COMMONWEALTH of VIRGINIA

Office of the Governor

John E. Littel
Secretary of Health and Human Resources

September 6, 2022

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 22-018, entitled "2022 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,

John E. Littel

Attachment

cc: Cheryl J. Roberts, Acting Director, Department of Medical Assistance Services
CMS, Region III

Transmittal Summary

SPA 22-018

I. IDENTIFICATION INFORMATION

Title of Amendment: 2022 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 2022 Appropriations Act requires DMAS to make the following changes:

a. Item 304.DD(7)(b): The state plan is being revised to implement supplemental physician payments for practice plans employed by or under contract with Chesapeake Regional Hospital to the maximum allowed by the Centers for Medicare and Medicaid Services. The department shall increase payments to Medicaid managed care organizations for the purpose of providing higher rates to physicians employed by or under contract with Chesapeake Regional Hospital based on the maximum allowed by CMS. The department shall revise its contracts with managed care organizations to incorporate these managed care directed payments, subject to approval by CMS.

b. Item 304.DDDD: The state plan is being revised to increase the rates for personal care services by 7.5 percent to reflect additional increases in the state minimum wage while maintaining the existing differential between consumer-directed and agency-directed rest-of-state rates as well as the northern Virginia and rest-of-state rates. (A corresponding rate increase of 7.5% will be provided for personal care services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.)

c. Item 304.IIII(1): The state plan is being revised to increase reimbursement rates for dental services by 30 percent.

d. Item 304.JJJJ: The state plan is being revised to increase reimbursement rates for physician primary care services, excluding those provided in emergency departments, to 80 percent of the federal FY 2021 Medicare equivalent as calculated by the department and consistent with the appropriation available for this purpose.

e. Item 304.KKKK: The state plan is being revised to update the rates for Private Duty and Skilled Nursing under the Early Periodic Screening, and Diagnosis Treatment (EPSDT) benefit. (A corresponding rate increase will be provided for these services and for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation,

Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, DD Case Management and Benefits Planning provided under home and community-based waivers, using the most recent rebasing estimates, based on DMAS' review of the model assumptions as appropriate and consistent with efficiency, economy, quality and sufficiency of care and reported no later than July 1, 2022. Rates shall be increased according to Tiered payments contained in the rebasing model, where appropriate for the type of service provided. These increases are not included in the state plan amendment but via waiver documentation.)

f. Item 304.LLLL: The state plan is being revised to increase reimbursement rates for obstetrics and gynecology covered services by 15 percent.

g. Item 304.MMMM: The state plan is being revised to increase reimbursement rates for children's covered vision services by 30 percent.

h. Item 304.QQQQ: The state plan is being revised to increase Medicaid rates for peer recovery and family support services in private and public community-based recovery services settings from $6.50 to $13.00 per 15 minutes for individuals and from $2.70 to $5.40 per 15 minutes for groups.

i. Item 304.RRRR: The state plan is being revised to increase rates by 12.5%, relative to the rates in effect prior to July 1, 2021, for consumer-directed facilitation services, mental health and early intervention case management services, and community behavioral health and habilitation services.

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. Item 304.DD(7)(b): The expected increase in annual aggregate expenditures is $0 in state general funds and $2,781,421 in federal funds in federal fiscal year 2022.

b. Item 304.DDDD: The expected increase in annual aggregate expenditures is $4,755 in state general funds and $6,102 in federal funds in federal fiscal year 2022.

c. Item 304.IIII(1): The expected increase in annual aggregate expenditures is $6,285,669 in state general funds, $506,734 in special funds, and $11,352,111 in federal funds in federal fiscal year 2022.

d. Item 304.JJJJ: The expected increase in annual aggregate expenditures is $29,252 in state general funds, $6,162 in special funds, and $86,459 in federal funds in federal fiscal year 2022.

e. Item 304.KKKK: The expected increase in annual aggregate expenditures is $671,439 in state general funds, $1,548 in special funds, and $875,462 in federal funds in federal fiscal year 2022.

f. Item 304.LLLL: The expected increase in annual aggregate expenditures is $8,661 in state general funds, $1,227 in special funds, and $19,907 in federal funds in federal fiscal year 2022.

g. Item 304.MMMM: The expected increase in annual aggregate expenditures is $2,732 in state general funds, $133 in special funds, and $4,952 in federal funds in federal fiscal year 2022.

h. Item 304.QQQQ: The expected increase in annual aggregate expenditures is $2,363 in state general funds, $269 in special funds, and $4,849 in federal funds in federal fiscal year 2022.

i. Item 304.RRRR: The expected increase in annual aggregate expenditures is $347,659 in state general funds, $15,569 in special funds, and $500,533 in federal funds in federal fiscal year 2022.

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

Prior Public Notice: Please see Attachment B-1.

Public Comments and Agency Analysis: N/A.

ATTACHMENT A-1

Commonwealth of Virginia

Lee, Meredith <meredith.lee@dmas.virginia.gov>

Tribal Notice – Non-Institutional Provider Reimbursement Changes

1 message

Lee, Meredith <meredith.lee@dmas.virginia.gov> Fri, Aug 19, 2022 at 3:34 PM
To: bradbybrown@gmail.com, chiefannerich@aol.com, chiefstephenadkins@gmail.com, jerry.stewart@cit-ed.org, Kara.Kearns@ihs.gov, Pamelathompson4@yahoo.com, rappahannocktrib@aol.com, regstew007@gmail.com, tabitha.garrett@ihs.gov, tribaladmin@monacannation.com, TribalOffice@monacannation.com, WFrankAdams@verizon.net, Mia Eubank <Mia.Eubank@ihs.gov>, Robert Gray <robert.gray@pamunkey.org>, Sam Bass <samflyingeagle48@yahoo.com>

Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid Acting Director Cheryl Roberts 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 allow DMAS to make non-institutional provider reimbursement changes as a result of items in the 2022 Appropriations Act.

