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State Name: Virginia

State Plan Amendment (SPA) #: 15-008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT #090220154009

February 24, 2016

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

Dear Ms. Jones:

We have reviewed State Plan Amendment (SPA) 15-008, Non-Institutional Provider Reimbursement Changes. This SPA proposes to eliminate the emergency room payment reduction for Level III physician services; increase supplemental payments for physicians affiliated with freestanding children's hospitals; and establish a supplemental payment for clinics operated by the Virginia Department of Health.

This SPA is acceptable. Therefore, we are approving SPA 15-008 with an effective date of July 1, 2015. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

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: 15-008

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, 2015

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 2015 $ 940,433
b. FFY 2016 $ 2,821,298

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Pen & ink changes 10/22/15 CLL

Attachment 4.19B, revised page 4.8, revised page 6.3.1, new page 7.1.1, revised pages 5 and 6

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Same pages

10. SUBJECT OF AMENDMENT

Non-Institutional Provider Reimbursement Changes

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2015
☐ 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: 8/12/15

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: 08/31/2015

18. DATE APPROVED: 2/24/2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/2015

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Francis McCullough

22. TITLE: Associate Regional Administrator

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

1. 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 12VAC30-80-20 for cost-based reimbursed providers.

§6. Fee-for-service providers. (12 VAC 30-80-30)

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: http://www.dmas.virginia.gov/Content_pgs/pr-ffs_new.aspx :

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).

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

§6.A. 2. Dentists' services: the agency's rate was set as of July 1, 2010, October 1, 2010, and July 1, 2011, and is effective for services on or after that date, respectively. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

§6.A. 3. Mental health services including: Community mental health services. (The agency's rates were set as of July 1, 2011 or earlier and are effective for services on or after that date.) Services of a licensed clinical psychologist; mental health services provided by a physician

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.
b. 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.

3.1. Intensive In-Home Services: The agency's hourly rates were set as of February 1, 2010, and are effective for services on or after that date.

These services are provided by Qualified Mental Health Professionals or other licensed professional. The Medicaid hourly fee is paid directly to an individual practitioner or billed on behalf of the practitioner through an employment arrangement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

Fee-for-service providers. (12 VAC 30-80-30)

17.5. Supplemental payment for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR § 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 143% of Medicare rates as defined in the supplemental payment calculation described in the Medicare Equivalent of the Average Commercial Rate methodology (See Supplement 6 to Attachment 4.19-B), subject to the following reduction. Final payments shall be reduced on a pro-rated basis so that total payments for freestanding children's hospital physician services are $400,000 less annually than would be calculated based on the formula in the previous sentence. Effective July 1, 2015, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 178% of Medicare rates as defined in the supplemental payment calculation for Type I physician services. Payments shall be made on the same schedule as Type I physicians.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE
ESTABLISHMENT OF RATE PER VISIT

19. Supplemental payments to state-owned or operated clinics.

a. Effective for dates of service on or after July 1, 2015, DMAS shall make supplemental payments to qualifying state-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 1, 2015. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual.

b. The amount of the supplemental payment made to each qualifying state-owned or operated clinic is determined by:
Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 19 d of this subsection and the amount otherwise actually paid for the services by the Medicaid program;

c. Payments for furnished services made under this section shall be made annually in lump sum payments to each clinic.

d. To determine the upper payment limit for each clinic referred to in subdivision 19 b of this subsection the state payment rate schedule shall be compared to the Medicare resource-based relative value scale (RBRVS) non-facility fee schedule per CPT code for a base period of claims. The base period claims shall be extracted from the MMIS and exclude crossover claims.