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§1. General. The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in §1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

1. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

2. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

3. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

4. Reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.
a. No payment shall be made for services for the following Never Events: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
b. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
c. Reductions in provider payment may be limited to the extent that the following apply:

   i. The identified provider-preventable conditions would otherwise result in an increase in payment.
   ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

   d. Providers or members may request full payment based on lack of access to services for Medicaid members.
   e. In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

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§2. Services which are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision 2c of subsection D below. The upper limit for reimbursement shall be no higher than payments for Medicare patients in accordance with 42 CFR 447.321. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be noncovered as a component of payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform CMS-approved cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. All cost reports shall be reviewed and reconciled to final costs within 180 days of the receipt of a completed cost report. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

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§2B. Services which are reimbursed on a cost basis

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. For dates of service prior to January 1, 2014, outpatient hospital services including rehabilitation hospital outpatient services and excluding laboratory

a. Definitions. The following words and terms, when used in this regulation, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency room and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with the Code of Virginia, Chapter 10, Title 32.1, §§32.1-323 et seq.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

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"Recent injury" means an injury which has occurred less than 72 hours prior to the emergency room visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency rooms and reimburse for non-emergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in Supplement 1 to Attachment 4.19 B, rendered in emergency rooms which DMAS determines were non-emergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician which may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for (2) above. Services not meeting certain criteria shall be paid under the methodology of (1) above. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilipticus, or other conditions considered life-threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

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(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

§2.D.1. c. Limitation to allowable cost. Effective for services on and after July 1, 2003, reimbursement of hospitals for outpatient services shall be at various percentages of allowable cost, with cost to be determined as provided in §2.A, §2.B, and §2.C on pages 1 and 2 of 15. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date, shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One Hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

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§2.D.1.c. (2) Type Two Hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be at 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be at 77% of allowable cost.

(c) Effective October 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be at 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be at 76% of allowable cost.

§2.D.1. d. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12 VAC 30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

§2.D.2. Rehabilitation agencies operated by state agencies for physical therapy, occupational therapy, and speech-language therapy services. The reimbursement methodology for physical therapy, occupational therapy, and speech-language therapy applicable to other rehabilitation agencies, is based on Attachment 4.19-B, Supplement 5.

a. Allowable cost shall be determined as provided in subsections §2.A and §2.B of page 1 of 15 and §2.C of page 2 of 15 of this section.

b. The following additional procedures shall be followed:

(1) The CMS-approved cost report determined reimbursable costs for physical therapy, occupational therapy, and speech-language pathology service cost centers. General service costs are stepped down to each service cost center (including any non-reimbursable service cost centers). The cost report shall calculate a ratio of cost to charges for each reimbursable service cost center. Cost finding shall be determined according to Medicare principles.

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2.D.2. Rehabilitation agencies operated by state agencies for physical therapy, occupational therapy, and speech-language therapy services. The reimbursement methodology for physical therapy, occupational therapy, and speech-language therapy applicable to other rehabilitation agencies is based on Attachment 4.19-B, Supplement 5.

a. Allocable cost shall be determined as provided in subsections 2.A and 2.B of page 1 and 2C of page 2 of this section.

b. The following additional procedures shall be followed:

(1) The CMS-approved cost report determined reimbursable costs for physical therapy, occupational therapy, and speech-language pathology service cost centers. General service costs are stepped down to each service cost center (including any non-reimbursable service cost centers). The cost report shall calculate a ration of cost to charges for each reimbursable service cost center. Cost finding shall be determined according to Medicare principles.

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(2) All cost reports shall be reviewed and reconciled to final costs within 180 days of the receipt of a completed cost report. DMS shall issue a Notice of Program Reimbursement at the time of the reconciliation that denotes the amount due to or from the provider.

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(3) The provider shall be paid on an interim basis for each claim using the methodology in Attachment 4.19-B, Supplement 5. In addition, on a quarterly basis DMAS shall make an interim lump sum payment based on the difference between estimated costs and interim claim payments in the prior quarter. Estimated costs shall be determined by multiplying the overall ratio of cost to charges from the most recent settled cost report times billed charges.