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! -- Meredith Lee

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Meredith Lee
Policy, Regulations, and Manuals Supervisor
Division of Policy, Regulation, and Member Engagement
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
meredith.lee@dmas.virginia.gov
(804) 371-0552

Tribal Notice Letter, signed_8_19_22.pdf
257K

ATTACHMENT A-2

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL J. ROBERTS
ACTING DIRECTOR

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

August 19, 2022

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to 2022 Non-Institutional Provider Reimbursement Changes.

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 make changes to non-institutional provider reimbursement as a result of items in the 2022 Appropriations Act. These items include:

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

1. Item 304.DD(7)(b): The state plan is being revised to implement supplemental physician payments for practice plans employed by or under contract with Chesapeake Regional Hospital to the maximum allowed by the Centers for Medicare and Medicaid Services. The department shall increase payments to Medicaid managed care organizations for the purpose of providing higher rates to physicians employed by or under contract with Chesapeake Regional Hospital based on the maximum allowed by CMS. The department shall revise its contracts with managed care organizations to incorporate these managed care directed payments, subject to approval by CMS.

2. Item 304.DDDD: The state plan is being revised to increase the rates for personal care services by 7.5 percent to reflect additional increases in the state minimum wage while maintaining the existing differential between consumer-directed and agency-directed rest-of-state rates as well as the northern Virginia and rest-of-state rates. (A corresponding rate increase of 7.5% will be provided for personal care services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.)

3. Item 304.IIII(1): The state plan is being revised to increase reimbursement rates for dental services by 30 percent.

4. Item 304.JJJJ: The state plan is being revised to increase reimbursement rates for physician primary care services, excluding those provided in emergency departments, to 80 percent of the federal FY 2021 Medicare equivalent as calculated by the department and consistent with the appropriation available for this purpose.

5. Item 304.KKKK: The state plan is being revised to update the rates for Private Duty and Skilled Nursing under the Early Periodic Screening, and Diagnosis Treatment (EPSDT) benefit. (A corresponding rate increase will be provided for these services and for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, DD Case Management and Benefits Planning provided under home and community-based waivers, using the most recent rebasing estimates, based on DMAS' review of the model assumptions as appropriate and consistent with efficiency, economy, quality and sufficiency of care and reported no later than July 1, 2022. Rates shall be increased according to Tiered payments contained in the rebasing model, where appropriate for the type of service provided. These increases are not included in the state plan amendment but via waiver documentation.)

6. Item 304.LLLL: The state plan is being revised to increase reimbursement rates for obstetrics and gynecology covered services by 15 percent.

7. Item 304.MMMM: The state plan is being revised to increase reimbursement rates for children's covered vision services by 30 percent.

8. Item 304.QQQQ: The state plan is being revised to increase Medicaid rates for peer recovery and family support services in private and public community-based recovery services settings from $6.50 to $13.00 per 15 minutes for individuals and from $2.70 to $5.40 per 15 minutes for groups.

9. Item 304.RRRR: The state plan is being revised to increase rates by 12.5%, relative to the rates in effect prior to July 1, 2021, for consumer-directed facilitation services, mental health and early intervention case management services, and community behavioral health and habilitation services.

The tribal comment period for this SPA is open through September 18, 2022. You may submityour comments directly to Meredith Lee, DMAS Policy, Regulation, and Member Engagement Division, by phone(804) 371-0552, or via email: Meredith.Lee@dmas.virginia.gov. Finally, if you prefer regular mail you may send your comments or questions to:

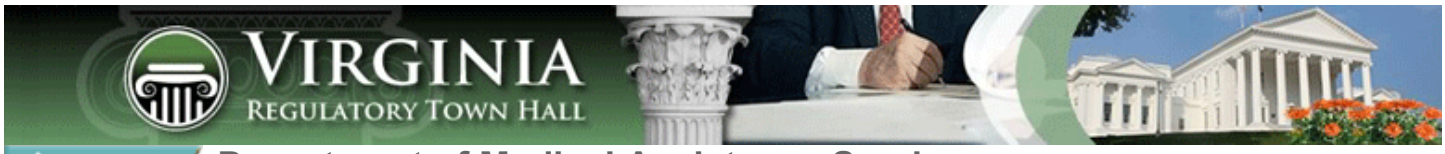
Virginia Department of Medical Assistance Services
Attn: Meredith Lee
600 East Broad StreetRichmond, VA 23219

Please forward this information to any interested party.

Sincerely,

Cheryl J. Roberts
Acting Director

ATTACHMENT B-1



Agency Department of Medical Assistance Services

Board Board of Medical Assistance Services

Edit Notice

General Notice

Public Notice - Intent to Amend State Plan - 2022 Non-Institutional Provider Reimbursement Changes

Date Posted: 6/30/2022

Expiration Date: 12/30/2022

Submitted to Registrar for publication: YES

No comment forum defined for this notice.

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 June 30, 2022

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 Meredith Lee, DMAS, 600 Broad Street, Suite 1300, Richmond, VA 23219, or via e-mail at: Meredith.Lee@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 Meredith Lee 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 (**https://townhall.virginia.gov**) on the General Notices page, found at: **https://townhall.virginia.gov/L/generalnotice.cfm**

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

1. In accordance with the 2022 Special Session, Item 304.DD(7)(b), the state plan is being revised to implement supplemental physician payments for practice plans employed by or under contract with Chesapeake Regional Hospital to the maximum allowed by the Centers for Medicare and Medicaid Services. The department shall increase payments to Medicaid managed care organizations for the purpose of providing higher rates to physicians employed by or under contract with Chesapeake Regional Hospital

based on the maximum allowed by CMS. The department shall revise its contracts with managed care organizations to incorporate these managed care directed payments, subject to approval by CMS.

The expected increase in annual aggregate expenditures is $0 in state general funds and $2,781,421 in federal funds in federal fiscal year 2022.

