COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, MD
Secretary of Health and Human Resources

June 4, 2021

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Dear Mr. McMillion:

Attached for your review and approval is amendment 21-016, entitled "2021 Non-Institutional Provider Reimbursement Changes" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

Sincerely,

Daniel Carey, MD, MHCM

Attachment

cc: Karen Kimsey, Director, Department of Medical Assistance Services
CMS, Region III

Transmittal Summary

SPA 21-016

I. IDENTIFICATION INFORMATION

Title of Amendment: 2021 Non-Institutional Provider Reimbursement Changes

II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

Purpose: The 2021 Appropriations Act, Items 313.EEEE, UUUU, and VVVV require DMAS to make changes to the state plan. These changes will: 1) increase the rates for psychiatric services by 14.7 percent for psychiatric services to the equivalent of 110 percent of Medicare rates; 2) increase rates for anesthesiologists to reflect the equivalent of 70 percent of the 2019 Medicare rates; and 3) increase supplemental physician payments for a freestanding children's hospital serving children in Planning District 8. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by CMS and all other Virginia Medicaid fee-for-service payments.

Substance and Analysis: The section of the State Plan that is affected by this amendment is "Methods and Standards for Establishing Payment Rate – Other Types of Care"

Impact: a. The expected increase in annual aggregate expenditures as a result of the increase in rates for psychiatric services is $593,674 in state general funds, $ $46,102 in special funds, and $1,046,444 in federal funds in federal fiscal year 2021.

b. The expected increase in annual aggregate expenditures as a result of the increase in rates for anesthesiologists is $65,623 in state general funds, $189,985 in federal funds, and $13,379 in special funds in federal fiscal year 2021.

c. The expected increase in annual aggregate expenditures as a result of the supplemental physician payments for a freestanding children's hospital is $88,692 in state general funds and $88,692 in federal funds in federal fiscal year 2021.

Tribal Notice: Please see Attachments A-1 and A-2.

Prior Public Notice: Please see Attachment B-1.

Public Comments and Agency Analysis: Please see Attachment B-2.

ATTACHMENT A-1

Commonwealth of Virginia

Mcclellan, Emily <emily.mcclellan@dmas.virginia.gov>

Tribal Notice re: Increases in reimbursement rates for non-institutional Medicaid services

Mcclellan, Emily <emily.mcclellan@dmas.virginia.gov> Fri, May 21, 2021 at 2:45 PM
To: TribalOffice@monacannation.com, "chiefannerich@aol.com" <chiefannerich@aol.com>, Gerald Stewart <wasandson@cox.net>, Pam Thompson <Pamelathompson4@yahoo.com>, rappahannocktrib@aol.com, regstew007@gmail.com, robert.gray@pamunkey.org, Rufus Elliott <tribaladmin@monacannation.com>, Samuel Bass <samflyingeagle48@yahoo.com>, Stephen Adkins <chiefstephenadkins@gmail.com>, Frank <WFrankAdams@verizon.net>, "bradbybrown@gmail.com" <bradbybrown@gmail.com>, heather.hendrix@ihs.gov, "Garrett, Tabitha (IHS/NAS/RIC)" <tabitha.garrett@ihs.gov>, Kara.Kearns@ihs.gov

Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid Director Karen Kimsey indicating that the Dept. of Medical Assistance Services (DMAS) plans to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services. This SPA will increase the reimbursement rates for certain non-institutional Medicaid services.

If you would like a copy of the SPA documents or proposed text changes, or if you have any questions, please let us know.

Thank you! -- Emily McClellan

--
Emily McClellan
Regulatory Supervisor
Policy Planning and Innovation Division
Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
(804) 371-4300
www.dmas.virginia.gov

VIRGINIA'S MEDICAID PROGRAM DMAS *Improving the health and well-being of Virginians through access to high quality health care coverage*

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Tribal Notice letter (signed).pdf

307K

ATTACHMENT A-2

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

May 21, 2021

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to Increased Rates for Psychiatric Services, Anesthesia Services, and Increased Physician Supplemental Payments

Dear Tribal Leader and Indian Health Programs:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to amend the Virginia State Plan for Medical Assistance with the Centers for Medicare and Medicaid Services (CMS). Specifically, DMAS is providing you notice about a State Plan Amendment (SPA) that the Agency will file with CMS in order to increase rates for psychiatric services and increase supplemental payments for Children's National Medical Center.

