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State Name: Virginia

State Plan Amendment (SPA)#: 14-012

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Fifteen (15) SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

JUN 02 2015

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

RE: State Plan Amendment 14-012

Dear Mrs. Jones:

We have completed our review of State Plan Amendment (SPA) 14-012. This SPA modifies Attachment 3.1-A&B, Attachment 3.1-C, Attachment 4.19-A, and Attachment 4.19-B of Virginia's Title XIX State Plan. Specifically, the SPA makes amendments to comply with CMS policy for providing service by arrangement in psychiatric facilities.

We conducted our review of this SPA according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving state plan amendment 14-012 effective July 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, or require additional information, please call Gary Knight at (304) 347-5723.

Sincerely yours,

/S/

Timothy Hill
Director

Enclosures

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

CM 5/22/15

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 14-012

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: July 1, 2014

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: CM 5/22/15
42 CFR Part 447, 440.160, 440.130

7. FEDERAL BUDGET IMPACT
a. FFY 2014 $ 0
b. FFY 2015 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
CM 5/22/15
Attach. 3.1A/B, Suppl, pp 6.4, 6.4.1, 6.4.2; Attach 3.1-C, pp 3, 4, 5, 5.1; Attach. 4.19-A, pp 1, 1.1, 12, 17, 17.1, 17.2, 17.2.1; Attach. 4.19-B, p 4.5.1 of 15

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

10. SUBJECT OF AMENDMENT
Institutions for Mental Disease Reimbursement Changes; IMD Services by Arrangement CM 5/22/15

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
/S/

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 8/26/14

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

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED: JUN 02 2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL
/S/

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FMG

23. REMARKS

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY
NEEDY and MEDICALLY NEEDY

H. Inpatient psychiatric services shall be covered for individuals younger than age 21, for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2), for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

1. A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

2. A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children.

3. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12 VAC 30-50-100, 12 VAC 30-50-105, and 12 VAC 30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of 12 VAC 30-130-850 et seq.

4. a. The inpatient psychiatric services benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160, provided under the direction of a physician, pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals, and shall involve active treatment designed to achieve the child's discharge from inpatient status at the earliest possible time. The inpatient psychiatric services benefit shall include the following services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility: (i) arranges for and oversees the provision of all services; (ii) maintains all medical records of care furnished to the individual, and; (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor, of the facility, who is licensed to prescribe drugs shall be considered the referral.

   b. Eligible services provided under arrangement with the inpatient psychiatric facility shall vary by provider type as described in this section. For purposes of this section, emergency services means the same as is set out in 12 VAC 30-50-310 B.

1) State freestanding psychiatric hospitals shall arrange under contract for, maintain records of and ensure that physicians order these services (i) pharmacy services, and; (ii) emergency services.

2) Private freestanding psychiatric hospitals shall arrange under contract for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) transportation services; and (viii) emergency services.

3) Residential treatment centers, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment; (vii) vision services; (viii) dental, oral surgery, and orthodontic services; (ix) transportation services; and (x) emergency services.

5. Inpatient psychiatric services, as defined at 42 CFR 483.352, are reimbursable only when the treatment program is fully in compliance with i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, specifically, 42 CFR § 441.151(a), (b) and §§ 441.152 through 441.156, and ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

6. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT.

OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY
NEEDY and MEDICALLY NEEDY

I. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia. (12 VAC 30-50-130(B)(7))

J. Family Planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services which delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

hospital stays shall be preauthorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

C. All Medicaid services are subject to utilization review/audit. Absence of any of the required documentation may result in denial or retraction of any reimbursement. In each case for which payment for freestanding psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a freestanding psychiatric hospital consistent with 42 CFR 456.160.

2. The physician, physician assistant, or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician, must recertify at least every 60 days that the individual continues to require inpatient services in a psychiatric hospital.

3. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must perform a medical evaluation of the individual and appropriate professional personnel must make a psychiatric and social evaluation as cited in 42 CFR 456.170.

4. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each recipient patient as cited in 42 CFR 441.155 and 456.180. The plan shall also include a list of services provided under written contractual arrangement with the freestanding psychiatric hospital (see Attachment 3.1 A&B, Supplement 1, Item 4b pages 6.4 and 6.5 of 45 (12 VAC 30-50-130)) that will be furnished to the patient through the freestanding psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

D. If the eligible individual is 21 years of age or older, then, in order to qualify for Medicaid payment for this service, he must be at least 65 years of age.

