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

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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 + Payer5) / (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

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

The Medicare equivalent of the ACR demonstration shall be updated every three years. 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 the 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$_{\text{CPT code}}$ + Medicaid average units per claim$_{\text{CPT code}}$) * Average commercial per unit rate$_{\text{CPT code}}$

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 $_{\text{CPT code}}$ + Medicaid average units per claim$_{\text{CPT code}}$) * 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.