3. Supplemental payments to state owned hospitals for outpatient services.

a. In addition to payment for services set forth elsewhere in the State Plan,. DMAS makes supplemental payments to qualifying state government owned or operated hospitals for outpatient services furnished to Medicaid members on or after July 1, 2010. To qualify for a supplemental payment, the hospital must be part of a state academic health system or part of an academic health system that operates under a state authority.

b. The amount of the supplemental payment made to each qualifying hospital shall be equal to the difference between the total allowable cost and the amount otherwise actually paid for the services by the Medicaid program based upon cost settlement.

c. Payment for furnished services under this section shall be paid at settlement of the cost report.

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5. Supplemental Outpatient Payments for Non-State Government Owned Hospitals. Effective July 1, 2018, supplemental payments will be issued to qualifying non-state government owned hospitals for outpatient services provided to Medicaid patients.

   a. Qualifying Criteria. Qualifying hospitals are all non-state government owned acute care hospitals.

   b. Reimbursement Methodology. The supplemental payment shall equal outpatient hospital claim payments times the Upper Payment Limit (UPL) gap percentage.

      (1) The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each qualifying hospital between a reasonable estimate of the amount that would be paid under Medicare payment principles for outpatient hospital services provided to Medicaid patients (calculated in accordance with 42 CFR § 447.321) and what Medicaid paid for such services and the denominator is Medicaid claim payments to all qualifying hospitals for outpatient hospital services provided to Medicaid patients in the same year used in the numerator.

      (2) The annual UPL gap percentage will be calculated annually for each hospital using the most recent year for which comprehensive annual data are available and inflated to the state fiscal year for which payments are to be made.

6. Quarterly Payments. After the close of each quarter, beginning with the July 1, 2018, to September 30, 2018 quarter, each qualifying hospital shall receive supplemental payments for the outpatient services paid during the prior quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated by multiplying the Medicaid outpatient hospital payments paid in that quarter by the annual UPL gap percentage for each hospital.

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5. Supplemental Payments for Private Hospital Partners of Type One Hospitals. Quarterly supplemental payments shall be issued to qualifying private hospitals for outpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limits per state fiscal year. These supplemental payments will cease effective for dates of service on or after October 1, 2018.

a. Qualifying criteria. In order to qualify for the supplemental payment, the hospital must be currently enrolled as a Virginia Medicaid provider, and must be owned or operated by a private entity where a Type One hospital has a non-majority interest. Qualifying hospitals and their effective dates are listed below:

1. Culpeper Hospital, effective October 25, 2011;
2. Prince William Hospital, effective February 11, 2017;
3. Haymarket Hospital, effective February 11, 2017.

b. Reimbursement methodology. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than 2 years after the year in which the qualifying hospitals' entitlement arises. The annual supplemental payments in a fiscal year will be the lesser of:

1. The difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the fiscal year; or

2. $1,894 per Medicaid outpatient visit at Culpeper Hospital for state plan rate year 2012, $1,908 per Medicaid outpatient visit for state plan rate year 2017 for Prince William Hospital, and $1,844 per Medicaid outpatient visit for state plan rate year 2017 for Haymarket Hospital. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department);

3. For hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the limit calculated under the Social Security Act § 1923(g) and the hospital's DSH payments for the applicable payment period.

c. Limit. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

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6. Supplemental Outpatient Payments for Private Acute Care Hospitals.

A. Effective October 1, 2018, supplemental payments will be issued to qualifying private hospitals for outpatient services provided to Medicaid patients.

B. Definitions. See definitions in Attachment 4.19-A, page 17.5.

C. Qualifying Criteria. Qualifying hospitals are all in-state private acute care hospitals excluding public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, long-term acute care hospitals and critical access hospitals.

D. Reimbursement Methodology. The supplemental payment shall equal outpatient hospital claim payments times the "UPL gap percentage".

