12 VAC 30-70-425. Supplemental payments to non-state government owned hospitals for inpatient services.

A. Subject to legislative authorization as required and the availability of local, State, and Federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DMAS shall provide quarterly lump sum supplemental payments to participating non-state government-owned hospitals for services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for services to Medicaid patients and the maximum amount allowable under applicable federal regulations in accordance with 42 CFR § 447.272.

B. A qualifying hospital is owned or operated by a unit of government other than a state. The payment amount for a qualifying hospital participating according to the provisions in subsection A above is the hospital's proportionate share of the established pool of funds determined by dividing the participating hospital's Medicaid days provided during the most recent fiscal year by the total Medicaid days provided by all qualifying hospitals for the same fiscal year.

C. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR § 447.271.

12 VAC 30-70-426. Supplemental payments to state government-owned hospitals for inpatient services.

A. Subject to legislative authorization as required and the availability of State and federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DMAS shall provide lump sum supplemental payments to participating state government-owned hospitals for services provided to Medicaid patients on or after July 1, 2002. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments and the maximum allowable under applicable federal regulations in accordance with 42 CFR 447.272.

B. A qualifying hospital is owned or operated by the state. The payment amount for a qualifying hospital participating according to the provisions of subsection A above is the hospital's proportionate share of the established pool of funds determined by dividing the participating hospital's Medicaid days provided during the most recent fiscal year by the total Medicaid days provided by all qualifying hospitals for the same fiscal year.

C. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR 447.271.

12 VAC 30-80-20.

D. The services that are cost reimbursed are:

1. Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

2. Outpatient hospital services excluding laboratory.

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

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room 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 hospital 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 which 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 for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments which DMAS determines were 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 performed by the attending physician which may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for (2) above. Services not meeting certain criteria shall be paid under the methodology of (1) above. 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-9-CM diagnosis codes and necessary supporting documentation.

(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, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

3. Rural health clinic services provided by rural health clinics or other federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§329, 330, and 340.

4. Rehabilitation agencies. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

5. Comprehensive outpatient rehabilitation facilities.

6. Rehabilitation hospital outpatient services.

7. Supplemental payments to non-state government-owned hospitals for outpatient services.

a. Subject to legislative authorization as required and the availability of local, State, and Federal funds, and based upon a transfer agreement and the subsequent transfer of funds, the Department provides quarterly lump sum supplemental payments to participating non-state government-owned hospitals for outpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of

which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.

b. A qualifying hospital is owned or operated by a unit of government other than a state. The payment amount for a qualifying hospital participating according to the provisions in subsection 7A above is the hospital's proportionate share of the established pool of funds determined by dividing the participating hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

c. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR 447.325.

8. Supplemental payments to state government-owned hospitals for outpatient services.

a. Subject to legislative authorization as required and the availability of State and federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DMAS shall provide lump sum supplemental payments to participating state government-owned hospitals for outpatient services provided to Medicaid patients on or after July 1, 2002. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.

b. A qualifying hospital is owned or operated by the state. The payment amount for a qualifying hospital participating according to the provisions in subsection 8 a above is the

hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

c. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR 447.325.

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 (12VAC30-80-160 has obstetric/pediatric fees). Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public), except that reimbursement rates for designated physician services when performed in hospital outpatient settings shall be 50% of the reimbursement rate established for those services when performed in a physician's office. 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 which 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, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments which 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 which 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-9-CM diagnosis codes and necessary supporting documentation.

(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-9-CM code designations, and the impact on recipients and providers.

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).

a. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge.

b. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

c. 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 which 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, including services paid to local school districts.

8. Laboratory services (other than inpatient hospital).

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 to government-owned clinics.

a. Subject to legislative authorization as required and the availability of local, State, and Federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DMAS shall provide lump sum supplemental payments to participating government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 1, 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 their license to an eligible individual.

(1) Supplemental payments for state government-owned or operated clinics are made from a pool of funds equal to the difference between the Medicaid payments otherwise made to state government-owned or operated clinics for outpatient services and the maximum amount allowable under applicable federal regulations in accordance with 42 CFR 447.321. Payments are made to clinics that are either owned or operated by the state.

