

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601



Financial Management Group

December 22, 2021

Karen Kimsey, Director
The Commonwealth of Virginia
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond, VA 23219

Attn: Regulatory Coordinator

RE: Virginia State Plan Amendment (SPA) Transmittal Number 20-0012

Dear Ms. Kimsey:

We have reviewed the proposed State Plan Amendment (SPA) to Attachment 4.19-B of Virginia's state plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 25th, 2020. This plan amendment allows the pending, reviewing, and reduction of emergency department payment amounts for avoidable emergency room claims for state plan authorized fee-for-service benefits coded as 99282, 99283 and 99284.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1st, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Jerica Bennett at 1-410-786-1167 or jerica.bennett@cms.hhs.gov.

Sincerely,

Todd McMillion

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 0 - 0 1 2

2. STATE

Virginia

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

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

4. PROPOSED EFFECTIVE DATE

7/1/2020

5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION

42 CFR Part 447

7. FEDERAL BUDGET IMPACT

a. FFY 2020 \$ (\$2,642,866)

b. FFY 2021 \$ (\$10,624,321)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

4.19-B, pages 4.8 and 7.2.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Same as box #8.

10. SUBJECT OF AMENDMENT

Emergency Room Claims

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT²⁰²⁰

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED

Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME

Karen Kimsey

14. TITLE

Director

15. DATE SUBMITTED

9/25/2020

16. RETURN TO

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

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

September 25, 2020

18. DATE APPROVED

December 22, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

July 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

Todd McMillion

22. TITLE

Director, Division of Reimbursement Review

23. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

2. Supplemental Payments for FQHCs/RHCs selecting the PPS methodology. FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the FQHC/RHC receives from MCEs and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of each FQHCs/RHCs fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHCs/RHCs contract with MCE would have yielded under the PPS. If the PPS amount exceeds the total amount of supplemental and MCE payments, the FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC/RHC. If the PPS amount is less than the total amount of supplemental and MCE payments, the FQHC/RHC will refund to DMAS the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC.

D. These providers shall be subject to the same cost reporting submission requirements as specified in Attachment 4.19-B, page 1.1 for cost-based reimbursed providers.

§6. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the State agency fee schedule (Supplement 4 has information about the State agency fee schedule except as specified below) or actual charge (charge to the general public). Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private individual practitioners. Fee schedules and any annual /periodic adjustments to the fee schedule are published on the DMAS website at the following web address: <https://www.dmas.virginia.gov/for-providers/general-information/procedure-fee-files-cpt-codes/> Instructions on how to use the fee schedules are available at this site by clicking on "Overview." (<https://www.dmas.virginia.gov/media/2185/overview.pdf>) Procedure codes and rate effective dates (column: Eff_Date) are noted on the CPT procedure code look up for current rates and in the fee schedule files available for download.

1. Physicians' services. Payment for physician services shall be the lower of the State agency fee schedule or actual charge (charge to the general public) except that emergency room services 99282-99284 with a principal diagnosis on the Preventable Emergency Room Diagnosis List shall be reimbursed the rate for 99281.

TN No. 20-012

Approval Date 12/22/2021

Effective Date 7/1/20

Supersedes

TN No. 16-008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

3. The statewide base rate shall be equal to the total costs described below divided by the wage- adjusted sum of the EAPG weights for each facility. The wage-adjusted sum of the EAPG weights shall equal the sum of the EAPG weights times the labor percentage times the hospital's Medicare wage index plus the sum of the EAPG weights times the non-labor percentage. The base rate shall be determined for outpatient hospital services at least every three years so that total expenditures will equal the following:

a) When using base years prior to January 1, 2014, for all services, excluding all laboratory services and emergency services described in subdivision 3 c of this subsection, a percentage of costs defined in subsection A as reported in the available cost reports for the base period for each type of hospital as defined in Attachment 4.19-A, Methods and Standards for Establishing Payment Rates-Hospital Services, DRG-Payment Methodology (~~12VAC30-70-221~~).

(i) Type One Hospitals: Effective January 1, 2014, hospital outpatient operating reimbursement shall be calculated at 90.2 percent of cost and capital reimbursement shall be at 86 percent of cost inflated to the rate year.

(ii) Type Two Hospitals: Effective January 1, 2014, hospital outpatient operating and capital reimbursement shall be calculated at 76 percent of cost inflated to the rate year.

(iii) When using base years after January 1, 2014, the percentages described in subdivision 3 of this subsection shall be adjusted according to subdivision 3 c to 69.8% for Type Two hospitals.

(iv) For critical access hospitals, the operating rate shall be increased by using an adjustment factor or percent of cost reimbursement equal to 100% of cost, effective July 1, 2019.

b) Laboratory services (excluding laboratory services referred to the hospital but not associated with a hospital visit) calculated at the fee schedule in effect for the rate year. Laboratory services are reimbursed based on CPT codes listed in the fee schedules that are published on the DMAS website at the following web address: <https://www.dmas.virginia.gov/for-providers/general-information/procedure-fee-files-cpt-codes/>

c) Services rendered in emergency departments determined to be non-emergencies as prescribed in Attachment 4.19-B, section 2 D shall be calculated for base years after January 1, 2014 as the cost percentages in subdivision 3(a) of this subsection, adjusted to reflect services paid at the non-emergency reduced rate in the last base year prior to January 1, 2014.

d) Effective July 1, 2020, reimbursement for claims with procedure codes 99281-99284 and a principal diagnosis code on the Preventable Emergency Room Diagnosis List shall be based on an all-inclusive EAPG payment weight for claims with CPT 99281 and a principal diagnosis code on the Preventable Emergency Room Listing. All other procedures on the outpatient hospital claim shall be packaged in the all-inclusive payment for 99281-99284. DMAS shall calculate the all-inclusive payment weight for claims with 99281 using data from the most recent rebasing. The EAPG weight is published on the DMAS website at the following web address: <https://www.dmas.virginia.gov/for-providers/general-information/rate-setting/outpatient-eapg/>

~~3.~~ 4. Inflation adjustment to base year costs. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with DMAS, shall be used to update the base year costs to the midpoint of the rate year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Corrections made by Global Insight (or its successor), in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year. Inflation shall be applied to the costs identified in subdivision 3(a) of this subsection.

TN No. 20-012

Approval Date 12/22/2021

Effective Date 07-01-20

Supersedes

TN No. 19-008