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TO: BRIAN MCCORMICK
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Virginia Department of Medical Assistance Services

FROM: MICHELLE A. L'HOMMEDIEU 
Assistant Attorney General

DATE: April 28, 2015

SUBJECT: Fast Track Regulations Regarding Supplemental Payments for Various Provider Types (Hospitals affiliated with Type-One hospitals, physicians affiliated with publicly-funded Tidewater medical schools, and non-state government-owned nursing facilities)(4268/7078)

I am in receipt of the attached regulations to modify or establish supplemental payments for (i) private hospitals affiliated with Type-One hospitals, (ii) physicians affiliated with publicly-funded medical schools in the Tidewater area, and (iii) non-state government-owned nursing facilities. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate these regulations and if they comport with state and federal law.

Based on that review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority; and these regulations comport with the authorization granted under Chapter 2, Item 301 DDDD of the 2014 *Acts of the Assembly*.

Pursuant to Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the

normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

Because these regulations will amend the State Plan, approval by CMS will also be required. If you have any questions or need additional information about these regulations, please contact me at 786-6005.

cc: Kim F. Piner, Esquire

Attachment

Project 4190 - Fast-Track

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Supplemental Payments for Various Provider Types (Hospitals, EVMS Physicians, NFs)

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-70-428. Supplemental payments for private hospital partners of Type One hospitals .

A. Effective for dates of service on or after October 25, 2011, quarterly supplemental payments will be issued to qualifying private hospitals for inpatient services rendered during the quarter.

B. Qualifying criteria. In order to qualify for the supplemental payment, the hospital must be currently enrolled as a Virginia Medicaid provider, and must be owned or operated by a private entity in which a Type One hospital has a non-majority interest.

C. Reimbursement methodology.

1. Hospitals **not** participating in the Medicaid Disproportionate Share Hospital (DSH) program shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than 2 years after the year in which the qualifying hospitals' entitlement arises. The annual supplemental payments in any fiscal year shall be the lesser of:

a. The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the fiscal year; or

b.\$14,620 per Medicaid discharge for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department.

2. Hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than 2 years after the year in which the qualifying hospitals' entitlement arises. The annual supplemental payments in any fiscal year shall be the lesser of:

a. The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the fiscal year;

b.\$14,620 per Medicaid discharge for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department;

or,

c. The difference between the limit calculated under the *Social Security Act* § 1923(g) and the hospital's DSH payments for the applicable payment period.

D. Limit. Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit per state fiscal year.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-80-20. Services that 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 with the exception provided for in

subdivision D 1 d of this section. 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 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 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 that 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. Outpatient hospital services, including rehabilitation hospital outpatient services and excluding laboratory services.

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 that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse 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 rendered in emergency departments that 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 that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 1 b (1) of this subsection.

Such criteria shall include, but not be limited to:

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

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

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

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

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

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

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

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

c. Limitation of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at various percentages as noted in subdivisions 1 c (1) and 1 c (2) of this subsection of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

(2) Type Two hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be 77% of allowable cost.

(c) Effective October 1, 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be 76% of allowable cost.

d. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

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

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

2. Rehabilitation agencies or comprehensive outpatient rehabilitation.

a. Effective July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities that are operated by community services boards or state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

b. Effective October 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities operated by state agencies shall be reimbursed their costs. For reimbursement methodology applicable to all other rehabilitation agencies, see 12VAC30-80-200.

3. (RESERVED.)

4. Supplemental payments for private hospital partners of Type One hospitals. Effective for dates of service on or after October 25, 2011, quarterly supplemental payments shall be issued to qualifying private hospitals for outpatient services rendered during the quarter.

a. In order to qualify for the supplemental payment, the hospital shall be currently enrolled as a Virginia Medicaid provider and shall be owned or operated by a private entity in which a Type One hospital has a non-majority interest.

b. Reimbursement methodology.

(1) Hospitals **not** participating in the Medicaid Disproportionate Share Hospital (DSH) program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than 2 years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in a fiscal year shall be the lesser of:

(a) The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid individuals during the fiscal year; or

(b) \$1,894 per Medicaid outpatient visit for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department.

(2) Hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than 2 years after the year in which the qualifying hospital's entitlement arises. The annual supplemental payments in a fiscal year shall be the lesser of:

(a) The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid individuals during the fiscal year; or

(b) \$1,894 per Medicaid outpatient visit for state plan rate year 2012. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department; or,

(c) The difference between the limit calculated under the Social Security Act § 1923(g) and the hospital's DSH payments for the applicable payment period.

c. Limit. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

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

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

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

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

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

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

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

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

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and

reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

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

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

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

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

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

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

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

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

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

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

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

2. Dentists' services.

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

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

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

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME) and supplies.