The changes will: 1) increase rates for psychiatric services by 14.7 percent to the equivalent of 110 percent of Medicare rates, effective July 1, 2021; 2) increase rates for anesthesiologists to reflect the equivalent of 70 percent of the 2019 Medicare rates; and 3) increase the supplemental physician payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 (Children's National Medical Center) to the maximum allowed by the Centers for Medicare and Medicaid Services (CMS) within the limit of the appropriation.

The tribal comment period for this SPA is open through June 20, 2021. You may submit your comments directly to Emily McClellan, DMAS Policy Division, by phone (804) 371-4300, or via email: Emily.McClellan@dmas.virginia.gov Finally, if you prefer regular mail you may send your comments or questions to:

Virginia Department of Medical Assistance Services
Attn: Emily McClellan
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,

Karen Kimsey

Karen Kimsey

ATTACHMENT B-1

Virginia.gov Agencies | Governor

Agency **Department of Medical Assistance Services**

Board **Board of Medical Assistance Services**

General Notice

Edit Notice

Public Notice - Intent to Amend State Plan - Non-Institutional Provider Reimbursement Changes

Date Posted: 5/21/2021

Expiration Date: 10/20/2021

Submitted to Registrar for publication: YES

30 Day Comment Forum is underway. Began on 5/21/2021 and will end on 6/20/2021

LEGAL NOTICE

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF INTENT TO AMEND

(Pursuant to §1902(a)(13) of the *Act (U.S.C. 1396a(a)(13)*)

THE VIRGINIA STATE PLAN FOR MEDICAL ASSISTANCE

This Notice was posted on May 21, 2021

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to provide for changes to the *Methods and Standards for Establishing Payment Rates — Other Types of Care (12 VAC 30-80)*.

This notice is intended to satisfy the requirements of 42 C.F.R. § 447.205 and of § 1902(a)(13) of the *Social Security Act*, 42 U.S.C. § 1396a(a)(13). A copy of this notice is available for public review from Emily McClellan, DMAS, 600 Broad Street, Suite 1300, Richmond, VA 23219, or via e-mail at: emily.mcclellan@dmas.virginia.gov

DMAS is specifically soliciting input from stakeholders, providers and beneficiaries, on the potential impact of the proposed changes discussed in this notice. Comments or inquiries may be submitted, in writing, within 30 days of this notice publication to Emily McClellan and such comments are available for review at the same address. Comments may also be submitted, in writing, on the Town Hall public comment forum attached to this notice.

This notice is available for public review on the Regulatory Town Hall (www.townhall.com), on the General Notices page, found at: https://townhall.virginia.gov/L/generalnotice.cfm

In accordance with the 2021 Appropriations Act, Items 313.EEEE, UUUU, and VVVV, DMAS will be making the following changes:

Methods & Standards for Establishing Payment Rates-Other Types of Care (12 VAC 30-80)

1. The state plan is being revised to increase rates for psychiatric services by 14.7 percent to the equivalent of 110 percent of Medicare rates, effective July 1, 2021.

The expected increase in annual aggregate expenditures is $593,674 in state general funds, $ $46,102 in special funds, and $1,046,444 in federal funds in federal fiscal year 2021.

2. The state plan is being revised to increase rates for anesthesiologists to reflect the equivalent of 70 percent of the 2019 Medicare rates.

The expected increase in annual aggregate expenditures is $65,623 in state general funds, $189,985 in federal funds, and $13,379 in special funds in federal fiscal year 2021.

3. The state plan is being revised to increase the supplemental physician payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 to the maximum allowed by the Centers for Medicare and Medicaid Services within the limit of the appropriation provided for this purpose. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by the Centers for Medicare and Medicaid Services and all other Virginia Medicaid fee-for-service payments.

The expected increase in annual aggregate expenditures is $88,692 in state general funds and $88,692 in federal funds in federal fiscal year 2021.

Contact Information

Name / Title:	Emily McClellan / *Regulatory Manager*
Address:	Division of Policy and Research 600 E. Broad St., Suite 1300 Richmond, 23219
Email Address:	**Emily.McClellan@dmas.virginia.gov**
Telephone:	(804)371-4300 FAX: (804)786-1680 TDD: (800)343-0634

This general notice was created by Emily McClellan on 05/21/2021 at 12:53pm

ATTACHMENT B-2

Virginia.gov Agencies | Governor

Public comment forums

Make your voice heard! Public comment forums allow all Virginia's citizens to participate in making and changing our state regulations.