2. In accordance with the 2022 Special Session, Item 304.DDDD, the state plan is being revised to increase the rates for agency-directed and consumer-directed personal care services under the Early Periodic Screening, and Diagnosis and Treatment (EPSDT) benefit by 7.5 percent to reflect additional increases in the state minimum wage while maintaining the existing differential between consumer-directed and agency-directed rest-of-state rates as well as the northern Virginia and rest-of-state rates. (A corresponding rate increase of 7.5% will be provided for these services and for companion and respite services provided under home and community- based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.)

The expected increase in annual aggregate expenditures is $4,755 in state general funds and $6,102 in federal funds in federal fiscal year 2022.

3. In accordance with the 2022 Special Session, Item 304.IIII(1), the state plan is being revised to increase reimbursement rates for dental services by 30 percent.

The expected increase in annual aggregate expenditures is $6,285,669 in state general funds, $506,734 in special funds, and $11,352,111 in federal funds in federal fiscal year 2022.

4. In accordance with the 2022 Special Session, Item 304.JJJJ, the state plan is being revised to increase reimbursement rates for physician primary care services, excluding those provided in emergency departments, to 80 percent of the federal FY 2021 Medicare equivalent as calculated by the department and consistent with the appropriation available for this purpose.

The expected increase in annual aggregate expenditures is $29,252 in state general funds, $6,162 in special funds, and $86,459 in federal funds in federal fiscal year 2022.

5. In accordance with the 2022 Special Session, Item 304.KKKK, the state plan is being revised to update the rates for Private Duty and Skilled Nursing under the Early Periodic Screening, and Diagnosis Treatment (EPSDT) benefit. (A corresponding rate increase will be provided for these services and for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, DD Case Management and Benefits Planning provided under home and community- based waivers, using the most recent rebasing estimates, based on DMAS' review of the model assumptions as appropriate and consistent with efficiency, economy, quality and sufficiency of care and reported no later than July 1, 2022. Rates shall be increased according to Tiered payments contained in the rebasing model, where appropriate for the type of service provided. These increases are not included in the state plan amendment but via waiver documentation.)

The expected increase in annual aggregate expenditures is $671,439 in state general funds, $1,548 in special funds, and $875,462 in federal funds in federal fiscal year 2022.

6. In accordance with the 2022 Special Session, Item 304.LLLL, the state plan is being revised to increase reimbursement rates for obstetrics and gynecology covered services by 15 percent.

The expected increase in annual aggregate expenditures is $8,661 in state general funds, $1,227 in special funds, and $19, 907 in federal funds in federal fiscal year 2022.

7. In accordance with the 2022 Special Session, Item 304.MMMM, the state plan is being revised to increase reimbursement rates for children's covered vision services by 30 percent.

The expected increase in annual aggregate expenditures is $2,732 in state general funds, $133 in special funds, and $4,952 in federal funds in federal fiscal year 2022.

8. In accordance with the 2022 Special Session, Item 304.QQQQ, the state plan is being revised to increase Medicaid rates for peer recovery and family support services in private and public community-based recovery services settings from $6.50 to $13.00 per 15 minutes for individuals and from $2.70 to $5.40 per 15 minutes for groups.

The expected increase in annual aggregate expenditures is $2,363 in state general funds, $269 in special funds, and $4,849 in federal funds in federal fiscal year 2022.

9. In accordance with the 2022 Special Session, Item 304.RRRR, the state plan is being revised to increase rates by 12.5%, relative to the rates in effect prior to July 1, 2021, for consumer-directed facilitation services, mental health and early intervention case management services, and community behavioral health and habilitation services.

The expected increase in annual aggregate expenditures is $347,659 in state general funds, $15,569 in special funds, and $500,533 in federal funds in federal fiscal year 2022.

Contact Information

Name / Title:	Meredith Lee / *Policy, Regulations, and Manuals Supervisor*
Address:	Division of Policy and Research 600 E. Broad Street, Suite 1300 Richmond, 23219
Email Address:	**Meredith.Lee@dmas.virginia.gov**
Telephone:	(804)371-0552 FAX: (804)786-1680 TDD: (800)343-0634

This general notice was created by Meredith Lee on 06/30/2022 at 6:11am

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

6.A. 2. Dentists' services: Dental services, dental provider qualifications and dental service limits are identified in Attachment 3.lA&B, Supplement 1, page 16.1 and 16.1.1. Dental services are paid based on procedure codes which are listed in the Agency' fee schedule rate, effective ~~July 26, 2020~~ July 1, 2022. ~~The state agency fee schedule is published on the DMAS website at: http://www.dmas.virginia.gov/files/links/1080/Fee%20Schedule.pdf~~ All rates are published on the DMAS website at www.dmas.virginia.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

6.A. 3. Mental health services

a. Professional services furnished by non-physicians, as described in 3.1A&B, Supplement 1, page 7 and page 11. These services are reimbursed using CPT codes. The agency's fee schedule rate is based on the methodology described in Attachment 4-19B, page 4.8, section 6 (A) 1.

(i) Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists in Attachment 4-19B, page 4.8, section 6 (A) 1.

(ii) Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric, or licensed marriage and family therapists shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

b. Intensive In-Home, as defined per Supplement 1 to Attachment 3.1A&B, Supplement 1, page 6.0.2, and provided by the individuals who are listed in Attachment 3.1A&B, Supplement 1, page 6.0.3 and defined in Attachment 3.1A&B, Supplement 1, page 6.0.1, is reimbursed on an hourly unit of service. The Agency's rates were set as of ~~July 1, 2011~~ July 1, 2022, and are effective for services on or after that date.

c. Therapeutic Day Treatment, as defined per Supplement 1 to Attachment 3.1A&B, page 6.0.4, and provided by the individuals who are listed in Attachment 3.1A&B, Supplement 1, page 6.1 and defined in Attachment 3.1A&B, Supplement 1, page 6.0.1,is reimbursed based on the following units of service: One unit = 2 to 2.99 hours; Two units = 3 to 4.99 hours; Three units = 5 plus hours. No room and board is included in the rates for therapeutic day treatment. The Agency's rates were set as of ~~July 1, 2011~~ July 1, 2022, and are effective for services on or after that date.