1. The annual UPL gap percentage is the percentage calculated where the numerator is the UPL gap for outpatient services for private hospitals and the denominator is Medicaid claim payments to all qualifying hospitals for outpatient hospital services provided to Medicaid patients in the same year used in the numerator.

2. The annual UPL gap percentage will be calculated annually.

E. Quarterly Payments. After the close of each quarter, beginning with the quarter including the CMS effective date of all necessary state plan amendments authorizing increased payments to qualifying hospitals, each qualifying hospital shall receive supplemental payments for the outpatient services paid during the prior quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated based on the Medicaid outpatient hospital payments paid in that quarter multiplied by the annual UPL gap percentage. Payments will be made quarterly based on applying a uniform per service add on (UPL gap percentage described in the SPA) to outpatient hospital payments in the prior quarter.

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B. Data collection. 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. **[THIS TEXT NEEDS TO COME OUT - should have been removed by SPA 14-012 but was missed]**

5.2. Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). (12 VAC 30-80-25)

A. Consistent with the Benefit Improvement Protection Act (BIPA) of 2000, Section 702, the Department of Medical Assistance Services (DMAS) adopts the Alternative Payment Methodology. This alternative payment methodology continues established reasonable cost reimbursement using Medicare principles of reimbursement. The State shall make interim payments on a per visit basis and shall reconcile to actual costs via the year-end cost report. The methodology used to determine the payment amount is: (1) agreed to by the State and the center or clinic, and (2) results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

1. Newly qualified FQHCs/RHCs adopting the alternative payment methodology after Federal Fiscal Year 2000 will have initial payments established through pro-forma cost reporting methods.

2. At the end of the cost reporting cycle, the State shall compare the alternative per visit rate to the PPS rate and reimburse the center/clinic the higher of the alternative rate or the PPS rate for the number of visits recorded during the reporting period.

B. In the event a FQHC/RHC does not select the Alternative Payment Methodology, the Department of Medical Assistance Services (DMAS) shall provide payment consistent with the new Prospective Payment System (PPS) as prescribed by the BIPA of 2000, Section 702.

1. Baseline PPS Rate Methodology. The PPS baseline payment period (January 1, 2001 – September 30, 2001) rate shall be determined by averaging 100% of the FQHCs/RHCs reasonable costs of providing Medicaid-covered services during the providers' 1999 and 2000 fiscal years, adjusted to take into account any increase or decrease in the scope of services furnished during provider FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Beginning October 1, 2001, and for each fiscal year thereafter, each FQHC/RHC shall be entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled

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under the Benefit Improvement Protection Act (BIPA) of 2000 in the previous fiscal year, adjusted by the percentage change in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC/RHC during its fiscal year.

2. For new FQHCs/RHCs that qualify on or after fiscal year 2000, the DMAS will compare the new clinic/center to other centers/clinics in the same or adjacent areas, as defined by the current U.S. Department of Commerce, Bureau of Economic Analysis, Metropolitan Statistical Area Component County List, issued by the Office of Management and Budget, with similar case loads for purposes of establishing an initial payment rate. If no comparable center/clinic exists, the DMAS will compute a center/clinic specific rate based upon the clinic's pro-forma budget or historical costs adjusted for changes in scope of services. At the end of the first fiscal year, initial payments will be reconciled to equate to 100% of costs. After the initial year, payment shall be increased or decreased using the MEI and adjusted for changes in the scope of services as described above.

C. Supplemental payments. As specified in the BIPA of 2000, Section 702, in the case of services furnished by FQHC/RHC pursuant to a contract between the center and a managed care entity (MCE), provision is hereby made for payment to the center of clinic at least quarterly by the Commonwealth of a supplemental payment equal to the amount (if any) by which the amount determined under A or B above exceeds the mount of the payments provided under such HMO contract.

