



# COMMONWEALTH of VIRGINIA

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## MEMORANDUM

**TO:** EMILY MCCLELLAN  
Regulatory Supervisor  
Virginia Department of Medical Assistance Services

**FROM:** USHA KODURU *UK*  
Assistant Attorney General

**DATE:** November 23, 2020

**SUBJECT:** Exempt final regulations regarding potentially preventable hospital readmissions and avoidable emergency room visits (5561/9013)

I have reviewed the attached exempt final regulations to reduce payments to physicians and hospitals for emergency room claims for codes 99282, 99283, and 99284 to the payment amount for code 99281 when the principle diagnosis appears on the Preventable Emergency Room Diagnosis List. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services (“DMAS”) has the legal authority to amend the regulations and if the regulation comport with state and federal law.

Based on my review and pursuant to the 2020 Appropriations Act, Items 313 AAAAA and BBBBB, the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, in accordance with Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act (“APA”) and has not exceeded that authority. It is my view that the amendment of these regulations is exempt from the procedures of Article 2 of the APA pursuant to Va. Code § 2.2-4006(A)(4)(a).

If you have any questions about this matter, please contact me at 786-4072.

cc: Kim F. Piner, Esquire

Attachment

## Article 2

### Prospective (DRG-Based) Payment Methodology

#### **12VAC30-70-221. General.**

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12VAC30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12VAC30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12VAC30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12VAC30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12VAC30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12VAC30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. For Type Two hospitals, payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of full-time equivalent (FTE) interns and residents as reported on the cost report. Effective April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs.

7. As stipulated in 12VAC30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12VAC30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"AP-DRG" means all patient diagnosis related groups.

"APR-DRG" means all patient refined diagnosis related groups.

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" means the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" means the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid inpatient utilization rate in excess of 14%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and
2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.
3. Subdivision 2 of this definition does not apply to a hospital:
  - a. At which the inpatients are predominantly individuals under 18 years of age; or
  - b. Which does not offer nonemergency obstetric services as of December 21, 1987.

"DRG" means diagnosis related groups.

"DRG cases" means medical or surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" or "Medicaid inpatient utilization rate" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage or Medicaid inpatient utilization rate includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days and nonpaid or denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income care, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth. Effective July 1, 2014, the definition for Medicaid utilization percentage or Medicaid inpatient utilization rate is defined in 12VAC30-70-301 C.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric distinct part unit (DPU), divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The costs shall be calculated by multiplying the per diems and ancillary cost-to-charge ratios from each hospital's cost ending in the state fiscal year used as the base year to the corresponding days and ancillary charges by revenue code for each hospital's groupable cases.

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and includes (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD, as defined in 12VAC30-95-5. Not all mental disorders are covered. For coverage

information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A & B (12VAC30-50-95 through 12VAC30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" means when patients are readmitted to the same hospital for the same or a similar diagnosis ~~within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as new cases.~~ Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Type One hospitals" means those hospitals that were state-owned teaching hospitals on January 1, 1996.

"Type Two hospitals" means all other hospitals.

"Uncompensated care costs" or "UCC" means unreimbursed costs incurred by hospitals from serving self-pay, charity, or Medicaid patients without regard to disproportionate share adjustment payments.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper. Effective October 1, 2014, "ungroupable cases" means cases assigned to DRG 955 (ungroupable) and DRG 956 (ungroupable) as determined by the APR-DRG grouper.

D. The all patient diagnosis related groups (AP-DRG) grouper shall be used in the DRG payment system. Effective October 1, 2014, DMAS shall replace the AP-DRG grouper with the all patient refined diagnosis related groups (APR-DRG) grouper for hospital inpatient reimbursement. The APR-DRG grouper will produce a DRG as well as a severity level ranging from 1 to 4. DMAS shall phase in the APR-DRG weights by blending in 50% of the full APR-DRG weights with

50% of fiscal year (FY) 2014 AP-DRG weights for each APR-DRG group and severity level in the first year. In the second year, the blend will be 75% of full APR-DRG weights and 25% of the FY 2014 AP-DRG weights. Full APR-DRG weights shall be used in the third year and succeeding years for each APR-DRG group and severity. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's 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, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology	
Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation	Cost report file

unit or hospital	
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims history file
Outlier adjustment factor	Federal Register

### **12VAC30-70-231. Operating payment for DRG cases.**

A. The operating payment for DRG cases that are not transfer cases shall be equal to the hospital specific operating rate per case, as determined in 12VAC30-70-311, times the DRG relative weight, as determined in 12VAC30-70-381.

B. Exceptions.

1. Special provisions for calculating the operating payment for transfer cases are provided in 12VAC30-70-251.

2. Readmissions within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case.

3. Effective July 1, 2020, readmissions within six to thirty days of discharge shall be paid at fifty percent of the normal rate unless it is a planned readmission, an obstetrical readmission, an admission to critical access hospitals, or in any case where the patient was originally discharged against medical advice.

### **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 Department of Medical Assistance Services (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) except that emergency room services 99282-99284 with a principal diagnosis on the Preventable Emergency Room Diagnosis List shall be reimbursed the rate for 99281. The Preventable Emergency Room Diagnosis List shall be based on the list used for Managed Care Organization clinical efficiency rate adjustments.

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](http://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 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 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, 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 November 1, 2018, the supplemental payment amount shall be the difference between the Medicaid payments otherwise made for physician services and 145% of the 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) or personal care services for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200 or covered under Early and Periodic Screening, Diagnosis, and Treatment. 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 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% of the Medicare rate and shall reflect changes annually based on changes in the Medicare rate. Federally qualified health centers and rural health centers 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:

"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, the Department of Medical Assistance Services (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.

"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.

"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, effective July 1, 2019, the operating rate shall be based on an adjustment factor equal to 100% of cost reimbursement.

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.

d. Effective July 1, 2020, reimbursement for claims with procedure codes 99281-99284 and a principal diagnosis code on the Preventable Emergency Room Diagnosis List shall be based on an all inclusive EAPG payment weight for claims with CPT 99281 and a principal diagnosis code on the Preventable Emergency Room Listing. All other procedures on the outpatient hospital claim shall be packaged in the all inclusive payment for 99281-99284. DMAS shall calculate the all-inclusive payment weight for claims with 99281 using data from the most recent rebasing. The Preventable Emergency Room Diagnosis List shall be based on the list used for Managed Care Organization clinical efficiency rate adjustments.

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