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:

Services which are reimbursed on a cost-basis.

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.

Services which are reimbursed on a cost-basis.

(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~~REPEALED.

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.

12VAC30-80-25. Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

A. Consistent with the Benefits Improvement and Protection Act (BIPA) of 2000, Section 702, DMAS adopts the alternative payment methodology. This alternative payment methodology continues established reasonable cost reimbursement using Medicare principles of reimbursement. The Commonwealth shall make interim payments on a per visit basis and shall reconcile to actual costs via the year-end cost report. The methodology used to determine the payment amount is: (1) agreed to by the Commonwealth and the center or clinic, and (2) results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

1. Newly qualified FQHCs/RHCs adopting the alternative payment methodology after Federal Fiscal Year 2000 will have initial payments established through pro-forma cost reporting methods.

2. At the end of the cost reporting cycle, the Commonwealth shall compare the alternative per visit rate to the PPS rate and reimburse the center/clinic the higher of the alternative rate or the PPS rate for the number of visits recorded during the reporting period.

B. In the event a FQHC/RHC does not select the alternative payment methodology, DMAS shall provide payment consistent with the new Prospective Payment System (PPS) as prescribed by the BIPA of 2000, Section 702.

1. Baseline PPS rate methodology. The PPS baseline payment period (January 1, 2001 – September 30, 2001) rate shall be determined by averaging 100% of the FQHCs/RHCs reasonable costs of providing Medicaid-covered services during the providers' 1999 and 2000 fiscal years, adjusted to take into account any increase or decrease in the scope of services furnished during provider FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Beginning October 1, 2001, and for each fiscal year thereafter, each FQHC/RHC shall be entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under BIPA of 2000 in the previous fiscal year, adjusted by the percentage change in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC/RHC during its fiscal year.

2. For new FQHCs/RHCs that qualify on or after fiscal year 2000, the DMAS will compare the new center/clinic to other clinics/centers in the same or adjacent areas, as defined by the current U.S. Department of Commerce, Bureau of Economic Analysis, Metropolitan Statistical Area Component County List, issued by the Office of Management and Budget, with similar case loads for purposes of establishing an initial payment rate. If no comparable clinic/center exists, the DMAS will compute a clinic/center specific rate based upon the clinic's pro-forma budget or historical costs adjusted for changes in scope of services. At the end of the first fiscal year, initial payments will be reconciled to equate to 100% of costs. After the initial year, payment shall be increased or decreased using the MEI and adjusted for changes in the scope of services as described above.

C. Supplemental payments. As specified in the BIPA of 2000, Section 702, in the case of services furnished by FQHC/RHC pursuant to a contract between the center and a managed care entity (MCE), provision is hereby made for payment to the center or clinic at least quarterly by the Commonwealth of a supplemental payment equal to the amount (if any) by which the amount determined under A or B above exceeds the amount of the payments provided under such HMO contract.

1. Supplemental payments for FQHCs/RHCs selecting the alternative methodology. FQHCs/RHCs that provide services under a contract with an MCE will receive quarterly state supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from the MCE or MCEs and the payments the FQHC/RHC would have received under the alternative methodology. At the end of the FQHC's/RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE or MCEs would have yielded under the alternative methodology. If the alternative amount exceeds the total amount of supplemental and MCE payments, the FQHC/RHC will be paid the difference between the amount calculated using the alternative methodology and actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC. If the alternative amount is less than the total amount of supplemental and MCE payments, the FQHC/RHC will refund the difference to DMAS between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC.

2. Supplemental payments for FQHCs/RHCs selecting the PPS methodology. FQHCs/RHCs that provide services under a contract with a MCE will

receive quarterly state supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from MCEs and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of each FQHC's/RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE would have yielded under the PPS. If the PPS amount exceeds the total amount of supplemental and MCE payments, the FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC/RHC. If the PPS amount is less than the total amount of supplemental and MCE payments, the FQHC/RHC will refund to DMAS the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC.

D. These providers shall be subject to the same cost reporting submission requirements as specified in 12VAC30-80-20 for cost-based reimbursed providers.

CERTIFIED:

6/5/2002
DATE

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