Definitions. The following words and terms when used in this part 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%.

(2) For DME items with no DMERC rate, the agency shall use the agency fee schedule amount. The reimbursement rates for DME and supplies shall be listed in the DMAS Medicaid Durable Medical Equipment (DME) and Supplies Listing and updated periodically. The agency fee schedule shall be available on the agency website at www.dmas.virginia.gov.

(3) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, less shipping and handling, plus 30%. The manufacturer's net charge to the provider shall be the cost to the provider minus all available discounts to the provider. Additional information specific to how DME providers, including manufacturers who are enrolled

as providers, establish and document their cost or costs for DME codes that do not have established rates can be found in the relevant agency guidance document.

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

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

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

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active

therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

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

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services.

8. Laboratory services (other than inpatient hospital).

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

10. X-Ray services.

11. Optometry services.
12. Medical supplies and equipment.
13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.
14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.
15. Clinic services, as defined under 42 CFR 440.90.
16. Supplemental payments for services provided by Type I physicians.
 - a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.
 - b. Effective July 2, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for Type I physician services and Medicare rates. Effective August 13, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 143% of Medicare rates. Effective January 3, 2012, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 181% of Medicare rates. The

methodology for determining the Medicare equivalent of the average commercial rate is described in 12 VAC 30-80-300.

c. Supplemental payments shall be made quarterly.

d. Payment will not be made to the extent that this would duplicate payments based on physician costs covered by the supplemental payments.

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

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and

143% of Medicare rates as defined in the supplemental payment calculation for Type I physician services subject to the following reduction. Final payments shall be reduced on a pro-rated basis so that total payments for freestanding children's hospital physician services are \$400,000 less annually than would be calculated based on the formula in the previous sentence. Payments shall be made on the same schedule as Type I physicians.

18. Supplement payments for services provided by physicians affiliated with publicly-funded medical schools in the Tidewater area.

a. In addition to payments for physician services specified elsewhere in the State Plan, DMAS provides supplemental payments to physicians affiliated with publicly funded medical schools in the Tidewater area for furnished services provided on or after October 1, 2012. A physician affiliated with a publicly-funded medical school 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 has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective October 1, 2012, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 135% of Medicare rates. The methodology for determining the Medicare Equivalent of the Average Commercial Rate is described in 12 VAC30-80-300.

1819. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or

operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

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

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

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

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

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

d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3) of this subsection, Medicaid payments to nonstate government-owned or operated

clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B 2) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

4920. Personal Assistance Services (PAS) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the DMAS website (<http://dmasva.dmas.virginia.gov>).

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

Part II

Nursing Home Payment System

Subpart I

General

12VAC30-90-19. ~~Certified public expenditures~~ Supplemental payments for locally-owned nonstate government-owned nursing facilities.

A. In addition to payments made elsewhere, effective July 1, 2005, DMAS shall draw down federal funds to cover unreimbursed Medicaid costs for inpatient services provided by nonstate government-owned nursing homes as certified by the provider through cost reports. A local government nursing facility is defined as a provider owned or operated by a county, city, or other local government agency, instrumentality, authority or commission.

B. Effective July 1, 2014, DMAS shall make additional supplemental payments to nonstate government-owned nursing facilities that meet the requirements in subsection A. Quarterly supplemental payment for each facility shall be calculated in the following manner:

1. Annually calculate for each nursing facility what Medicare would have paid for Medicaid services in the base year, which is the most recently available state fiscal year, using the Medicare skilled nursing facility prospective payment system updated for market basket adjustments and other rate changes to the rate year, which is the upcoming state fiscal year.

2. Annually calculate for each facility what Medicaid paid in the base year including any supplemental payments resulting from subsection A updated for inflation and other rate changes to the rate year.

3. Calculate a per diem supplemental payment for each facility by subtracting Medicaid expenditures calculated in B(2) from what Medicare would have paid calculated in B(1) and dividing the result by the number of paid days for each facility in the base year.

4. At the end of each quarter of the rate year, calculate the number of paid days in the quarter for each facility and multiply it by the per diem supplemental payment for each facility.

C. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available upper payment in the current state fiscal year.