of this section.

(1) Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists in subdivision A 1 of this section.

(2) Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric, or licensed marriage and family therapists shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

b. Intensive in-home services are reimbursed on an hourly unit of service. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

c. Therapeutic day treatment services are reimbursed based on the following units of service: one unit equals two to 2.99 hours per day; two units equals three to 4.99 hours per day; three units equals five or more hours per day. No room and board is included in the rates for therapeutic day treatment. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

d. Therapeutic group home services (formerly called level A and level B group home services) shall be reimbursed based on a daily unit of service. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

e. Therapeutic day treatment or partial hospitalization services shall be reimbursed based on the following units of service: one unit equals two to three hours per day; two units equals four to 6.99 hours per day; three units equals seven or more hours per day. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

f. Psychosocial rehabilitation services shall be reimbursed based on the following units of service: one unit equals two to 3.99 hours per day; two units equals four to 6.99 hours per day; three units equals seven or more hours per day. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

g. Crisis intervention services shall be reimbursed on the following units of service: one unit equals two to 3.99 hours per day; two units equals four to 6.99 hours per day; three units equals seven or more hours per day. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

h. Intensive community treatment services shall be reimbursed on an hourly unit of service. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

i. Crisis stabilization services shall be reimbursed on an hourly unit of service. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

j. Independent living and recovery services (previously called mental health skill building services) shall be reimbursed based on the following units of service: one unit equals one to 2.99 hours per day; two units equals three to 4.99 hours per day. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

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 or 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 or 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 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. Reserved.

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, except for services in ambulatory surgery clinics reimbursed under 12VAC30-80-35.

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

a. In addition to payments for physician services specified elsewhere in this chapter, 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. 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 1, 2017, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 256% of Medicare rates. Effective May 1, 2017, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 258% 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 chapter, 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 described in the Medicare equivalent of the average commercial rate methodology (see 12VAC30-80-300), 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. Effective July 1, 2015, 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 178% of Medicare rates as defined in the supplemental payment calculation for Type I physician services. Payments shall be made on the same schedule as Type I physicians.

18. Supplemental payments for services provided by physicians affiliated with Eastern Virginia Medical Center.

a. In addition to payments for physician services specified elsewhere in this chapter, the Department of Medical Assistance Services provides supplemental payments to physicians affiliated with Eastern Virginia Medical Center for furnished services provided on or after October 1, 2012. A physician affiliated with Eastern Virginia Medical Center is a physician who is employed by a publicly funded medical school that is a political subdivision of the Commonwealth of Virginia, who provides clinical services through the faculty practice plan affiliated with the publicly funded medical school, and who has entered into contractual arrangements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective October 1, 2015, the supplemental payment amount shall be the difference between the Medicaid payments otherwise made for physician services and 137% 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.

19. Supplemental payments for services provided by physicians at freestanding children's hospitals serving children in Planning District 8.

a. In addition to payments for physician services specified elsewhere in this chapter, DMAS shall make supplemental payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 with more than 50% Medicaid inpatient utilization in fiscal year 2014. This applies to physician practices affiliated with Children's National Health System.

b. The supplemental payment amount for qualifying physician services shall be the difference between the Medicaid payments otherwise made and 178% of Medicare rates but no more than $551,000 for all qualifying physicians. The methodology for determining allowable percent of Medicare rates is based on the Medicare equivalent of the average commercial rate described in this chapter.

c. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter. Any quarterly payment that would have been due prior to the approval date shall be made no later than 90 days after the approval date.

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

a. In addition to payments for clinic services specified elsewhere in this chapter, DMAS provides supplemental payments to qualifying nonstate government-owned or government-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 government-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 20 d of this subsection and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 20 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 20 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 will be made annually in a lump sum during the last quarter of the fiscal year.

d. To determine the aggregate upper payment limit referred to in subdivision 20 b (3) of this subsection, Medicaid payments to nonstate government-owned or government-operated clinics will be divided by the "additional factor" whose calculation is described in 12VAC30-80-190 B 2 in regard to the state agency fee schedule for Resource Based Relative Value Scale. 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.

21. Personal assistance services (PAS) (also known as personal care services) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200 or covered under EPSDT. 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. The agency's rates, based upon one-hour increments, were set as of July 1, 2019, and shall be effective for services on and after that date.

