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TO: EMILY MCCLELLAN
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FROM: MICHELLE A. L'HOMMEDIU 
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DATE: June 15, 2018

SUBJECT: Final/Exempt Regulations – CHKD Hospital Inflation, FFS Providers & Reimbursement Services on a Cost Basis (4989/8309)

I have reviewed the attached exempt final regulations regarding inflation adjustments for Fiscal Years 2017 and 2018 for Children's Hospital of the King's Daughters. 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 regulations comport with state and federal law.

The changes in these regulations reflect changes in Virginia's 2016-18 Biennium Budget. Based on my review, it is my view that the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, under 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. Based on the foregoing, it is my view that the amendments to these regulations are exempt from the procedures of Article 2 of the APA under Virginia Code § 2.2-4006(A)(4)(a).

It is my understanding that the proposed changes will amend the State Plan and that any approval necessary from CMS has been obtained. If you have any questions, please contact me at 786-6005.

cc: Kim F. Piner, Esq.

Attachment

Project 5387 - none

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CHKD Hospital Inflation, FFS Providers, & Reimbursement Services on Cost Basis

12VAC30-70-351. Updating rates for inflation.

A. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department shall be used to update the base year standardized operating costs per case, as determined in 12VAC30-70-361, and the base year standardized operating costs per day, as determined in 12VAC30-70-371, to the midpoint of the upcoming state fiscal 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.

B. The inflation adjustment for hospital operating rates, disproportionate share hospitals (DSH) payments, and graduate medical education payments shall be eliminated for fiscal year (FY) 2010. The elimination of the inflation adjustments shall not be applicable to rebasing in FY 2011.

C. In FY 2011, hospital operating rates shall be rebased; however the 2008 base year costs shall only be increased 2.58% for inflation. For FY 2011 there shall be no inflation adjustment for graduate medical education (GME) or freestanding psychiatric facility rates. The inflation adjustment shall be eliminated for hospital operating rates, GME payments, and freestanding psychiatric facility rates for FY 2012. The inflation adjustment shall be 2.6% for inpatient hospitals, including hospital operating rates, GME payments, DSH payments, and freestanding

psychiatric facility rates for FY 2013, and 0.0% for the same facilities for FY 2014, FY 2015, and FY 2016. For FY 2017, the inflation adjustment for inpatient hospital operating rates, GME, DSH, and freestanding psychiatric hospitals shall be 50% of the adjustment calculated in subsection A of this section. In FY 2018, the inflation adjustment for inpatient hospital operating rates, GME, DSH, and freestanding psychiatric hospitals shall be eliminated for inpatient hospitals. A full inflation adjustment payment shall be made in both FY 2017 and FY 2018 to Virginia freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009.

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

A. Payments for services listed in this section 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 e 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 CMS-approved 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, DMAS or its designee shall take action in accordance with its policies to assure that an overpayment is not being made. All cost reports shall be reviewed and reconciled to final costs within 180 days of the receipt of a completed cost report. The cost report will be judged complete when DMAS has all of the following:

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

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. For dates of service prior to January 1, 2014, outpatient hospital services, including rehabilitation hospital outpatient services and excluding laboratory services.

a. Definitions. The following words and terms when used in this section 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. The last cost report with a fiscal year end on or after December 31, 2013, shall be used for reimbursement for dates of service through December 31, 2013, based on this section. Reimbursement shall be based on charges reported for dates of service prior to January 1, 2014. Settlement will be based on four months of runout from the end of the provider's fiscal year. Claims for services paid after the cost report runout period will not be settled.

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 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. Supplement payments to Type One hospitals for outpatient services.

a. In addition to payments for services set forth elsewhere in the State Plan, DMAS makes supplemental payments to qualifying state government owned or operated hospitals for outpatient services furnished to Medicare members on or after July 1, 2010. To qualify for a supplement payment, the hospital must be part of the 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 shall be equal to the difference between the total allowable cost and the amount otherwise actually paid for the services by the Medicaid program based on cost settlement.

c. Payment for furnished services under this section shall be paid at settlement of the cost report.

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 enrolled currently as a Virginia Medicaid provider and shall be owned or operated by a private entity in which a Type One hospital has a nonmajority 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 two 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 DSH program shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than two 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;

(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 § 1923(g) of the Social Security Act 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): Except as otherwise noted in this section, state developed fee schedule rates are the same for both governmental and private individual practitioners. Fee schedules and any annual/periodic adjustments to the fee schedules are published on the DMAS website at the following web address: <http://www.dmas.virginia.gov>.

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).
2. Dentists' services.
3. Mental health services including: (i) community mental health services, (ii) services of a licensed clinical psychologist, (iii) mental health services provided by a physician, or (iv) peer support services.
 - 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 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.

(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 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. 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. Effective January 1, 2013, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 197% of Medicare rates. Effective April 8, 2014, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 201% of Medicare rates.

c. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

d. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter.

e. Payment will not be made to the extent that the payment 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 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, 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 described in the Medicare equivalent of the average commercial rate methodology (see 12VAC30-80-300), subject to the following reduction. Final payments shall be reduced on a prorated 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. 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 October 1, 2015, the supplemental payment amount shall be the difference between the Medicaid payments otherwise made for physician services and 137% of 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 the regulations, 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) 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 at <http://www.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.

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:

"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.

"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, 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.

"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.

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.

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.

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 FY 2017 and FY 2018 to Virginia freestanding children's hospitals with greater than 50 percent 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