d. Therapeutic Group Home services (formerly called Level A and Level B group home services), as defined per Supplement 1 to Attachment 3.1A&B, page 6.2, shall be reimbursed based on a daily unit of service. No room and board is included in the rates for therapeutic group home services. The Agency's rates were set as of ~~July 1, 2011~~ July 1, 2022, and are effective for services on or after that date.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - OTHER TYPES OF CARE

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d-1. Mental Health Intensive Outpatient services are reimbursed based on a per-diem unit that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of ~~July 1, 2021~~ July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-2. Residential Crisis Stabilization is reimbursed based on a per-diem unit. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of ~~December 1, 2021~~ July 1, 2022 and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-3. 23-Hour Residential Crisis Stabilization is a form of Residential Crisis Stabilization that is provided as a 23-hour service and is reimbursed on a per-diem unit. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of ~~December 1, 2021~~ July 1, 2022 and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for- providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-4. Multisystemic Therapy is reimbursed based on a 15-minute unit of service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of ~~December 1, 2021~~ July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-5. Functional Family Therapy is reimbursed based on a 15-minute unit of service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of ~~December 1, 2021~~ July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE - OTHER TYPES OF CARE

e. Mental Health Partial Hospitalization Program services are reimbursed based on a per diem unit that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of ~~July 1, 2021~~ July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee- files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

f. Psychosocial Rehabilitation is reimbursed based on the following units of service: One unit = 2 to 3.99 hours per day; Two units = 4 to 6.99 hours per day; Three units = 7 + hours per day. The rates account for the wages, employee costs, and other allowable costs associated with providing this service. The Agency's rates were set as of ~~July 1, 2011~~ July 1, 2022, and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

g. Mobile Crisis Response is reimbursed based on a 15-minute unit of service. The rates account for the wages, employee costs, and other allowable costs associated with providing this service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of ~~December 1, 2021~~ July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure- fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

h. Assertive Community Treatment is reimbursed on a daily unit of service that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The Agency's rates were set as of ~~July 1, 2021~~ July 1, 2022, and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

i. Community Stabilization is reimbursed on a 15 minute unit of service that accounts for the wages, employee costs, and other allowable costs associated with providing this service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of ~~December 1, 2021~~ July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

j. Independent Living and Recovery Services (previously called Mental Health Skill-Building Services) are reimbursed based on the following units of service: One unit is 1 to 2.99 hours per day, two units is 3 to 4.99 hours per day. The rates account for the wages, employee costs, and other allowable costs associated with providing this service The Agency's rates were set as of ~~July 1, 2011~~ July 1, 2022 and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/pr ocedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

Section 6 A (3), continued.

(p) Peer Support Services and Family Support Partners, as defined per Supplement 1 to Attachment 3.1A&B, pages 54 through 59, and furnished by enrolled providers or provider agencies, shall be reimbursed based on the agency fee schedule for 15-minute units of service. The agency's rates were set as of ~~July 1, 2017~~ July 1, 2022, and are effective for services on or after that date. All rates are published on the DMAS website at: www.dmas.virginia.gov. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (ex. case management for persons with chronic mental illness).

(i) Peer Support Services and Family Support Partners shall not be reimbursed if the services operate in the same building as other day services unless (i) there is a distinct separation between services in staffing, program description, and physical space and (ii) Peer Support Services or Family Support Partners do not impede, interrupt, or interfere with the provision of the primary service.

(ii) Family Support Partners services shall not be reimbursed for an individual who resides in a congregate setting in which the caregivers are paid (such as child caring institutions, or any other living environment that is not comprised of more permanent caregivers) unless (i) the individual is actively preparing for transition back to a single-family unit, (ii) the caregiver is present during the intervention, (iii) the service is directed to supporting the unification/reunification of the individual and his/her caregiver and (iv) the service takes place in that home and community.

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16.1 Reimbursement for personal care services for individuals enrolled in the Medicaid Buy-In program described in Attachment 2.6A, Supplement 8a, p 1-3 or for personal care services covered under EPSDT. All governmental and private providers are reimbursed according to the same published fee schedule~~, located on the Agency's website at the following address: https://www.dmas.virginia.gov/for-providers/general-information/procedure-fee-files-cpt-codes/~~. All rates are published on the DMAS website at www.dmas.virginia.gov. The Agency's rates, based upon one-hour increments, were set as of ~~January 1, 2022~~ July 1, 2022, and shall be effective for 1902(a) state plan authorized services on and after that date. Qualifying overtime for consumer-directed personal care provided under EPSDT will be paid 150% of the fee schedule, and qualifying sick leave for consumer –directed personal care provided under EPSDT will be at 100% of the fee schedule.

16.1.a. Reimbursement for consumer-directed services facilitator services under EPSDT as described per Supplement 1 to Attachment 3.1A&B, pages 6.4.7 & 6.4.8. All governmental and private providers are reimbursed according to the same published fee schedule, located on the DMAS website at www.dmas.virginia.gov. The Agency's rates were set as of July 1, 2022, and shall be effective for services provided on and after that date.

16.2. Private duty nursing services covered under EPSDT as defined per Supplement 1 to Attachment 3.1A&B, page 6.4.8, with provider qualifications on page 6.4.8, are reimbursed based on a 15-minute unit of service in accordance with the State Agency fee schedule. The fee schedule is the same for both governmental and private providers and was set as of ~~August 8, 2021~~ July 1, 2022 and shall be effective for services provided on and after that date. The state agency fee schedule is published on the DMAS website at ~~https://www.dmas.virginia.gov/for-providers/general-information/procedure-fee-files-cpt-codes/~~ www.dmas.virginia.gov.

16.3 Medical Supplies, Equipment and Appliances (assistive technology) covered under EPSDT, as defined per Supplement 1 to Attachment 3.1 A&B, page 6.4.9, with provider qualifications on page 6.4.10. The service shall be reimbursed based upon the total cost of all AT incurred by the provider.

