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

September 15, 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 21-0016**

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 June 21st, 2021.This plan amendment provides updates to 1) increase the rates for psychiatric services by 14.7 percent for psychiatric services to the equivalent of 110 percent of Medicare rates; 2) increase rates for anesthesiologists to reflect the equivalent of 70 percent of the 2019 Medicare rates; and 3) increase supplemental physician payments for a freestanding children's hospital serving children in Planning District 8.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1st, 2021. 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

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: 21-0016

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: 7/1/2021

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 447

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ 1,325,121
b. FFY 2022 $ 5,328,743

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, page 7.1
Attachment 4.19B, Supp 4, pages 1, 2, 3, 4

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

10. SUBJECT OF AMENDMENT
2021 Non-Institutional Provider Reimbursement Changes

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
Karen Kimsey

13. TYPED NAME: Karen Kimsey

14. TITLE: Director

15. DATE SUBMITTED: 6/21/2021

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: June 21, 2021

18. DATE APPROVED: September 15, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL
Todd McMillion

21. TYPED NAME: Todd McMillion

22. TITLE: Director, Division of Reimbursement Review

23. REMARKS

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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OTHER TYPES OF CARE

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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The State Agency Fee Schedule (12 VAC 30-80-190)

A. Reimbursement of fee-for-service providers. Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for- service providers, with the exception of Home Health services (see Supplement 3), and durable medical equipment services (see 12VAC30-80-30), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS). The RBRVS fees shall be the same for both public and private providers. One goal of this methodology is to prevent the total cost of reimbursement for physicians to increase or decrease solely as a result of changes in the Medicare conversion factor.

B. Fee schedule.

1. For those services or procedures which are included in the RBRVS publishedby the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.
   a. Effective for dates of service on or after July 1, 2008, DMAS shall implement site of service differentials and employ both non-facility and facility RVUs. The implementation shall be budget-neutral using the methodology in subsection 2 below.
   b. Effective for dates of service on or after July 1, 2011, DMAS shall use the unadjusted Medicare facility RVU.

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2. 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 inexpenditure 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.

3. 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:

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

(2) Obstetrical/Gynecological Services (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) of this subsection, as defined by the AMA'sannual 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~~2~~e(1) and 3~~2~~e(3) 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 listedin ~~32~~e(1) of this subsection, as defined by the AMA's annual publication of the CPTmanual, 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 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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C. 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. Effective July 1, 2021, the practitioner rates for anesthesiologists shall be increased to reflect the equivalent of 70 percent of the 2019 Medicare rates.

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.