22. Supplemental payments to state-owned or state-operated clinics.

a. Effective for dates of service on or after July 1, 2015, DMAS shall make supplemental payments to qualifying state-owned or state-operated clinics for outpatient services provided to Medicaid patients on or after July 1, 2015. 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.

b. The amount of the supplemental payment made to each qualifying state-owned or state-operated clinic is determined by calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 19 b of this subsection and the amount otherwise actually paid for the services by the Medicaid program.

c. Payments for furnished services made under this section shall be made annually in lump sum payments to each clinic.

d. To determine the upper payment limit for each clinic referred to in subdivision 19 b of this subsection, the state payment rate schedule shall be compared to the Medicare resource-based relative value scale nonfacility fee schedule per Current Procedural Terminology code for a base period of claims. The base period claims shall be extracted from the Medical Management Information System and exclude crossover claims.

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~~,~~. As of July 1, 2019, payments for hospice services in a nursing facility are ~~equal to at least 95%~~ 100% 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.

C. Effective July 1, 2019, the telehealth originating site facility fee shall be increased to 100 percent of the Medicare rate and shall reflect changes annually based on any changes in the Medicare rate. Federally Qualified Health Centers

(FQHCs) and Rural Health Centers (RHCs) are exempt from this reimbursement change.

12VAC30-80-36. Fee-for-service providers: outpatient hospitals.

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

"Enhanced ambulatory patient group" or "EAPG" means a defined group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Diseases (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

"EAPG relative weight" means the expected average costs for each EAPG divided by the relative expected average costs for visits assigned to all EAPGs.

"Base year" means the state fiscal year for which data is used to establish the EAPG base rate. The base year will change when the EAPG payment system is rebased and recalibrated. In subsequent rebasings, DMAS shall notify affected providers of the base year to be used in this calculation.

"Cost" means the reported cost as described in 12VAC30-80-20 A and B.

"Cost-to-charge ratio" equals the hospital's total costs divided by the hospital's total charges. The cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Medicare wage index" means the Medicare wage index published annually in the Federal Register by the Centers for Medicare and Medicaid Services. The indices used in this section shall be those in effect in the base year.

B. Effective January 1, 2014, the prospective enhanced ambulatory patient group (EAPG) based payment system described in this subsection shall apply to reimbursement for outpatient hospital services (with the exception of laboratory services referred to the hospital but not associated with an outpatient hospital visit, which will be reimbursed according to the laboratory fee schedule).

1. The payments for outpatient hospital visits shall be determined on the basis of a hospital-specific base rate per visit multiplied by the relative weight of the EAPG (and the payment action) assigned for each of the services performed during a hospital visit.

2. The EAPG relative weights shall be the weights determined and published periodically by DMAS and shall be consistent with applicable Medicaid reimbursement limits and policies. The weights shall be updated at least every three years.

3. The statewide base rate shall be equal to the total costs described in this subdivision divided by the wage-adjusted sum of the EAPG weights for each facility. The wage-adjusted sum of the EAPG weights shall equal the sum of the EAPG weights multiplied by the labor percentage times the hospital's Medicare wage index plus the sum of the EAPG weights multiplied by the nonlabor percentage. The base rate shall be determined for outpatient hospital services at least every three years so that total expenditures will equal the following:

a. When using base years prior to January 1, 2014, for all services, excluding all laboratory services and emergency services described in subdivision 3 c of this subsection, a percentage of costs as reported in the available cost reports for the base period for each type of hospital as defined in 12VAC30-70-221.

(1) Type One hospitals. Effective January 1, 2014, hospital outpatient operating reimbursement shall be calculated at 90.2% of cost, and capital reimbursement shall be at 86% of cost inflated to the rate year.

(2) Type Two hospitals. Effective January 1, 2014, hospital outpatient operating and capital reimbursement shall be calculated at 76% of cost inflated to the rate year.

(3) When using base years after January 1, 2014, the percentages described in subdivision 3 a of this subsection shall be adjusted according to subdivision 3 c of this subsection.

(4) For critical access hospitals, the operating rate shall be increased by using an adjustment factor or percent of cost reimbursement equal to 100%, effective July 1, 2019.

b. Laboratory services, excluding laboratory services referred to the hospital but not associated with a hospital visit, are calculated at the fee schedule in effect for the rate year.

c. Services rendered in emergency departments determined to be nonemergencies as prescribed in 12VAC30-80-20 D 1 b shall be calculated at the nonemergency reduced rate reported in the base year for base years prior to January 1, 2014. For base years after January 1, 2014, the cost percentages in subdivision 3 a of this subsection shall be adjusted to reflect services paid at the nonemergency reduced rate in the last year prior to January 1, 2014.