16.4 Reserved.

16.5 Hospice services, as defined per Attachment 3.1 A&B, Supplement 1, pages 33-37. Hospice services payments are effective October 1 annually and are equivalent to the annual Medicaid hospice rates published by CMS. As of July 1, 2019, room and board will be reimbursed at a rate equal to 100 percent of the skilled nursing facility rate for Medicaid members receiving hospice services who reside in a nursing facility. Hospice services shall be paid according to the location of the service delivery and not the location of the Agency's home office. Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to Medicaid members. During the twelve (12) month period beginning October 1 of each year and ending September 30 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid members during the same period.

Services that are included in the hospice reimbursement are: (a) Routine Home Care where most hospice care is provided - Days 1- 60; (b) Routine Home Care where most hospice care is provided-Days 61 and over; (c) Continuous Home Care; (d) Hospice Inpatient Respite Care; (e) Hospice General Inpatient Care; (f) Service Intensity Add-On (SIA) will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member' s life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.

16.3.1 Effective July 1, 2019, the telehealth originating site facility fee shall be set at 100 percent of the Medicare rate and shall reflect changes annually based on any changes in the Medicare rate.

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16.6. Applied Behavior Analysis Services are reimbursed based on a 15-minute unit of service. The agency's rates were set as of ~~April 1, 2012~~ July 1, 2022 and are effective for services on or after that date. All governmental and private providers are reimbursed according to the same published fee schedule, located on the agency's website at the following address: https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header "Search CPT Codes."

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18.5. Supplemental payments for services provided by physicians affiliated with Eastern Virginia Medical Center Physicians.

a. In addition to payment for physician services specified elsewhere in the State Plan, DMAS provides supplemental payments to physicians affiliated with Eastern Virginia Medical Center Physicians ~~for furnished services provided on or after October 1, 2012~~. A physician affiliated with Eastern Virginia Medical Center Physicians 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 has entered into contractual arrangements for the assignment of payment in accordance with 42 CFR 447.10.

b. Effective ~~October 1, 2021~~ July 1, 2022, the supplemental payment amount shall be the difference between the ~~Medicaid payments otherwise made for physician services and the Medicare equivalent of the average commercial rate (ACR) percentage times the Medicare rates~~ average commercial rate (ACR) approved by CMS and the payments otherwise made to physicians. The methodology for determining the Medicare Equivalent of the Average Commercial Rate is described in, Supplement 6, Attachment 4.19-B.

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

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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 to meet the requirements of Section 1902(a)(30)(A) of the Social Security Act (the Act) that Medicaid payments be "consistent with efficiency, economy, and quality of care." The methodology for determining allowable percent of Medicare rates and distributing supplemental payments to qualifying providers is based on the Medicare equivalent of the average commercial rate described on the Medicaid.gov website at https://www.medicaid.gov/medicaid/financial-management/payment-limit-demonstrations/index.html under the "Qualified Practitioner Services Average Commercial Rate" section and 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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18.2 Supplemental payments for services provided by physicians at general acute care non-state government owned hospitals.

a. In addition to payments for physician services specified elsewhere in the State Plan, DMAS shall make supplemental payments for general acute care non-state government owned hospitals. This applies to physician practices employed by or under contract with general acute care non-state government owned hospitals.

b. The supplemental payment amount for qualifying physician services shall be the maximum allowed by the Centers for Medicare and Medicaid Services to meet the requirements of Section 1902(a)(30)(A) of the Social Security Act (the Act) that Medicaid payments be "consistent with efficiency, economy, and quality of care." The methodology for determining allowable percent of Medicare rates and distributing supplemental payments to qualifying providers is based on the Medicare equivalent of the average commercial rate described on the Medicaid.gov website at https://www.medicaid.gov/medicaid/financial-management/payment-limit-demonstrations/index.html under the "Qualified Practitioner Services Average Commercial Rate" section and 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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(n.b. this page follows J.1 [now K] on Page 9 of 15, of Attachment 4.19-B)

J. 2. Targeted case management for Early Intervention (Part C) Children.

a. Targeted case management for children from birth to age three who have developmental delay who are in need of early intervention is reimbursed at the lower of the state agency fee schedule or actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of ~~October 11, 2011~~ July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

b. Case management may not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services, and intensive in-home services for children and adolescents.

c. Case management defined for another target group shall not be billed concurrently with this case management service except for case management services for high risk infants provided under 12 VAC 30-50-410. Providers of early intervention case management shall coordinate services with providers of case management services for high risk infants, pursuant to 12 VAC 30-50-410, to ensure that services are not duplicated.

d. Each entity receiving payment for services as defined in Section 3.1-A will be required to furnish the following to the Medicaid agency, upon request:

i. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and,

ii. cost information by practitioner.

Future rate updates will be based on information obtained from the providers. DMAS monitors the provision of Targeted Case Management through Post-Payment Review (PPR). PPRs ensure that paid services were rendered appropriately, in accordance with State and Federal policies and program requirements, provided in a timely manner, and paid correctly.

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12 VAC 30-80-110

Reimbursement for Targeted Case Management for Seriously Mentally Ill Adults and Emotionally Disturbed Children and for Youth At Risk of Serious Emotional Disturbance.

1. Targeted case management services for seriously mentally ill adults and emotionally disturbed children defined in § 2 of Supplement 2 to Attachment 3.1-A or for youth at risk of serious emotional disturbance defined in § 3 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of ~~September 10, 2013~~ July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of serious emotional disturbance may not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services , and intensive in-home services for children and adolescents.

3. Case management defined for another target group shall not be billed concurrently with these case management services.

4. Each provider receiving payment for these services will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of these services furnished Medicaid members; and,
    b. Cost information by practitioner furnishing these services.
5. Rate updates will be based on utilization and cost information obtained from the providers.

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12 VAC 30-80-110

Reimbursement Targeted Case Management for Individuals with Intellectual Disability.