See our public comment policy

Currently showing **8** comment forums closed within the last 21 days for the Department of Medical Assistance Services.

Recently closed
Recently opened
Active Forums
More filter options

Regulatory Activity Forums (7) | Guidance Document Forums (1)

Actions (1) | Periodic Reviews () | Petitions for Rulemaking () | General Notices (6)

Board of Medical Assistance Services

View Comments	Update to Direct Support Professional Assurance Form (DMAS Form P242a)	General Notice	Update to Direct Support Professional Assurance Form (DMAS Form P242a) Closed: 6/18/21 6 comments Last comment: 6/17/21 5:13 pm
View Comments	Update to Supervisor Assurance Form (DMAS Form P245a)	General Notice	Update to Supervisor Assurance Form (DMAS Form P245a) Closed: 6/18/21 4 comments Last comment: 6/16/21 3:10 pm
View Comments	UIpdated DSP and Supervisor Competencies Checklist (DMAS Form P241a)	General Notice	UIpdated DSP and Supervisor Competencies Checklist (DMAS Form P241a) Closed: 6/18/21 14 comments Last comment: 6/17/21 5:17 pm
View Comments	Draft ARTS Provider Manual Opioid Treatment Services Supplement	General Notice	Draft ARTS Provider Manual Opioid Treatment Services Supplement Closed: 6/19/21 5 comments Last comment: 6/9/21 8:43 am
View Comments	Draft Local Education Agency Provider Manual	General Notice	Draft Local Education Agency Provider Manual Closed: 6/19/21 0 comments
View Comments	Public Notice - Intent to Amend State Plan - Non-Institutional Provider Reimbursement Changes	General Notice	Public Notice - Intent to Amend State Plan - Non-Institutional Provider Reimbursement Changes Closed: 6/20/21 0 comments
View Comments	Chapter: [12 VAC 30 - 70] Methods and Standards for Establishing Payment Rates; in-Patient Hospital Care	Action:	Fee For Service Supplemental Payments and Hospital Assessment Stage: Proposed Closed: 6/11/21 0 comments

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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OTHER TYPES OF CARE

d. To determine the aggregate upper payment limit referred to in subdivision 18 b(3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190) in regard to the state agency fee schedule for RBRVS. 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.

18.1. 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 the State Plan, DMAS shall make supplemental payments for physicians employed at a freestanding children's hospital serving children in planning district 8 with more than 50 percent 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.~~maximum allowed by the Centers for Medicare and Medicaid Services within the limit of the appropriation provided for this purpose. The methodology for determining allowable percent of Medicare rates is based on the Medicare equivalentof the average commercial rate described in Supplement 6.

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.

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

The State Agency Fee Schedule (12 VAC 30-80-190)

A. Reimbursement of fee-for-service providers. Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for- service providers, with the exception of Home Health services (see Supplement 3), and durable medical equipment services (see 12VAC30-80-30), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS). The RBRVS fees shall be the same for both public and private providers. One goal of this methodology is to prevent the total cost of reimbursement for physicians to increase or decrease solely as a result of changes in the Medicare conversion factor.

B. Fee schedule.

1. For those services or procedures which are included in the RBRVS publishedby the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.

a. Effective for dates of service on or after July 1, 2008, DMAS shall implement site of service differentials and employ both non-facility and facility RVUs. The implementation shall be budget-neutral using the methodology in subsection 2 below.

~~b. The implementation of site-of-service shall be transitioned over a four-year period.~~

~~(1) Effective for dates of service on or after July 1, 2008, DMAS shall calculate the transitioned facility RVU by adding 75 percent of the difference between the non-facility RVU and non-facility RVU to the facility RVU.~~

~~(2) Effective for dates of service on or after July 1, 2009, DMAS shall calculate the transitioned facility RVU by adding 50 percent of the difference between the non-facility RVU and non-facility RVU to the facility RVU.~~

~~(3) Effective for dates of service on or after July 1, 2010, DMAS shall calculate the transitioned facility RVU by adding 25 percent of the difference between the non-facility RVU and non-facility RVU to the facility RVU.~~

~~(4)~~ b. Effective for dates of service on or after July 1, 2011, DMAS shall use the unadjusted Medicare facility RVU.

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2. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by CMS. CMS publishes separate CFs for Anesthesia services versus all other procedures and services. DMAS shall adjust CMS's CFs by additional factors so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. DMAS may revise the additional factors when CMS updates its RVUs or CFs so that no change inexpenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by CMS. The calculation of the additional factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule.