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STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

E. If younger than 21 years of age, it shall be documented that the individual requiring admission to a free-standing psychiatric hospital is under 21 years of age, that treatment is medically necessary and that the necessity was identified as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening. Required patient documentation shall include, but not be limited to, the following:

1. An EPSDT physician's screening report showing the identification of the need for further psychiatric evaluation and possible treatment.

2. A diagnostic evaluation documenting a current (active) psychiatric disorder included in the DSM-III-R that supports treatment recommended. The diagnostic evaluation must be completed prior to admission.

3. For admission to free-standing psychiatric hospital for psychiatric services resulting from an EPSDT screening, a certification of the need for services as defined at 42 CFR §441.152 by an interdisciplinary team meeting the requirements of 42 CFR §441.153 or §441.156 and The Psychiatric Treatment of Minors Act (§16.1-335 et seq. *Code of Virginia*).

4. If a Medicaid eligible individual is admitted in an emergency to a freestanding psychiatric hospital on a Saturday, Sunday, holiday, or after normal working hours, it shall be the provider's responsibility obtain the required authorization on the next work day following such an admission.

5. The absence of any of the above required documentation shall result in DMAS's denial of the requested preauthorization and coverage of subsequent hospitalization.

F. To determine that the DMAS enrolled mental hospital providers are in compliance with the regulations governing mental hospital utilization control found in 42 CFR §456.150, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit. The hospital shall make all requested records available and shall provide an appropriate place for the auditors to conduct such a review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in the 42 CFR §§456.200 through 456.245.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in the 42 CFR §§ 456.205 through 456.206.

3. Verification of Utilization Management Committee meetings, since including dates and lists of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

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4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR §§456.241 through 456.245.

5. Topic of one on-going Medical Care Evaluation Study to determine the hospital is in compliance with 42 CFR §§456.245.

6. From a list of randomly selected paid claims, the free-standing psychiatric hospital must provide a copy of the certification for services, a copy of the physician admission certification, a copy of the required medical, psychiatric, and social evaluation, and a written plan of care for each selected stay to determine the hospital's compliance with the *Code of Virginia* §§16.1-335 through 16.1-348 and 42 CFR §§441.152, 456.160, 456.170, and §§456.180 through 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.

7. The freestanding psychiatric hospital shall not receive a per diem reimbursement for any day that:

   a. The comprehensive plan of care fails to include, within three business days of the initiation of the service provided under arrangement, all services that the individual needs while at the freestanding psychiatric hospital and that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider of services under arrangement;

   b. The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;

   c. The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

   d. The referral to the service provided under written contractual arrangement was not present in the patient's freestanding psychiatric hospital record or the record of the provider of services under arrangement;

   e. The medical records from the provider of services under arrangement (i.e., any admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings) were not present in the patient's freestanding psychiatric hospital record, or had not been requested in writing by the freestanding psychiatric hospital within seven business days of completion of the service or services provided under arrangement; or

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f. The freestanding psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the freestanding psychiatric hospital shall have a fully executed contract with the emergency services provider prior to submission of the emergency services provider's claim for payment.

8. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service billed prior to receiving a referral from the freestanding psychiatric hospital or in excess of the amounts in the referral.

9. The hospital may appeal in accordance with the *Code of Virginia* § 2.2-4000 et seq. any adverse decisions resulting from such audits which results in retraction of payment. The appeal must be requested pursuant to the requirements of 12 VAC 30-20-500 et seq.

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State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

CHAPTER 70.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES; INPATIENT HOSPITAL CARE.

PART V.
INPATIENT HOSPITAL PAYMENT SYSTEM.

Article 1.
Application of Payment Methodologies.

12 VAC 30-70-200. Repealed.

12 VAC 30-70-201. Application of payment methodologies.

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals shall be subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Inpatient hospital facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be reimbursed costs except for inpatient psychiatric services furnished under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for individuals younger than age 21. These inpatient services shall be reimbursed according to 12 VAC 30-70-415 and shall be provided according to the requirements set forth in Attachment 3.1 A&B, Supplement 1, Item 4b (pp 6 et seq. of 45 (12 VAC 30-50-130) and Attachment 3.1 C (p 1.1 of 43 et seq. (12 VAC 30-60-25(H)). Facilities may also receive disproportionate share hospital (DSH) payments. The criteria for DSH eligibility and the payment amount shall be based on subsection G of 12VAC30-70-50. If the DSH limit is exceeded by any facility, the excess DSH payments shall be distributed to all other qualifying DBHDS facilities in proportion to the amount of DSH they otherwise receive.