1. Targeted case management for individuals with intellectual disability defined in § 4 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of ~~September 10, 2013~~ July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for individuals with intellectual disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with this case management service

4. Each provider receiving payment for this service will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of this service furnished Medicaid members; and,
    b. Cost information by practitioner furnishing this service.
5. Rate updates will be based on utilization and cost information obtained from the providers

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12 VAC 30-80-110

Reimbursement for Targeted Case Management for Individuals with Developmental Disability

1. Targeted case management for individuals with developmental disability defined in § 5 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of ~~August 2, 2016~~ July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for individuals with developmental disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with this case management service.

4. Each entity receiving payment for this service will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of this service furnished Medicaid members; and,
    b. Cost information by practitioner furnishing this service.
5. Rate updates will be based on information obtained from the providers.

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ESTABLISHMENT OF RATE PER VISIT

1. 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 for each sub-category as defined in Section 3(d) and calculated according to section 3(c) 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 in expenditure 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.

2. 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 each sub-category ~~as defined in Section 3(d) and calculated according to section 3(c) for:~~. Sub-categories are defined according to categorizations provided in the American Medical Association's (AMA's) annual publication of the Current Procedural Terminology (CPT) as:

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

(2) Obstetrical/Gynecological Services (OBGYN) 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 ~~3(e)(1)~~ 2(d)(1) and 2(d)(6) 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 ~~3(e)(1)~~ 2(d)(1), ~~and~~ ~~3e(3)~~ 2(d)(3), and 2(d)(6) 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 listed in ~~32(e)(1)~~ 2(d)(1) and 2(d)(6) 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~~)~~;

(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 defined as any remaining 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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ESTABLISHMENT OF RATE PER VISIT

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

C. Effective July 1, 2022, rates for OBGYN services shall be increased by 15%.

D. Effective July 1, 2022, rates for adult primary and preventive services defined as E&M procedures, excluding those listed in 2(d)(1) and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients age 21 and over shall be increased by 16.1% to reflect the equivalent of 80% of the 2021 Medicare rates.

E. Effective July 1, 2022, rates for pediatric primary services defined as E&M procedures excluding those listed in 2(d)(1), 2(d)(3), and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients under age 21 shall be increased by 7.9% to reflect the equivalent of 80% of the 2021 Medicare rates.

F. Effective July 1, 2022, rates for children's covered vision care services defined as ophthalmology procedures in effect at the time the service is provided, for recipients under age 21, shall be increased by 30%.

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: 22-0018

2. STATE: VA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 15,631,796
b. FFY 2023 $ 90,947,258

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, revised pages 5, 5.1, 5.2, 6, 6.0.4, 6.2.1, 6.2.1.1, 6.4.1, 7.1, 7.1-A (new), 9.02, 9.1C, 9.1D, 9.1E

Attachment 4.19B, Supp 4, pages 2, 3, 4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same as box #7.

9. SUBJECT OF AMENDMENT
2022 Non-Institutional Provider Reimbursement Changes

10. 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

11. SIGNATURE OF STATE AGENCY OFFICIAL
Cheryl Roberts

12. TYPED NAME
Cheryl J. Roberts

13. TITLE
Acting Director

14. DATE SUBMITTED
08/31/22

15. RETURN TO
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Policy, Regulations, and Manuals Supervisor

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

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6.A. 2. Dentists' services: Dental services, dental provider qualifications and dental service limits are identified in Attachment 3.lA&B, Supplement 1, page 16.1 and 16.1.1. Dental services are paid based on procedure codes which are listed in the Agency' fee schedule rate, effective July 1, 2022. All rates are published on the DMAS website at www.dmas.virginia.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

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6.A. 3. Mental health services

a. Professional services furnished by non-physicians, as described in 3.1A&B, Supplement 1, page 7 and page 11. These services are reimbursed using CPT codes. The agency's fee schedule rate is based on the methodology described in Attachment 4-19B, page 4.8, section 6 (A) 1.

(i) Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists in Attachment 4-19B, page 4.8, section 6 (A) 1.

(ii) Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric, or licensed marriage and family therapists shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

b. Intensive In-Home, as defined per Supplement 1 to Attachment 3.1A&B, Supplement 1, page 6.0.2, and provided by the individuals who are listed in Attachment 3.1A&B, Supplement 1, page 6.0.3 and defined in Attachment 3.1A&B, Supplement 1, page 6.0.1, is reimbursed on an hourly unit of service. The Agency's rates were set as of July 1, 2022, and are effective for services on or after that date.

c. Therapeutic Day Treatment, as defined per Supplement 1 to Attachment 3.1A&B, page 6.0.4, and provided by the individuals who are listed in Attachment 3.1A&B, Supplement 1, page 6.1 and defined in Attachment 3.1A&B, Supplement 1, page 6.0.1,is reimbursed based on the following units of service: One unit = 2 to 2.99 hours; Two units = 3 to 4.99 hours; Three units = 5 plus hours. No room and board is included in the rates for therapeutic day treatment. The Agency's rates were set as of July 1, 2022, and are effective for services on or after that date.

d. Therapeutic Group Home services (formerly called Level A and Level B group home services), as defined per Supplement 1 to Attachment 3.1A&B, page 6.2, shall be reimbursed based on a daily unit of service. No room and board is included in the rates for therapeutic group home services. The Agency's rates were set as of July 1, 2022, and are effective for services on or after that date.