4. Inflation adjustment to base year costs. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with DMAS, shall be used to update the base year costs to the midpoint of the rate year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by Global Insight (or its successor) in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year. Inflation shall be applied to the costs identified in subdivision 3 a of this subsection. The inflation adjustment for state fiscal year 2017 shall be 50% of the full inflation adjustment calculated according to this section. There shall be no inflation adjustment for state fiscal year 2018. A full inflation adjustment shall be made in both fiscal year 2017 and fiscal year 2018 to Virginia freestanding children's hospitals with greater than 50% Medicaid utilization in 2009.

5. Hospital-specific base rate. The hospital-specific base rate per case shall be adjusted for geographic variation. The hospital-specific base rate shall be equal to the labor portion of the statewide base rate multiplied by the hospital's Medicare wage index plus the nonlabor percentage of the statewide base rate. The labor percentage shall be determined at each rebasing based on the most recently reliable data. For rural hospitals, the hospital's Medicare wage index used to calculate the base rate shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher. A base rate differential of 5.0% shall be established for freestanding Type Two children's hospitals. The base rate for non-cost-reporting hospitals shall be the average of the hospital-specific base rates of in-state Type Two hospitals.

6. The total payment shall represent the total allowable amount for a visit including ancillary services and capital.

7. The transition from cost-based reimbursement to EAPG reimbursement shall be transitioned over a four-year period. DMAS shall calculate a cost-based base rate at January 1, 2014, and at each rebasing during the transition.

a. Effective for dates of service on or after January 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 75% of the cost-based base rate and 25% of the EAPG base rate.

b. Effective for dates of service on or after July 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 50% of the cost-based base rate and 50% of the EAPG base rate.

c. Effective for dates of service on or after July 1, 2015, DMAS shall calculate the hospital-specific base rate as the sum of 25% of the cost-based base rate and 75% of the EAPG base rate.

d. Effective for dates of service on or after July 1, 2016, DMAS shall calculate the hospital-specific base rate as the EAPG base rate.

8. To maintain budget neutrality during the first six years of the transition to EAPG reimbursement, DMAS shall compare the total reimbursement of hospital claims based on the parameters in subdivision 3 of this subsection to EAPG reimbursement every six months based on the six months of claims ending three months prior to the potential adjustment. If the percentage difference between the reimbursement target in subdivision 3 of this subsection and EAPG reimbursement is greater than 1.0%, plus or minus, DMAS shall adjust the statewide base rate by the percentage difference the following July 1 or January 1. The first possible adjustment would be January 1, 2015, using reimbursement between January 1, 2014, and October 31, 2014.

C. The enhanced ambulatory patient group (EAPG) grouper version used for outpatient hospital services shall be determined by DMAS. Providers or provider representatives shall be given notice prior to implementing a new grouper.

D. The primary data sources used in the development of the EAPG payment methodology are the DMAS hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals. The following table identifies key data elements that are used to develop the EAPG payment methodology. DMAS may supplement this data with similar data for Medicaid services furnished by managed care organizations if DMAS determines that it is reliable.

Data Elements for EAPG Payment Methodology	
Data Elements	Source
Total charges for each outpatient hospital visit	Claims history file
Number of groupable claims lines in each EAPG	Claims history file
Total number of groupable claim lines	Claims history file
Total charges for each outpatient hospital revenue line	Claims history file
Total number of EAPG assignments	Claims history file
Cost-to-charge ratio for each hospital	Cost report file
Medicare wage index for each hospital	Federal Register

12VAC30-80-190. State agency fee schedule for RBRVS.

A. Reimbursement of fee-for-service providers. Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for-service providers, with the exception of home health services (see 12VAC30-80-180) and durable medical equipment services (see 12VAC30-80-30), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS).

B. Fee schedule.

1. For those services or procedures which are included in the RBRVS published by the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.

a. Effective for dates of service on or after July 1, 2008, DMAS shall implement site of service differentials and employ both nonfacility and facility RVUs. The implementation shall be budget neutral using the methodology in subdivision 2 of this subsection.

b. The implementation of site of service shall be transitioned over a four-year period.

(1) Effective for dates of service on or after July 1, 2008, DMAS shall calculate the transitioned facility RVU by adding 75% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(2) Effective for dates of service on or after July 1, 2009, DMAS shall calculate the transitioned facility RVU by adding 50% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(3) Effective for dates of service on or after July 1, 2010, DMAS shall calculate the transitioned facility RVU by adding 25% of the difference between the nonfacility RVU and nonfacility RVU to the facility RVU.

(4) Effective for dates of service on or after July 1, 2011, DMAS shall use the unadjusted Medicare facility RVU.

2. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by CMS. DMAS shall adjust CMS' CFs by additional factors so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. DMAS may revise the additional factors when CMS updates its RVUs or CFs so that no change in expenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by CMS. The calculation of the additional factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule. The determination of the additional factors required above shall be accomplished by means of the following calculation:

a. The estimated amount of DMAS expenditures if DMAS were to use Medicare's RVUs and CFs without modification, is equal to the sum, across all relevant procedure codes, of the RVU value published by the CMS, multiplied by the applicable conversion factor published by the CMS, multiplied by the number of occurrences of the procedure code in DMAS patient claims in the most recent period of time (at least six months).

b. The estimated amount of DMAS expenditures, if DMAS were not to calculate new fees based on the new CMS RVUs and CFs, is equal to the sum, across all relevant procedure codes, of the existing DMAS fee multiplied by the number of occurrences of the procedures code in DMAS patient claims in the period of time used in subdivision 2 a of this subsection.

c. The relevant additional factor is equal to the ratio of the expenditure estimate (based on DMAS fees in subdivision 2 b of this subsection) to the expenditure estimate based on unmodified CMS values in subdivision 2 a of this subsection.

d. DMAS shall calculate a separate additional factor for:

(1) Emergency room services (defined as the American Medical Association's (AMA) publication of the Current Procedural Terminology (CPT) codes 99281, 99282, 99283, 99284, and 992851 in effect at the time the service is provided);

(2) Obstetrical/gynecological services (defined as maternity care and delivery procedures, female genital system procedures, obstetrical/gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) publication of the Current Procedural Terminology (CPT) manual in effect at the time the service is provided);

(3) Pediatric preventive services (defined as preventive E&M procedures, excluding those listed in subdivision 2 d (1) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21);

(4) Pediatric primary services (defined as evaluation and management (E&M) procedures, excluding those listed in subdivisions 2 d (1) and 2 d (3) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21);

(5) Adult primary and preventive services (defined as E&M procedures, excluding those listed in subdivision 2 d (1) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients age 21 and over); ~~and~~

(6) Effective July 1, 2019, psychiatric services as defined by the American Medical Association's annual publication of the CPT manual, in effect at the time the service is provided; and

~~(6)~~ (7) All other procedures set through the RBRVS process combined.

3. For those services or procedures for which there are no established RVUs, DMAS shall approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service methodology.

4. Fees shall not vary by geographic locality.

5. Effective for dates of service on or after July 1, 2007, fees for emergency room services (defined in subdivision 2 d (1) of this subsection) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

C. Effective for dates of service on or after May 1, 2006, fees for obstetrical/gynecological services (defined in subdivision B 2 d (2) of this section) shall be increased by 2.5% relative to the fees in effect on July 1, 2005.

D. Effective for dates of service on or after May 1, 2006, fees for pediatric services (defined in subdivisions B 2 d (3) and (4) of this section) shall be increased by 5.0% relative to the fees in effect on July 1, 2005. Effective for dates of service on or after July 1, 2006, fees for pediatric services (defined in subdivisions B 2 d (3) and (4) of this section) shall be increased by 5.0% relative to the fees in effect on May 1, 2006. Effective for dates of service on or after July 1, 2007, fees for pediatric primary services (defined in subdivision B 2 d (4) of this section) shall be increased by 10% relative to the fees that would otherwise be in effect.

E. Effective for dates of service on or after July 1, 2007, fees for pediatric preventive services (defined in subdivision B 2 d (3) of this section) shall be increased by 10% relative to the fees that would otherwise be in effect.

F. Effective for dates of service on or after May 1, 2006, fees for adult primary and preventive services (defined in subdivision B 2 d (4) of this section) shall be increased by 5.0% relative to the fees in effect on July 1, 2005. Effective for dates of service on or after July 1, 2007, fees for adult primary and preventive services (defined in subdivision B 2 d (5) of this section) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

G. Effective for dates of service on or after July 1, 2007, fees for all other procedures set through the RBRVS process combined (defined in subdivision B 2 d (6) of this section) shall be increased by 5.0% relative to the fees that would otherwise be in effect.

H. Effective for dates of service on or after July 1, 2010, fees for all procedures set through the RBRVS process shall be decreased by 3.0% relative to the fees that would otherwise be in effect.

I. Effective for dates of service on or after October 1, 2010, through June 30, 2011, the 3.0% fee decrease in subsection H of this section shall no longer be in effect.

J. Effective for dates of service on or after July 1, 2019, rates for adult primary care services shall be increased by 5% and rates for emergency department services shall be increased by 1%.

K. Effective for dates of service on or after July 1, 2019, rates for psychiatric services shall be increased by 21 percent.