1. Supplemental Payments for FQHCs/RHCs selecting the alternative 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 MCE(s) and the payments the FQHC/RHC would have received under the alternative methodology. At the end of 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(s) would have yielded under the alternative methodology. If the alternative amount exceeds the total amount of the supplemental and MCE payments, the FQHC/RHC will be paid the difference between the amount calculated using the alternative methodology and actual number of visit, and the total amount of supplemental and MCE payments received by the FQHC/RHC. If the alternative amount is less than the total amount of supplemental and MCE payments, the FQHC/RHC will refund the difference to DMAS between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments are received by the FQHC/RHC.

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2. 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 Attachment 4.19-B, page 1.1 (12VAC30-80-20) for cost-based reimbursed providers.

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REIMBURSEMENT FOR INDIAN HEALTH SERVICE TRIBAL 638 HEALTH FACILITIES

**A. Reimbursement for Tribal Health Clinics**

1. Services provided by or through facilities of the Indian Health Services (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act, also known as Tribal 638 facilities, are paid at the applicable IHS OMB rate published in the annual Federal Register or Federal Register Notices by IHS.

2. The most current published IHS OMB outpatient per visit rate, also known as the outpatient all-inclusive rate, is paid for up to five (5) outpatient visits per beneficiary per calendar day for professional services. An outpatient visit is defined as a face-to-face or telemedicine contact between any health care professional, at or through the IHS facility as described above, authorized to provide services under the State Plan and a beneficiary for the provision of Title XIX defined services, as documented in the beneficiary's medical record.

3. To be included in the outpatient per visit rate are certain pharmaceutical/drugs, dental services, rehabilitative services, behavioral health services, any and all ancillary services, and emergency room services provided on-site and medical supplies incidental to the services provided to the beneficiary.

**B. Payments to Tribal 638 Programs**

Virginia Medicaid reimburses Tribal 638 facilities in accordance with the most recently published Federal Register. Encounters/visits are limited to healthcare professionals as approved under the Virginia Medicaid State Plan. A tribal health program selecting to enroll as a FQHC and agreeing to an alternate payment methodology (APM) will be paid using the APM.

**C. Alternative Payment Methodology for Tribal Facilities Recognized as FQHCs**

1. Outpatient health programs or facilities operated by a Tribe or Tribal organization that choose to be recognized as FQHCs in accordance with Section 1905 (I)(2)(B) of the Social Security Act and the Indian Self-Determination Act (Public Law 93-638) will be paid using an alternative payment methodology (APM) for services, that is the published, all-inclusive rate (AIR). The APM/AIR rate is paid for up to five face-to-face encounters/visits per recipient per day.

2. Virginia Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal facility so that the Agency can determine on an annual basis that the published, all-inclusive rate results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate. The PPS rate will be established by reference to the current rate applicable to one or more non-tribal FQHCs in the same or adjacent areas with similar caseloads. If such a non-tribal FQHC is not available, the PPS rate will be established by reference to the current rate applicable to

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one or more non-tribal FQHCs in the same or adjacent areas with a similar scope of services. If there is no non-tribal FQHC in the same or adjacent area with similar caseloads or similar scope of services, the PPS rate will be based on an average rate of non-tribal FQHCs throughout the state. The Tribal facility would not be required to report its costs for the purposes of establishing a PPS rate. The APM is effective for services provided on and after February 24, 2021.

3. The individual FQHC must agree to receive the APM.

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§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 :

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).

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6.A. 2. Dentists' services: Dental services, dental provider qualifications and dental service limits are identified in Attachment 3.l A&B, Supplement 1, page 16.1 and 16.1.1. Dental services are paid based on procedure codes which are listed in the Agency' fee schedule rate, effective January 1, 2024. All rates are published on the DMAS website at www.dmas.virginia.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

Dentures. Coverage and service limits for dentures are identified in Attachment 3.lA&B, Supplement 1, page 26.1. Dental services are paid based on procedure codes which are listed in the Agency' fee schedule rate, effective January 1, 2024. All rates are published on the DMAS website at www.dmas.virginia.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

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6.A. 3. Mental health services

a. Professional services furnished by non-physicians, as described in 3.1A&B, Supplement 1, page 7 and page 11. These services are reimbursed using CPT codes. The agency's fee schedule rate is based on the methodology described in Attachment 4-19B, page 4.11, section 6
(A) 1.