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d-1. Mental Health Intensive Outpatient services are reimbursed based on a per-diem unit that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-2. Residential Crisis Stabilization is reimbursed based on a per-diem unit. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2022 and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-3. 23-Hour Residential Crisis Stabilization is a form of Residential Crisis Stabilization that is provided as a 23-hour service and is reimbursed on a per-diem unit. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2022 and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-4. Multisystemic Therapy is reimbursed based on a 15-minute unit of service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-5. Functional Family Therapy is reimbursed based on a 15-minute unit of service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

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e. Mental Health Partial Hospitalization Program services are reimbursed based on a per diem unit that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee- files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

f. Psychosocial Rehabilitation is reimbursed based on the following units of service: One unit = 2 to 3.99 hours per day; Two units = 4 to 6.99 hours per day; Three units = 7 + hours per day. The rates account for the wages, employee costs, and other allowable costs associated with providing this service. The Agency's rates were set as of July 1, 2022, and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files- cpt-codes/ - go to the header for HCPC Codes and look for this service.

g. Mobile Crisis Response is reimbursed based on a 15-minute unit of service. The rates account for the wages, employee costs, and other allowable costs associated with providing this service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for- providers/procedure- fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

h. Assertive Community Treatment is reimbursed on a daily unit of service that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The Agency's rates were set as of July 1, 2022, and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt- codes/ - go to the header for HCPC Codes and look for this service.

i. Community Stabilization is reimbursed on a 15 minute unit of service that accounts for the wages, employee costs, and other allowable costs associated with providing this service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2022, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for- providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

j. Independent Living and Recovery Services (previously called Mental Health Skill-Building Services) are reimbursed based on the following units of service: One unit is 1 to 2.99 hours per day, two units is 3 to 4.99 hours per day. The rates account for the wages, employee costs, and other allowable costs associated with providing this service The Agency's rates were set as of July 1, 2022 and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/pr ocedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

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Section 6 A (3), continued.

(p) Peer Support Services and Family Support Partners, as defined per Supplement 1 to Attachment 3.1A&B, pages 54 through 59, and furnished by enrolled providers or provider agencies, shall be reimbursed based on the agency fee schedule for 15-minute units of service. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. All rates are published on the DMAS website at: www.dmas.virginia.gov. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (ex. case management for persons with chronic mental illness).

(i) Peer Support Services and Family Support Partners shall not be reimbursed if the services operate in the same building as other day services unless (i) there is a distinct separation between services in staffing, program description, and physical space and (ii) Peer Support Services or Family Support Partners do not impede, interrupt, or interfere with the provision of the primary service.

(ii) Family Support Partners services shall not be reimbursed for an individual who resides in a congregate setting in which the caregivers are paid (such as child caring institutions, or any other living environment that is not comprised of more permanent caregivers) unless (i) the individual is actively preparing for transition back to a single-family unit, (ii) the caregiver is present during the intervention, (iii) the service is directed to supporting the unification/reunification of the individual and his/her caregiver and (iv) the service takes place in that home and community.

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16.1 Reimbursement for personal care services for individuals enrolled in the Medicaid Buy-In program described in Attachment 2.6A, Supplement 8a, p 1-3 or for personal care services covered under EPSDT. All governmental and private providers are reimbursed according to the same published fee schedule. All rates are published on the DMAS website at www.dmas.virginia.gov. The Agency's rates, based upon one-hour increments, were set as of July 1, 2022, and shall be effective for 1902(a) state plan authorized services on and after that date. Qualifying overtime for consumer-directed personal care provided under EPSDT will be paid 150% of the fee schedule, and qualifying sick leave for consumer – directed personal care provided under EPSDT will be at 100% of the fee schedule.

16.1.a. Reimbursement for consumer-directed services facilitator services under EPSDT as described per Supplement 1 to Attachment 3.1A&B, pages 6.4.7 & 6.4.8. All governmental and private providers are reimbursed according to the same published fee schedule, located on the DMAS website at www.dmas.virginia.gov. The Agency's rates were set as of July 1, 2022, and shall be effective for services provided on and after that date.

16.2. Private duty nursing services covered under EPSDT as defined per Supplement 1 to Attachment 3.1A&B, page 6.4.8, with provider qualifications on page 6.4.8, are reimbursed based on a 15-minute unit of service in accordance with the State Agency fee schedule. The fee schedule is the same for both governmental and private providers and was set as of July 1, 2022 and shall be effective for services provided on and after that date. The state agency fee schedule is published on the DMAS website at www.dmas.virginia.gov.

16.3 Medical Supplies, Equipment and Appliances (assistive technology) covered under EPSDT, as defined per Supplement 1 to Attachment 3.1 A&B, page 6.4.9, with provider qualifications on page 6.4.10. The service shall be reimbursed based upon the total cost of all AT incurred by the provider.

16.4 Reserved.

16.5 Hospice services, as defined per Attachment 3.1 A&B, Supplement 1, pages 33-37. Hospice services payments are effective October 1 annually and are equivalent to the annual Medicaid hospice rates published by CMS. As of July 1, 2019, room and board will be reimbursed at a rate equal to 100 percent of the skilled nursing facility rate for Medicaid members receiving hospice services who reside in a nursing facility. Hospice services shall be paid according to the location of the service delivery and not the location of the Agency's home office. Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to Medicaid members. During the twelve (12) month period beginning October 1 of each year and ending September 30 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid members during the same period.

Services that are included in the hospice reimbursement are: (a) Routine Home Care where most hospice care is provided - Days 1- 60; (b) Routine Home Care where most hospice care is provided-Days 61 and over; (c) Continuous Home Care; (d) Hospice Inpatient Respite Care; (e) Hospice General Inpatient Care; (f) Service Intensity Add-On (SIA) will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member' s life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.

16.3.1 Effective July 1, 2019, the telehealth originating site facility fee shall be set at 100 percent of the Medicare rate and shall reflect changes annually based on any changes in the Medicare rate.

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16.6. Applied Behavior Analysis Services are reimbursed based on a 15-minute unit of service. The agency's rates were set as of July 1, 2022 and are effective for services on or after that date. All governmental and private providers are reimbursed according to the same published fee schedule, located on the agency's website at the following address: https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header "Search CPT Codes."

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18.5. Supplemental payments for services provided by physicians affiliated with Eastern Virginia Medical Center Physicians.

a. In addition to payment for physician services specified elsewhere in the State Plan, DMAS provides supplemental payments to physicians affiliated with Eastern Virginia Medical Center Physicians. A physician affiliated with Eastern Virginia Medical Center Physicians 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 has entered into contractual arrangements for the assignment of payment in accordance with 42 CFR 447.10.

b. Effective July 1, 2022, the supplemental payment amount shall be the difference between the average commercial rate (ACR) approved by CMS and the payments otherwise made to physicians. The methodology for determining the Medicare Equivalent of the Average Commercial Rate is described in, Supplement 6, Attachment 4.19-B.

