STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

Fee-for-service providers. (12VAC 30-80-30)

17.5. 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 described in the Medicare Equivalent of the Average Commercial Rate methodology (See Supplement 6 to Attachment 4.19-B), 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.

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(3) Pediatric preventive services (defined as Evaluation and Management (E&M) procedures, excluding those listed in 2(e)(1) of this subsection, as defined by the AMA's annual publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21;

(4) Pediatric primary services (defined as evaluation and management (E&M) procedures, excluding those listed in subdivisions 2e(1) and 2e(3) of this subsection, as defined by the AMA's publication of the CPR manual, in effect at the time the service is provided, for recipients under age 21;
(5) Adult primary and preventive services (defined as E&M procedures, excluding those listed in 2e(1) of this subsection, as defined by the AMA's annual publication of the CPT manual, in effect at the time the service is provided, for recipients age 21 and over); and,

(6) All other procedures set through the RBRVS process combined.

3. For those services or procedures for which there are no established RVUs DMAS shall approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service (FFS) methodology. The previous FFS methodology refers to the state agency fee schedule in effect prior to the implementation of RBVRS which was implemented and effective July 1, 1995.

4. Fees shall not vary by geographic locality.

C. Effective for dates of service on or after July 1, 2010, through September 30, 2010, fees for all procedures set through the RBRVS process shall be decreased by 3.0% relative to the fees that would otherwise be in effect.

D. Effective for dates of service on or after October 1, 2010, the 3.0% fee decrease in subsection C will no longer be in effect.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of practitioner services. All rates are published in the DMAS website, and may be found at:http://www.dmas.virginia.gov/pr-fee_files.htm. The fee schedule for rates based on the methodology described in this supplement tied to Medicare's annual update of RBRVS is updated each July 1, based on the methodology described in this supplement. Other rates based on the state agency fee schedule are effective as of July 1, 2011.

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12 VAC 30-80-300.

MEDICARE EQUIVALENT OF AVERAGE COMMERCIAL RATE.

Physician supplemental payment amounts shall be calculated using the Medicare equivalent of the average commercial rate (ACR) methodology prescribed by CMS. The following methodology describes the calculation of the supplemental payment. To compute the ACR by commercial payers, calculate the average amount reimbursed for each procedure code (e.g., CPT or HCPCS) by the top five commercial payers for a specified base period. Data from Medicare, Workers' Compensation and other non commercial payers and codes not reimbursed by Medicaid are excluded.

(Payer 1 + Payer 2 + Payer 3+ Payer 4+ Payer 5) / (5) = Average Commercial Reimbursement

To compute the reimbursement ceiling, multiply the average reimbursement rate as determined by the number of claims recorded in MMIS for each procedure code that was rendered to Medicaid members by eligible physicians during the base period. Add the product for all procedure codes. This total represents the total reimbursement ceiling.

(Average Commercial Reimbursement) X (Medicaid Count) = Total Reimbursement Ceiling

To determine the Medicare equivalent to the reimbursement ceiling, for each of the billing codes used to determine the reimbursement ceiling, multiply the Medicare rate by the number of claims recorded in MMIS for each procedure code that was rendered to Medicaid members during the base period. Add the product for all procedure codes. This sum represents the total Medicare reimbursement that would have been received. Divide the reimbursement ceiling (commercial payment) by Medicare reimbursement. This ratio expresses the ACR as a percentage of Medicare.

(Medicare Rate) X (Medicaid Count) = Total Medicare Reimbursement
(Total Reimbursement Ceiling) / (Total Medicare Reimbursement) = Medicare equivalent of the ACR

This single ratio is applied to the Medicare rates for reimbursable Medicaid practitioner services to determine the total allowable Medicaid payment, including both the regular base payment and supplemental payment.

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(Medicare equivalent of the average commercial rate) X (Medicare rate per CPT Code for all applicable CPT Codes) = Total Allowable Medicaid Payment

Total Allowable Medicaid Payment – Medicaid Base Payment = Maximum Supplemental Payment

The Medicare equivalent of the ACR demonstration shall be updated every three years.