(2) Supplemental payments for non-state government-owned or operated clinics are made from a pool of funds equal to the difference between the Medicaid payments otherwise made to non-state government-owned or operated facilities for outpatient services and the maximum amount allowable under applicable federal regulations in accordance with 42 CFR 447.321. Payments are made to clinics that are neither owned nor operated by the state.

b. The payment amount for a clinic participating according to the provisions of subsection 16a. is the clinic's proportionate share of the established pool of funds determined by dividing the participating clinic's payments for Medicaid outpatient services provided during the most recent fiscal year by the total payments for Medicaid outpatient services provided by all clinics for the same fiscal year.

c. A payment made to a clinic under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR 447.325.

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.

12 VAC 30-90-18. Additional payment to state government-owned or operated nursing facilities and intermediate care facilities for the mentally retarded. Subject to legislative authorization as required and the availability of State and Federal funds, and based upon an interagency transfer agreement and the subsequent transfer of funds, DMAS makes additional payments to participating state government-owned or operated nursing facilities or ICFs-MR for services provided to Medicaid patients on or after July 1, 2002. DMAS uses the following methodology to calculate the additional Medicaid payments to state government-owned or operated nursing facilities or ICFs-MR participating according to the provisions of this section:

A. For each State Fiscal Year, DMAS calculates the maximum additional payments that it can make to all state government-owned or operated nursing facilities or ICFs-MR in conformance with 42 CFR 447.272.

B. DMAS determines a total additional payment amount to be made in a manner not to exceed the maximum additional payment amount calculated in paragraph A above.

C. Using the latest fiscal period for which the state government-owned or operated nursing facilities or ICFs-MR have completed cost reports on file with DMAS, the Department determines the total Medicaid days reported by each state government-owned or operated nursing facility or ICF-MR for that fiscal period.

D. DMAS divides the total Medicaid days for each participating state government-owned or operated nursing facility or ICF-MR by the total Medicaid days for all state government-owned or operated nursing facilities or ICFs-MR to determine the supplementation factor for each.

E. For each participating state government-owned or operated nursing facility or ICF-MR, DMAS multiplies the state government-owned or operated nursing facility's or ICF-MR's supplementation factor determined in step 4 above by the total additional payment amount identified in step 2 above to determine the additional payment to be made to each state government-owned or operated nursing facility or ICF-MR.

12VAC30-90-19. Additional reimbursement for locally-owned nursing facilities or ICFs-MR.

A. Subject to legislative authorization as required and the availability of local, state, and federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DMAS makes additional payments to participating local government nursing facilities or ICFs-MR. A local government nursing facility or ICF-MR is defined as a provider owned or operated by a county, city, or other local government agency, instrumentality, authority or commission.

B. DMAS uses the following methodology to calculate the additional Medicaid payments to local government nursing facilities or ICFs-MR participating according to the provisions in subsection 19 A:

1. For each state fiscal year, DMAS calculates the maximum additional payments that it can make to ~~the~~ all local government nursing facilities or ICFs-MR in conformance with 42 CFR 447.272 (a).

2. DMAS determines a total additional payment amount to be made in a manner not to exceed the maximum additional payment amount calculated in subdivision 1 of this subsection.

3. Using the latest fiscal period for which the local government nursing facilities or ICFs-MR have completed cost reports on file with DMAS, the department determines the total Medicaid days reported by each local government nursing facility or ICF-MR for that fiscal period.

4. DMAS divides the total Medicaid days for each participating local government nursing facility or ICF-MR by the total Medicaid days for all local government nursing facilities or ICFs-MR to determine the supplementation factor for each.

5. For each participating local government nursing facility or ICF-MR, the department multiplies the local government nursing facility's or ICF-MR's supplementation factor determined in subdivision 4 of this subsection by the total additional payment amount identified in subdivision 2 of this subsection to determine the additional payment to be made to each local government nursing facility or ICF-MR.