(i) Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists in Attachment 4-19B, page 4.11, section 6 (A) 1.

(ii) 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.

b. Intensive In-Home, as defined per Supplement 1 to Attachment 3.1A&B, Supplement 1, page 6.0.2, and provided by the individuals who are listed in Attachment 3.1A&B, Supplement 1, page 6.0.3 and defined in Attachment 3.1A&B, Supplement 1, page 6.0.1, is reimbursed on an hourly unit of service. The Agency's rates were set as of January 1, 2024, and are effective for services on or after that date.

c. Therapeutic Day Treatment, as defined per Supplement 1 to Attachment 3.1A&B, page 6.0.4, and provided by the individuals who are listed in Attachment 3.1A&B, Supplement 1, page 6.1 and defined in Attachment 3.1A&B, Supplement 1, page 6.0.1,is reimbursed based on the following units of service: One unit = 2 to 2.99 hours; Two units = 3 to 4.99 hours; Three units = 5 plus hours. No room and board is included in the rates for therapeutic day treatment. The Agency's rates were set as of January 1, 2024, and are effective for services on or after that date.

d. Therapeutic Group Home services (formerly called Level A and Level B group home services), as defined per Supplement 1 to Attachment 3.1A&B, page 6.2, shall be reimbursed based on a daily unit of service. No room and board is included in the rates for therapeutic group home services. The Agency's rates were set as of July 1, 2022, and are effective for services on or after that date.

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d-1. Mental Health Intensive Outpatient services are reimbursed based on a per-diem unit that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of January 1, 2024, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-2. Residential Crisis Stabilization is reimbursed based on a per-diem unit. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of January 1, 2024 and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for- providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-3. 23-Hour Residential Crisis Stabilization is a form of Residential Crisis Stabilization that is provided as a 23-hour service and is reimbursed on a per-diem unit. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of January 1, 2024 and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-4. Multisystemic Therapy is reimbursed based on a 15-minute unit of service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of January 1, 2024, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for- providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

d-5. Functional Family Therapy is reimbursed based on a 15-minute unit of service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of January 1, 2024, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for- providers/procedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

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e. Mental Health Partial Hospitalization Program services are reimbursed based on a per diem unit that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The rate for this service does not include costs related to room and board or other unallowable facility costs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of January 1, 2024, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee- files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

f. Psychosocial Rehabilitation is reimbursed based on the following units of service: One unit = 2 to 3.99 hours per day; Two units = 4 to 6.99 hours per day; Three units = 7 + hours per day. The rates account for the wages, employee costs, and other allowable costs associated with providing this service. The Agency's rates were set as of January 1, 2024, and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files- cpt-codes/ - go to the header for HCPC Codes and look for this service.

g. Mobile Crisis Response is reimbursed based on a 15-minute unit of service. The rates account for the wages, employee costs, and other allowable costs associated with providing this service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of January 1, 2024, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for- providers/procedure- fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

h. Assertive Community Treatment is reimbursed on a daily unit of service that accounts for the wages, employee costs, and other allowable costs associated with providing this service. The Agency's rates were set as of January 1, 2024, and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt- codes/ - go to the header for HCPC Codes and look for this service.

i. Community Stabilization is reimbursed on a 15 minute unit of service that accounts for the wages, employee costs, and other allowable costs associated with providing this service. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of January 1, 2024, and is effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for- providers/procedure-fee-files- cpt-codes/ - go to the header for HCPC Codes and look for this service.

j. Independent Living and Recovery Services (previously called Mental Health Skill-Building Services) are reimbursed based on the following units of service: One unit is 1 to 2.99 hours per day, two units is 3 to 4.99 hours per day. The rates account for the wages, employee costs, and other allowable costs associated with providing this service The Agency's rates were set as of January 1, 2024 and are effective for services on or after that date. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/pr ocedure-fee-files-cpt-codes/ - go to the header for HCPC Codes and look for this service.