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

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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 to meet the requirements of Section 1902(a)(30)(A) of the Social Security Act (the Act) that Medicaid payments be "consistent with efficiency, economy, and quality of care." The methodology for determining allowable percent of Medicare rates and distributing supplemental payments to qualifying providers is based on the Medicare equivalent of the average commercial rate described on the Medicaid.gov website at https://www.medicaid.gov/medicaid/financial-management/payment-limit-demonstrations/index.html under the "Qualified Practitioner Services Average Commercial Rate" section and 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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18.2 Supplemental payments for services provided by physicians at general acute care non-state government owned hospitals.

a. In addition to payments for physician services specified elsewhere in the State Plan, DMAS shall make supplemental payments for general acute care non-state government owned hospitals. This applies to physician practices employed by or under contract with general acute care non-state government owned hospitals.

b. The supplemental payment amount for qualifying physician services shall be the maximum allowed by the Centers for Medicare and Medicaid Services to meet the requirements of Section 1902(a)(30)(A) of the Social Security Act (the Act) that Medicaid payments be "consistent with efficiency, economy, and quality of care." The methodology for determining allowable percent of Medicare rates and distributing supplemental payments to qualifying providers is based on the Medicare equivalent of the average commercial rate described on the Medicaid.gov website at https://www.medicaid.gov/medicaid/financial-management/payment-limit-demonstrations/index.html under the "Qualified Practitioner Services Average Commercial Rate" section and 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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(n.b. this page follows J.1 [now K] on Page 9 of 15, of Attachment 4.19-B)

J. 2. Targeted case management for Early Intervention (Part C) Children.

a. Targeted case management for children from birth to age three who have developmental delay who are in need of early intervention is reimbursed at the lower of the state agency fee schedule or actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

b. Case management may not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services, and intensive in-home services for children and adolescents.

c. Case management defined for another target group shall not be billed concurrently with this case management service except for case management services for high risk infants provided under 12 VAC 30-50-410. Providers of early intervention case management shall coordinate services with providers of case management services for high risk infants, pursuant to 12 VAC 30-50-410, to ensure that services are not duplicated.

d. Each entity receiving payment for services as defined in Section 3.1-A will be required to furnish the following to the Medicaid agency, upon request:

i. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and,

ii. cost information by practitioner.

Future rate updates will be based on information obtained from the providers. DMAS monitors the provision of Targeted Case Management through Post-Payment Review (PPR). PPRs ensure that paid services were rendered appropriately, in accordance with State and Federal policies and program requirements, provided in a timely manner, and paid correctly.

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12 VAC 30-80-110

Reimbursement for Targeted Case Management for Seriously Mentally Ill Adults and Emotionally Disturbed Children and for Youth At Risk of Serious Emotional Disturbance.

1. Targeted case management services for seriously mentally ill adults and emotionally disturbed children defined in § 2 of Supplement 2 to Attachment 3.1-A or for youth at risk of serious emotional disturbance defined in § 3 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of serious emotional disturbance may not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services , and intensive in-home services for children and adolescents.

3. Case management defined for another target group shall not be billed concurrently with these case management services.

4. Each provider receiving payment for these services will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of these services furnished Medicaid members; and,
    b. Cost information by practitioner furnishing these services.
5. Rate updates will be based on utilization and cost information obtained from the providers.

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12 VAC 30-80-110

Reimbursement Targeted Case Management for Individuals with Intellectual Disability.

1. Targeted case management for individuals with intellectual disability defined in § 4 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for individuals with intellectual disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with this case management service

4. Each provider receiving payment for this service will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of this service furnished Medicaid members; and,
    b. Cost information by practitioner furnishing this service.
5. Rate updates will be based on utilization and cost information obtained from the providers

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12 VAC 30-80-110

Reimbursement for Targeted Case Management for Individuals with Developmental Disability

1. Targeted case management for individuals with developmental disability defined in § 5 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for individuals with developmental disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with this case management service.

4. Each entity receiving payment for this service will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of this service furnished Medicaid members; and,
    b. Cost information by practitioner furnishing this service.
5. Rate updates will be based on information obtained from the providers.

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1. 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 for each sub-category as defined in Section 3(d) and calculated according to section 3(c) 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 in expenditure 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.

2. 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 each sub-category. Sub-categories are defined according to categorizations provided in the American Medical Association's (AMA's) annual publication of the Current Procedural Terminology (CPT) as:

(1) Emergency Room Services defined as CPT codes 99281, 99282, 99283, 99284, and 99285;

(2) Obstetrical/Gynecological Services (OBGYN) defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures;

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(3) Pediatric preventive services defined as Evaluation and Management (E&M) procedures, excluding those listed in 2(d)(1) and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients under age 21;

(4) Pediatric primary services defined as E&M procedures, excluding those listed in subdivisions 2(d)(1), 2(d)(3), and 2(d)(6) of this subsection, 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 2(d)(1) and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients age 21 and over;

(6) Effective July 1, 2019, psychiatric services in effect at the time the service is provided; and

(7) All other procedures defined as any remaining procedures set through the RBRVS process.

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

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

C. Effective July 1, 2022, rates for OBGYN services shall be increased by 15%.

D. Effective July 1, 2022, rates for adult primary and preventive services defined as E&M procedures, excluding those listed in 2(d)(1) and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients age 21 and over shall be increased by 16.1% to reflect the equivalent of 80% of the 2021 Medicare rates.

E. Effective July 1, 2022, rates for pediatric primary services defined as E&M procedures excluding those listed in 2(d)(1), 2(d)(3), and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients under age 21 shall be increased by 7.9% to reflect the equivalent of 80% of the 2021 Medicare rates.

F. Effective July 1, 2022, rates for children's covered vision care services defined as ophthalmology procedures in effect at the time the service is provided, for recipients under age 21, shall be increased by 30%.

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.