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State Name: Virginia

State Plan Amendment (SPA) #: 13-02

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #041820134018

JAN 2 6 2015

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

We have reviewed State Plan Amendment (SPA) 13-02, Supplemental Payments for Services Provided by Type One Physicians-Average Commercial Rate (ACR) Update. This SPA revises the maximum reimbursement to 197% of the Medicare Type One physicians, based on updated information on the average commercial rate furnished by the providers which are affected by this change (State academic health systems).

This SPA is acceptable. Therefore, we are approving SPA 13-02 with an effective date of January 1, 2013. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 13-02

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2013 $ 1,100,000
b. FFY 2014 $ 1,400,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-B, Page 6.3 of 15; Attach 4.19-B, Supp 6, pp 14 & 28

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages.

KB 1/20/15

10. SUBJECT OF AMENDMENT: Supplemental Payments for Services Provided by Type One Physicians -- ACR Update

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

2013

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: MARCH 27 2013

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MARCH 27, 2013

18. DATE APPROVED: JAN 22 2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JANUARY 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: FRANCIS McCullough

22. REMARKS: Associate Regional Administrator/DMCHO

Form CMS-179 (07/92)

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

17. Supplemental payments for services provided by Type One physicians.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Type One physicians for furnished services provided on or after July 2, 2002. A Type One 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. The methodology for determining the Medicare Equivalent of Average Commercial Rate is described in Supplement 6 to Attachment 4.19-B.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

ESTABLISHMENT OF RATE PER VISIT

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.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

ESTABLISHMENT OF RATE PER VISIT

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

The Medicare equivalent of the ACR demonstration shall be updated yearly. Only the professional component of radiology services and clinical laboratory services is included in the ACR calculation. Claims with a technical component were excluded from the demonstration.

Payments related to vaccine administration are excluded.

Reimbursement for anesthesia uses the same units of service (15-minute increments) for anesthesia claims as commercial payers and Medicare. Anesthesia claims are paid using a conversion factor which is multiplied by the sum of base units (for each procedure code) and the time units reported on the claim. The average commercial rates for the anesthesia codes were determined using the formula:

(Medicare anesthesia base $units_{CPTcode}$ + Medicaid average units per $claim_{CPTcode}$) * Average commercial per unit $rate_{CPTcode}$

For payers that reimburse providers using a flat rate for each procedure for certain anesthesia CPT codes, the commercial rate is determined using the following formula:

(Medicare anesthesia base $units_{CPTcode}$ + Medicaid average units per $claim_{CPTcode}$) * Commercial per unit $rate_{CPTcode}$

The commercial rates were then averaged for all payers to determine the average commercial rate for these specific codes.

The Medicare anesthesia rates were determined using the formula:
(Medicare anesthesia base $units_{CPTcode}$ + Medicaid average units per $claim_{CPTcode}$) * Medicare anesthesia conversion factor

No claims for CRNAs or other non-physicians administering anesthesia are included in the demonstration. Only physician claims are used in the demonstration. Both Virginia Medicaid and Medicare use 15-minute increments of time as units for anesthesia claims. The Virginia Medicaid method for payment of anesthesia services directly crosswalks to the Medicare payment methodology. Virginia Medicaid multiplies a conversion factor by the sum of the base units and time units reported on the claim to determine the anesthesia reimbursement for a procedure.