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Methods and Standards for Establishing Payment Rates: Other Types of Care

Section 6 A (3), continued

Reimbursement for outpatient substance use disorder services: Other Provides, including Licensed Mental Health Professionals (LMHP) (42 CFR 447, Subpart F)

(k) Outpatient substance use disorder services furnished by physicians or other licensed practitioners as described in Attachment 3.1 A&B, Supp 1, page 10.1 for assessment and evaluation or treatment of substance use disorders as defined per Attachment 3.1 A&B, Supp 1, page 49 shall be reimbursed using the methodology described in section 6(A)(Fee-for-Service Providers) of Attachment 4.19-B, page 4.8 and page 6 and in Supplement 4 to Attachment 4.19-B subject to the following reductions for psychotherapy services for other licensed practitioners. The same rates shall be paid to governmental and private providers. These services are reimbursed based on Current Procedural Terminology codes and Healthcare Common Procedure Coding System codes. The agency's rates were set as of April 1, 2017, and are updated as described in Supplement 4 to Attachment 4.19-B. All rates are published on the DMAS website: https://www.dmas.virginia.gov/#/searchcptcodes

(i) Services of a licensed clinical psychologist shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

(ii) Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed psychiatric nurse practitioners, licensed substance abuse treatment practitioners, or registered clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

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Methods and Standards for Establishing Payment Rates: Other Types of Care

Section 6 A (3), continued.
Reimbursement for substance use disorder services:

(l) Rates for the following addiction and recovery treatment physician and freestanding clinic services shall be basedon the Agency fee schedule: OTP and OBAT, which are described in Attachment 3.1A&B, Supplement 1, pages 45-49. OTP and OBAT services may be provided by physicians, other licensed practitioners, or in clinics, and shall use the following methodologies. For all of the these services, the same rates shall be paid to governmental and private providers. All rates are published on the DMAS website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/

- the induction of medication for alcohol use disorder (AUD) which is reimbursed per encounter; rate set as of April 1,2017
- Substance Use Care Coordination, which is reimbursed based on a monthly unit, rate set as of April 1, 2017
- Medication Administration, which is reimbursed per daily medication dose, rate set as of April 1, 2017
- Substance Use Disorder Counseling and Psychotherapy, which is reimbursed based on a 15-minute unit, rate set as of April 1, 2017
- Telehealth originating site facility fee, which is reimbursed per visit, rate set as of January 1, 2002

(li) The following services are reimbursed based on CPT codes, with the rates set on various dates: Physician/Nurse Practitioner Evaluation and management visits (rate set 7/1/16); Alcohol Breathalyzer (rate set 7/1/14); Presumptive drug class screening, any drug class (rate set 4.1.17); Definitive drug classes (rate set 4/1/17); RPR Test (rate set 7/1/14); Hepatitis B and C / HIV Tests (rate set 7/1/14); Pregnancy Test (rate set 7/1/14); TB Test (rate set 7/1/16); EKG (rate set 7/1/17).
The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency and quality of care.

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Section 6 A (3), continued.

(m) Community ARTS rehabilitation services. Per diem rates for partial hospitalization (ASAM Level 2.5) described in Attachment 3.IA&B, Supplement 1, page 52, and intensive outpatient (ASAM Level 2.1) described in Attachment 3.1 A&B, Supplement 1, page 50 for ARTS shall be based on the agency fee schedule. No room and board is included in the rates for partial hospitalization. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at www.dmas.virginia.gov.

(n) ARTS federally qualified health center or rural health clinic services (ASAM Level 1.0) described in Attachment 3.1 A&B, Supplement 1, page 49, for assessment and evaluation of treatment of substance use disorder shall be reimbursed using the methodology described in 4.19-B, page 4.6 (12VAC30-80-25).

(o) Substance use case management services. Substance use case management services, as described in Attachment 3.1 A&B, Supplement 2, page 40 (12 VAC 30-50-491) shall be reimbursed at a monthly rate based on the agency fee schedule. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payment shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at www.dmas.virginia.gov

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Section 6 A (3), continued.

