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

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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1. 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 in expenditure 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.

2. 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. Sub-categories are defined according to categorizations provided in the American Medical Association's (AMA's) annual publication of the Current Procedural Terminology (CPT) as:

(1) Emergency Room Services defined as CPT codes 99281, 99282, 99283, 99284, and 99285;

(2) Obstetrical/Gynecological Services (OBGYN) defined as Maternity Care and Delivery procedures, Female Genital System procedures, Obstetrical/Gynecological-related radiological procedures, and mammography procedures;

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(3) Pediatric preventive services defined as Evaluation and Management (E&M) procedures, excluding those listed in 2(d)(1) and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients under age 21;

(4) Pediatric primary services defined as E&M procedures, excluding those listed in subdivisions 2(d)(1), 2(d)(3), and 2(d)(6) of this subsection, 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 listed in 2(d)(1) and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients age 21 and over;

(6) Effective July 1, 2019, psychiatric services in effect at the time the service is provided; and

(7) All other procedures defined as any remaining procedures set through the RBRVS process.

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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A. Effective July 1, 2021, rates for psychiatric services shall be increased by 14.7 percent to the equivalent of 110 percent of Medicare rates.

B. Effective July 1, 2021, the practitioner rates for anesthesiologists shall be increased to reflect the equivalent of 70 percent of the 2019 Medicare rates.

C. Effective July 1, 2022, rates for OBGYN services shall be increased by 15%.

D. Effective July 1, 2022, rates for adult primary and preventive services defined as E&M procedures, excluding those listed in 2(d)(1) and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients age 21 and over shall be increased by 16.1% to reflect the equivalent of 80% of the 2021 Medicare rates.

E. Effective July 1, 2022, rates for pediatric primary services defined as E&M procedures excluding those listed in 2(d)(1), 2(d)(3), and 2(d)(6) of this subsection, in effect at the time the service is provided, for recipients under age 21 shall be increased by 7.9% to reflect the equivalent of 80% of the 2021 Medicare rates.

F. Effective July 1, 2022, rates for children's covered vision care services defined as ophthalmology procedures in effect at the time the service is provided, for recipients under age 21, shall be increased by 30%.

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.