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D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre-hospitalization and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E (12VAC30-50-540 through 12VAC30-50-580).

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12 VAC 30-70-320. Repealed.

12 VAC 30-70-321. Hospital specific operating rate per day.

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12 VAC 30-70-341, times the hospital's Medicare wage index plus the non-labor portion of the statewide operating rate per day.

B. For rural hospitals, the hospital's Medicare wage index used in this section shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher.

C. Effective July 1, 2008, and ending after June 30, 2010, the hospital-specific operating rate per day shall be reduced by 2.683 percent.

12 VAC 30-70-330. Repealed.

12 VAC 30-70-331. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals:

1. For Type One hospitals the adjustment factor shall be a calculated percentage that causes the type One hospital statewide operating rate per case to equal the type Two hospital statewide operating rate per case;

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2. Starting July 1, 1996, operating ceilings will be increased for inflation to the midpoint of the state fiscal year, not the hospital fiscal year. Inflation shall be based on the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS, increased by two percentage points per year. The most current table available prior to the effective date of the new rates shall be used.

For services to be paid at SFY 1998 rates, per diem rates shall be adjusted consistent with the methodology for updating rates under the DRG methodology 12 VAC 30-70-351.

3. There will be no disproportionate share hospital (DSH) per diem.

4. To pay capital cost through claims, a hospital specific adjustment to the per diem rate will be made. At settlement of each hospital fiscal year, this per diem adjustment will be eliminated and capital shall be paid as a pass-through.

5. This methodology shall be used after the transition period to reimburse days of hospital stays with admission dates before July 1, 1996.

6. This methodology shall be used after the transition period to make interim payments until such time as the DRG payment methodology is operational.

12 VAC 30-70-410. State university teaching hospitals.

For hospitals that were state owned teaching hospitals on January 1, 1996, all the calculations which support the determination of hospital specific rate per case and rate per day amounts under the prospective payment methodology shall be carried out separately from other hospitals, using cost data taken only from state university teaching hospitals. Rates to be used shall be determined on the basis of cost report and other applicable data from the most recent year for which reliable data are available at the time of re-basing.

12VAC 30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.

A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC30-70-271.

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C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio of total capital cost to total charges of the hospital, using data available from Medicare cost report.

E. Effective July 1, 2014, services provided under arrangement, as defined in 12 VAC 30-50-130(B)(6)(a) and (b), shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in Attachment 4.19-B (12 VAC 30-80), to a provider of services under arrangement if all of the following are met:

1. The services are included in the active treatment plan of care developed and signed as described in section 12 VAC 30-60-25(C)(4) and

2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.

12VAC30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.

A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all services provided under arrangement that are reimbursed in the manner described in subsection D of this section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the program shall take action in accordance with its policies to assure that an overpayment is not being made.

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D. Effective July 1, 2014, services provided under arrangement, as defined in 12 VAC 30-50-130(B)(6)(c), shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for these providers in 12 VAC 30-80, to a provider of services under arrangement if all of the following are met:

1. The services provided under arrangement are included in the active written treatment plan of care developed and signed as described in section 12 VAC 30-130-890 and

2. The services provided under arrangement are arranged and overseen by the residential treatment facility treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the residential treatment facility or under contract for services provided under arrangement.

12 VAC 30-70-420. Reimbursement of non-cost-reporting general acute care hospital providers.

A. Effective July 1, 2000, non-cost-reporting (general acute care hospitals that are not required to file cost reports) shall be paid based on DRG rates unadjusted for geographic variation increased by the average capital percentage among hospitals filing cost reports in a recent year.

B. Effective July 1, 2011, out-of-state hospitals shall be reimbursed the lesser of the amount reimbursed by the Medicaid program in the facility's home state or the rate defined in the subsection A of this section.

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12 VAC 30-70-420. Reimbursement of non-cost-reporting general acute care hospital providers. (continued)

C. Prior approval must be received from DMAS when a referral has been made for treatment to be received from a non-participating acute care facility (in-state or out-of-state). Prior approval will be granted for inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia under any one of the following conditions. It shall be the responsibility of the non-participating hospital, when requesting prior authorization for the admission of the Virginia resident to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than those specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is general practice for recipients in a particular locality to use medical resources in another state except in the case of an emergency because medical resources or supplementary resources are more readily available in another state.

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

(THE NEXT PAGE IS 4.6 OF 15)

THIS PAGE IS DELETED BY ACTION OF SPA 14-012, EFFECTIVE 7/1/2014.