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State Name: Virginia

State Plan Amendment (SPA) #19-005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street, Suite 9400
Philadelphia, Pennsylvania 19107

CENTERS FOR MEDICARE & MEDICAID SERVICES

Regional Operations Group

SWIFT #050620194017

May 8, 2019

Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Dr. Lee:

We are pleased to inform you of the approval of Virginia's State Plan Amendment (SPA) 19-005 to allow residents in professional counseling, psychology and supervisees in social work who completed the education requirements for licensure but have yet to meet the experience requirements to provide billable outpatient behavioral health services to Medicaid members. Also, this SPA removes the 21-day limit on inpatient psychiatric services. Length of stay will now be determined by medical necessity. Enclosed are the approved SPA pages and signed CMS-179 form. The effective date of this amendment is January 1, 2019.

If you have further questions about this SPA, please contact Michael Cleary of my staff at 215-861-4282.

Sincerely,

[redacted]

Sabrina Tillman-Boyd
Acting Deputy Director
Eastern Regional Operations Group

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: 19-005

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: January 1, 2019

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 440

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ -0-
b. FFY 2020 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1A&B, Supplement 1, pages 7, 8, 9, 11, ~~and~~ 16, and 16.0.1

Peer & info 3/29/19 EH

Peer & info 4/25/19 EH

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: LMHP-R, RP, and S May Provide Outpatient Psychiatric Services

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2019
☐ 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: [redacted]

13. TYPED NAME: Jennifer S. Lee, M.D.

14. TITLE: Director

15. DATE SUBMITTED: 3-19-19

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: March 22, 2019

18. DATE APPROVED: May 6, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Sabrina Tillman-Boyd

22. TITLE: Acting Deputy Director

23. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
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Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when (1) the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments, or (2) the immunization is necessary for the direct treatment of an injury; or (3) the immunization is a pneumococcal or influenza vaccination that is reasonable and necessary for the prevention of illness.

D. Outpatient psychiatric services.

1. Psychiatric services can be provided by or under the supervision of an individual licensed under state law to practice medicine or osteopathy. Only the following licensed or registered providers are permitted to provide psychiatric services under the supervision of an individual licensed under state law to practice medicine or osteopathy: an LMHP, LMHP-R, LMHP-RP, or LMHP-S as defined in Attachment 3.1A&B, Supplement 1, pages 31 and 31.1. Medically necessary psychiatric services shall be covered by DMAS or its designee and shall be directly and specifically related to an active written plan designed and signature dated by one of the healthcare professionals listed in this paragraph.

2. Psychiatric services shall be considered appropriate when an individual meets the following criteria:
   a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels which have been impaired;
   b. Exhibits deficits in peer relations, dealing with authority, is hyperactive, has poor impulse control, is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, abilities to learn, and/or ability to participate in employment, educational, or social activities;
   c. Is at risk for developing or requires treatment for maladaptive coping strategies; and
   d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

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E. Any procedure considered experimental is not covered.

F. RESERVED.

G. Physician visits to inpatient psychiatric hospital patients are restricted to medically necessary authorized (for enrolled providers)/approved (for non-enrolled providers) inpatient hospital days.

H. [Reserved.]

I. Reimbursement shall not be provided for physician services provided to recipients in the inpatient setting whenever the facility is denied reimbursement.

J. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions. The requirements of mandatory outpatient surgery do not apply to recipients in a retroactive eligibility period.

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K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, or leukemia. Transplant services for liver, heart, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as capable of providing high quality care in the performance of the requested transplant. 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 transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse 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 (12 VAC 30-50-540 through 570).

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6. Medical care by other licensed practitioners within the scope of their practice as defined by State Law.

A. Podiatrists' Services.

1. Covered Podiatry services are defined ass reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by State law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity and/or for utilization control.

B. Optometrists' Services.

1. Diagnostic examination and optometric treatment procedures and services by opthamologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all requirements. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' Services

1. Not provided.

D. In accordance with 42 CFR 440.60, licensed or registered practitioners (including an LMHP, LMHP-R, LHMP-RP, or LMHP-S, as defined in Attachment 3.1 A&B, Supplement 1, page 31 and 31.1) may provide medical care or any other type of remedial care or services, other than physician services, within the scope of practice as defined under state law.

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7. Home Health Services.

A. Services must be ordered or prescribed by a physician. Home health services shall be provided in accordance with 42 CFR 440.70 and the guidance found in the Virginia Medicaid Home Health Manual.

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to five visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional services unless authorized by DMAS.

C. Home health aide services provided by a home health agency.

1. Home Health Aides must function under the supervision of a registered nurse.

2. Home Health Aides must meet the certification requirements specified in 42 CFR 484.80.

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§8 Private duty nursing services.

A. Not provided.

§9 Clinic services.

A. Reserved.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;
2. are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and
3. except in the case of nurse-midwife services, as specified in 42 CFR §440.165, are furnished by or under the direction of a physician or dentist.

C. Reimbursement to community mental health clinics for psychotherapy services is provided only when performed by a qualified therapist. For purposes of this section, a qualified therapist is:

1. A licensed physician who has completed three years of post-graduate residency training in psychiatry;

2. An individual licensed or registered by one of the boards administered by the Department of Health Professions to provide psychotherapy services including an LMHP, LMHP-R, LMHP-RP, or LMHP-S, as defined in Attachment 3.1A&B, Supplement 1, pages 31 and 31.1.

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