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 D2~~c~~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 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

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

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

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

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

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

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

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

D. The services that are cost reimbursed are:

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

2. Outpatient hospital services excluding laboratory.

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

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

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

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

"Recent injury" means an injury 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, including those obstetric and pediatric procedures contained in 12VAC30-80-160, 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 2 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 2b (1) of this subsection. Such criteria shall include, but not be limited to:

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

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

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

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

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

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

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

c. Limitation to 80% of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at 80% of allowable cost, with cost to be determined as provided in A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, 2003, 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. Operating costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Capital costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Operating and capital costs of Type One hospitals shall continue to be reimbursed at 94.2% and 90% of cost respectively.

~~c.~~d. Outpatient reimbursement methodology prior to July 1, 2003. DMAS shall continue to reimburse for outpatient hospital services, with the exception of Direct Graduate Medical Education for interns and residents, at 100% of reasonable costs less a 10 percent reduction for allowable capital costs and a 5.8 percent reduction for allowable operating costs. This methodology shall continue to be in effect after July 1, 2003, for Type One hospitals.

~~d.~~ e. 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 12 VAC 30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

3. Rehabilitation agencies operated by Community Services Boards. For the reimbursement methodology applicable to other rehabilitation agencies, see 12 VAC 30-80-200. 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.

4. Comprehensive outpatient rehabilitation facilities.

5. Rehabilitation hospital outpatient services.

6. Supplemental payments to nonstate government-owned hospitals for outpatient services.

a. The department provides lump sum supplemental payments to participating nonstate government-owned hospitals for furnished outpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to all nonstate government-owned hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321. A participating hospital is one with respect to which a transfer agreement has been made and implemented.

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

c. A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified in 42 USC §1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other participating hospitals in the same manner and subject to the same limitations as set forth above.

d. For the period from December 16, 2001, through May 13, 2002, aggregate payments to nonstate

government-owned hospitals shall not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. For the period beginning May 14, 2002, aggregate payments to these hospitals shall not exceed 100% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles.

e. To determine the reasonable estimate of the amount that would be paid under Medicare payment principles, each hospital's outpatient cost to charge ratio will be calculated and applied to its Medicaid outpatient charges. The reasonable estimate will be the sum of the calculations for all hospitals. The calculation will use data from the last settled cost report for all nonstate government-owned hospitals at the beginning of the state fiscal year for which calculations are made. However, for state fiscal year 2002, only data from the last settled cost report at the beginning of state fiscal year 2003 will be used. Charges and Medicaid payments will be trended forward using the Virginia-specific DRI-hospital inflation factors. Additional adjustments will be made for any statutory changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.

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

a. In addition to payments for services set forth elsewhere in this State Plan, DMAS provides supplemental payments to qualifying state government-owned or operated hospitals for outpatient services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be part of a state academic health system or part of an academic health system that operates under a state authority.

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

(1) Calculating for each hospital the annual difference between the upper payment limit attributed to each qualifying hospital calculated according to this subdivision 7d and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 7 b (1) for each qualifying hospital by the aggregate difference for all such qualifying hospitals; and

(3) Multiplying the proportion determined in subdivision 7 b (2) by the aggregate upper payment limit amount for all state owned or operated hospitals as determined in accordance with 42 CFR 447.321 less all payments made to such hospitals other than under this section.

(4) A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified at 42 USC §1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other qualifying hospitals in the same manner and subject to the same limitations as set forth above.

c. Payments for furnished services 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 amount referred to in subdivision 7 b (3), the following methodology will be used. A ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment-to-charge ratio will be multiplied by the Medicaid charges for each hospital. The upper payment limit will be the sum of the product of that

multiplication for all hospitals. The calculation will use data from the most recently settled cost report for all state government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

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

12VAC30-80-200. Prospective reimbursement for rehabilitation agencies.

A. Effective for dates of service on and after July 1, 2003, rehabilitation agencies, excluding those operated by Community Services Boards, shall be reimbursed a prospective rate equal to the lesser of the agency's cost per visit for each type of rehabilitation service (physical therapy, occupational therapy, and speech therapy) or a statewide ceiling established for each type of service. The prospective ceiling for each type of service shall be equal to 112% of the weighted median cost per visit, for such services, of rehabilitation agencies. The weighted median shall be calculated using a base year to be determined by the Department. Effective July 1, 2003, the weighted median calculated and the resulting ceiling shall be applicable to all services beginning on and after July 1, 2003, and all services in provider fiscal years beginning in SFY2004.

B. In each provider fiscal year, each provider's prospective rate shall be determined based on the cost report from the previous year and the ceiling, calculated by DMAS, that is applicable to the state fiscal year in which the provider fiscal year begins.

C. For providers with fiscal years that do not begin on July 1, 2003, services 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 before and after that date. Costs apportioned before that date shall be settled based on allowable costs, and those after shall be settled based on the prospective methodology.

D. Beginning with state fiscal years beginning on and after July 1, 2004, the ceiling and the provider specific cost per visit shall be adjusted for inflation, from the previous year to the

prospective year, using the nursing facility inflation factor published for Virginia by DRI, applicable to the calendar year in progress at the start of the state fiscal year.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

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