3. For non-anesthesia services, ~~The~~ the determination of the additional adjustment factors for each applicable procedure and service sub-category required above shall be ~~accomplished by means of the following~~ calculation calculated with patient claims data from the most recent period of time (at least six months) as the ratio of the estimated total expenditures for the sub-category using DMAS fees divided by the estimated total expenditures for the sub-category using Medicare fees:

a. The estimated amount of DMAS expenditures ~~if DMAS were to use~~ using Medicare~~'s~~ fees is calculated using Medicare RVUs and CFs without modification~~, is equal to the sum, across all relevant procedure codes, of~~For each procedure code and modifier combination that has RVU values published by CMS, the RVU value ~~value published by the CMS,~~ is multiplied by the applicable Medicare CF ~~conversion factor~~ published by the CMS to get the estimated price that Medicare would pay for the service or procedure. The estimated Medicare fee for each procedure code and modifier combination is then multiplied by the number of occurrences of the ~~procedure code~~combination in the DMAS patient claims. All expenditures by procedure code/modifier combination are summed to get the total estimated amount DMAS expenditures would be using Medicare fees ~~in the most recent period of time (at least six months).~~

b. The estimated amount of DMAS expenditures, if DMAS ~~were not to calculate new fees based on the new CMS RVUs and CFs is equal to the sum~~ used its existing fees, across all relevant procedure codes and modifier combinations with RVU values~~, of the~~ is calculated as the sum of the existing DMAS fee multiplied by the number of occurrences of the procedure ~~codes~~code/modifier combination in DMAS patient claims ~~in the period of time used in subdivision 2a of this subsection~~.

c. The relevant ~~additional~~adjustment factor for the sub-category is equal to the ratio of the expenditure estimate (based on DMAS fees in subdivision ~~2b~~3b of this subsection) to the expenditure estimate based on unmodified CMS values in subdivision ~~2a~~3a of this subsection.

~~d. During the transition to "site of service" described in subsection B.1.b. above,the additional factors will be adjusted by the same percentage so as to spend any estimated~~

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~~savings from the implementation of "site of service".~~

~~e.~~ d. DMAS shall calculate ~~a~~ separate additional adjustment factors for:

(1) Emergency Room Services (defined as the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) codes 99281, 99282, 99283, 99284, and 99285);

(2) Obstetrical/Gynecological Services (defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual);

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(3) Pediatric preventive services (defined as Evaluation and Management (E&M) procedures, excluding those listed in ~~2~~3(e)(1) of this subsection, as defined by the AMA'sannual 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 3~~2~~e(1) and 3~~2~~e(3) of this subsection, as defined by the AMA's publication of the CPT 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 listedin ~~32~~e(1) of this subsection, as defined by the AMA's annual publication of the CPTmanual, in effect at the time the service is provided, for recipients age 21 and over);

(6) Effective July 1, 2019, psychiatric services as defined by the American Medical Association's annual publication of the CPT manual, in effect at the time the service is provided; and

(7) 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 RBRVS which was implemented and effective July 1, 1995.~~percent of billed charges. The billed charges shall be multiplied by the Budget Neutral factor calculated in Attachment 4.19-B, Supplement 4, page 2, paragraph 2. Billed charges shall not exceed the provider's usual and customary charges.

4. Fees shall not vary by geographic locality.

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

~~E. Effective for dates of service on and after July 1, 2019, rates for adult primary care services shall be increased by 5% and rates for Emergency Department services shall be increased by 1%.~~

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~~F.~~ C. ~~Effective for dates of service on and after July 1, 2019, rates for psychiatric services shall be increased by 21 percent.~~ Effective July 1, 2021, rates for psychiatric services shall be increased by 14.7 percent to the equivalent of 110 percent of Medicare rates.

D. Effective July 1, 2021, the practitioner rates for anesthesiologists shall be increased to reflect the equivalent of 70 percent of the 2019 Medicare rates.

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/ . 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.

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: 21-0016

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: 7/1/2021

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 447

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ 1,325,121
b. FFY 2022 $ 5,328,743

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, page 7.1
Attachment 4.19B, Supp 4, pages 1, 2, 3, 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same as box #8.

10. SUBJECT OF AMENDMENT
2021 Non-Institutional Provider Reimbursement Changes

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
Karen Kimsey

13. TYPED NAME: Karen Kimsey

14. TITLE: Director

15. DATE SUBMITTED: 5/21/2021

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

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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d. To determine the aggregate upper payment limit referred to in subdivision 18 b(3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190) in regard to the state agency fee schedule for RBRVS. 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.

