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

A. In addition to payments for inpatient hospital services provided for elsewhere in this State Plan, DMAS makes supplemental payments to non-state government-owned or operated hospitals for services provided to Medicaid patients on or after July 1, 2002. To qualify for a supplemental payment, the hospital must be owned or operated by a unit of government or public entity other than the state.

B. The amount of the supplemental payment made to each non-state government-owned or operated hospital is determined by:

1. Calculating for each hospital the annual difference between the lower of the limit specified in 42 CFR § 447.271 or the limit specified at 42 U.S.C. § 1396r-4(g) and the amount otherwise actually paid for the services by the Medicaid program;
2. Dividing the difference determined in (1) for the hospital by the aggregate difference for all such hospitals; and
3. Multiplying the proportion determined in (2) by the aggregate upper payment limit amount for all such hospitals as determined in accordance with 42 CFR § 447.272 less all payments made to such hospitals other than under this section.

C. Payments 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.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

___1/17/2003_____ _/s/ P. W. Finnerty_____
Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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

A. In addition to payments for inpatient hospital services provided for elsewhere in this State Plan, DMAS makes supplemental payments to state government-owned or operated hospitals for services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be owned or operated by the state.

B. The amount of the supplemental payment made to each state government-owned or operated hospital is determined by:

1. Calculating for each hospital the annual difference between the lower of the limit specified in 42 CFR § 447.271 or the limit specified at 42 U.S.C. § 1396r-4(g) and the amount otherwise actually paid for the services by the Medicaid program;
2. Dividing the difference determined in (1) for the hospital by the total difference for all such hospitals; and
3. Multiplying the proportion determined in (2) by the aggregate upper payment limit amount for all such hospitals as determined in accordance with 42 CFR § 447.272 less all payments made to such hospitals other than under this section.

C. Payments under this section may be made in one or more installments at such time, within the fiscal year or thereafter, as is determined by DMAS.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

___1/17/2003_____
Date

_/s/ P. W. Finnerty_____
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-80-20. Services which are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

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

a. In addition to payments for services set forth elsewhere in this State Plan, DMAS provides supplemental payments to non-state government-owned or operated hospitals for outpatient services provided to Medicaid patients on or after July 1, 2002. To qualify for a supplemental payment, the hospital must be owned or operated by a unit of government other than the state.

b. The amount of the supplemental payment made to each non-state government-owned or operated hospital is determined by:

~~1.~~(1) Calculating the difference between the lower of the limit specified in 42 CFR § 447.325 or the limit specified at 42 U.S.C. § 1396r-4 (g) and the amount otherwise actually paid for the services by the Medicaid program;

~~2.~~(2) Dividing the difference determined in (1) by the aggregate upper payment limit amount for all such hospitals; and

~~3.~~(3) Multiplying the proportion determined in (2) by the aggregate upper payment limit amount for all such hospitals as determined in accordance with 42 CFR § 447.321 less all payments made to such hospitals other than under this section.

~~c.~~c. Payments 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.

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

a. In addition to payments for services set forth elsewhere in this State Plan, DMAS

provides supplemental payments to state government-owned or operated hospitals for outpatient services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment the hospital must be owned or operated by the state.

b. The amount of the supplemental payment made to each hospital is determined by:

(1) Calculating the difference between the lower of the limit specified in 42 CFR § 447.325 or the limit specified at 42 U.S.C. § 1396r-4(g) and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in (1) by the aggregate upper payment limit amount for all such hospitals; and

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

c. Payments 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.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

1/17/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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 state government-owned clinics.

a. In addition to payments for clinic services specified elsewhere in this state plan, DMAS provides supplemental payments to 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 their license to an eligible individual.

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

(1) Calculating for each clinic the annual difference between the amount that would be paid for inpatient services provided to Medicaid eligibles under the Medicare program and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in (1) for the clinic by the aggregate difference for all such clinics; and

(3) Multiplying the proportion determined in (2) 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 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.

17. Supplemental payments for services provided by Type I physicians. RESERVED.

18. Supplemental payments to non-state government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in this state plan, DMAS provides supplemental payments to non-state 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 their license to an eligible individual.

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

(1) Calculating for each clinic the annual difference between the limit specified in 42 CFR § 447.325 and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in (1) for the clinic by the aggregate difference for all such clinics; and

(3) Multiplying the proportion determined in (2) 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 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.

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.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

___1/17/2003_____ _/s/ P. W. Finnerty_____

Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-90-17. Additional payment to state government-owned or operated intermediate care facilities for the mentally retarded (ICF/MR).

In addition to payments for ICF/MR services set forth elsewhere in this State Plan, DMAS makes supplemental payments to state government-owned or operated ICFs/MR for services provided to Medicaid patients on or after July 2, 2002. DMAS uses the following methodology to calculate the additional Medicaid payments to state government-owned or operated ICFs/MR:

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 the total Medicaid days reported by each state government-owned or operated ICF/MR for a fiscal period using cost reports from the most recent fiscal year for which all state government-owned or operated ICFs/MR have acceptable cost reports on file with DMAS.

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

D. For each state government-owned or operated ICF/MR, DMAS multiplies the facility's supplementation factor determined in (C.) above by the total additional payment amount identified in (A.) above to determine the additional payment to be made to each state government-owned or operated ICF/MR.

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

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

1/17/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12 VAC 30-90-18. Additional payment to state government-owned or operated nursing facilities. In addition to payments for nursing facility services set forth elsewhere in this State Plan, DMAS makes supplemental payments to state government-owned or operated nursing facilities for services provided to Medicaid patients on or after July 2, 2002. DMAS uses the following methodology to calculate the additional Medicaid payments to state government-owned or operated nursing facilities:

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

B. DMAS determines the total Medicaid days reported by each state government-owned or operated nursing facility for a fiscal period using cost reports from the most recent fiscal year for which all state government-owned or operated nursing facilities have acceptable cost reports on file with DMAS:

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

D. For each state government-owned or operated nursing facility, DMAS multiplies the facility's supplementation factor determined in (C.) above by the total additional payment amount identified in (A.) above to determine the additional payment to be made to each state government-owned or operated nursing facility.

E. Payments 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.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

1/17/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director

Dept. of Medical Assistance Services