18.1. 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 the State Plan, DMAS shall make supplemental payments for physicians employed at a freestanding children's hospital serving children in planning district 8 with more than 50 percent 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 maximum allowed by the Centers for Medicare and Medicaid Services within the limit of the appropriation provided for this purpose. The methodology for determining allowable percent of Medicare rates is based on the Medicare equivalentof the average commercial rate described in Supplement 6.

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.

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The State Agency Fee Schedule (12 VAC 30-80-190)

A. Reimbursement of fee-for-service providers. Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for- service providers, with the exception of Home Health services (see Supplement 3), and durable medical equipment services (see 12VAC30-80-30), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS). The RBRVS fees shall be the same for both public and private providers. One goal of this methodology is to prevent the total cost of reimbursement for physicians to increase or decrease solely as a result of changes in the Medicare conversion factor.

B. Fee schedule.

1. For those services or procedures which are included in the RBRVS publishedby the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.
   a. Effective for dates of service on or after July 1, 2008, DMAS shall implement site of service differentials and employ both non-facility and facility RVUs. The implementation shall be budget-neutral using the methodology in subsection 2 below.
   b. Effective for dates of service on or after July 1, 2011, DMAS shall use the unadjusted Medicare facility RVU.

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2. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by CMS. CMS publishes separate CFs for Anesthesia services versus all other procedures and services. DMAS shall adjust CMS's CFs by additional factors so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. DMAS may revise the additional factors when CMS updates its RVUs or CFs so that no change inexpenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by CMS. The calculation of the additional factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule.

3. For non-anesthesia services, the determination of the additional adjustment factors for each applicable procedure and service sub-category required above shall be calculated with patient claims data from the most recent period of time (at least six months) as the ratio of the estimated total expenditures for the sub-category using DMAS fees divided by the estimated total expenditures for the sub-category using Medicare fees:

a. The estimated amount of DMAS expenditures using Medicare~~'s~~ fees is calculated using Medicare RVUs and CFs without modification. For each procedure code and modifier combination that has RVU values published by CMS, the RVU value is multiplied by the applicable Medicare CF published by the CMS to get the estimated price that Medicare would pay for the service or procedure. The estimated Medicare fee for each procedure code and modifier combination is then multiplied by the number of occurrences of the combination in the DMAS patient claims. All expenditures by procedure code/modifier combination are summed to get the total estimated amount DMAS expenditures would be using Medicare fees.

b. The estimated amount of DMAS expenditures, if DMAS used its existing fees, across all relevant procedure codes and modifier combinations with RVU values is calculated as the sum of the existing DMAS fee multiplied by the number of occurrences of the procedure code/modifier combination in DMAS patient claims.

c. The relevant adjustment factor for the sub-category is equal to the ratio of the expenditure estimate (based on DMAS fees in subdivision 3b of this subsection) to the expenditure estimate based on unmodified CMS values in subdivision 3a of this subsection.

d. DMAS shall calculate separate additional adjustment factors for:

(1) Emergency Room Services (defined as the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) codes 99281, 99282, 99283, 99284, and 99285);

(2) Obstetrical/Gynecological Services (defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual);

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(3) Pediatric preventive services (defined as Evaluation and Management (E&M) procedures, excluding those listed in ~~2~~3(e)(1) of this subsection, as defined by the AMA'sannual 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 3~~2~~e(1) and 3~~2~~e(3) of this subsection, as defined by the AMA's publication of the CPT 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 listedin ~~32~~e(1) of this subsection, as defined by the AMA's annual publication of the CPTmanual, in effect at the time the service is provided, for recipients age 21 and over);

(6) Effective July 1, 2019, psychiatric services as defined by the American Medical Association's annual publication of the CPT manual, in effect at the time the service is provided; and

(7) 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 percent of billed charges. The billed charges shall be multiplied by the Budget Neutral factor calculated in Attachment 4.19-B, Supplement 4, page 2, paragraph 2. Billed charges shall not exceed the provider's usual and customary charges.

4. Fees shall not vary by geographic locality.

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C. Effective July 1, 2021, rates for psychiatric services shall be increased by 14.7 percent to the equivalent of 110 percent of Medicare rates.

D. Effective July 1, 2021, the practitioner rates for anesthesiologists shall be increased to reflect the equivalent of 70 percent of the 2019 Medicare rates.

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/ . 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.