(p) Peer Support Services and Family Support Partners, as defined per Supplement 1 to Attachment 3.1A&B, pages 54 through 59, and furnished by enrolled providers or provider agencies, shall be reimbursed based on the agency fee schedule for 15-minute units of service. The agency's rates were set as of January 1, 2024, and are effective for services on or after that date. All rates are published on the DMAS website at: www.dmas.virginia.gov. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (ex. case management for persons with chronic mental illness).

(i) Peer Support Services and Family Support Partners shall not be reimbursed if the services operate in the same building as other day services unless (i) there is a distinct separation between services in staffing, program description, and physical space and (ii) Peer Support Services or Family Support Partners do not impede, interrupt, or interfere with the provision of the primary service.

(ii) Family Support Partners services shall not be reimbursed for an individual who resides in a congregate setting in which the caregivers are paid (such as child caring institutions, or any other living environment that is not comprised of more permanent caregivers) unless (i) the individual is actively preparing for transition back to a single-family unit, (ii) the caregiver is present during the intervention, (iii) the service is directed to supporting the unification/reunification of the individual and his/her caregiver and (iv) the service takes place in that home and community.

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§6 A Fee for service providers.
4. Podiatry
5. Nurse-midwife services
6. Durable medical equipment (DME).

Definitions. The following words and terms, when used in this part, shall have the following meanings unless the context clearly indicates otherwise:

"DMERC" means the Durable Medical Equipment Regional Carrier rate as published by Medicare at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/.

"HCPCS" means the Healthcare Common Procedure Coding System as published by Ingenix (copyright 2006), as may be periodically updated.

a. Reimbursement method.

(1) Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of durable medical equipment. The agency's fee schedule rate was set as of July 1, 2010, and is effective for services provided on or after that date.

(2) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10% or the average of the Medicare competitive bid rates for all providers in Virginia markets. For dates of service on or after July 1, 2014, DME items subject to the Medicare competitive bidding program shall be reimbursed the lower of the current DMERC rate minus 10% or the average of the Medicare competitive bid rates in Virginia markets.

(3) For DME items with no DMERC rate, the agency shall use the fee schedule amount. The reimbursement rates for durable medical equipment and supplies shall be listed in the appropriate agency guidance document. The fee schedule is available on the agency website at www.dmas.virginia.gov.

(4) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the net manufacturer's charge to the provider, less shipping and handling, plus 30%.

b. Subject to CMS' approval, DMAS shall have the authority to amend the DME fee schedule as it deems appropriate and with notice to providers. DMAS shall determine alternate pricing, based on agency research, for any code which does not have a DMERC rate.

c. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be under specified procedure codes and reimbursed as determined by the agency.

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(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12 VAC 30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

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§6 A Fee for service providers. Durable Medical Equipment (continued)

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, and suction machines. Ventilators, non-continuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services, including services paid to local school districts
8. Laboratory services (Other than inpatient hospital) The agency's rates for clinical laboratory services were set as of July 1, 2014, and are effective for services on or after that date.
9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)
10. X-Ray services.
11. Optometry services
12. Reserved.
13. Home health services: Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3. (12 VAC30-80-180)
14. Physical therapy, occupational therapy, and speech, hearing, language disorders services when rendered to non-institutionalized recipients. Physical therapy, occupational therapy, and speech-language therapy services furnished by state rehabilitation agencies are paid on a cost basis (see sec. 2D, page 4.1). All other services under this section furnished by rehabilitation agencies are paid rates established by Supplement 5.
15. Clinic services, as defined under 42 CFR 440.90, except for services in amblulatory surgery clinics reimbursed under Attachment 4.19-B, page 7.2 (12 VAC 30-80-35).
16. Supplemental payments to state government-owned or operated clinics.
*(Repealed effective July 1, 2005)*

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16.1 Reimbursement for personal care services for individuals enrolled in the Medicaid Buy-In program described in Attachment 2.6A, Supplement 8a, p 1-3 or for personal care services covered under EPSDT. All governmental and private providers are reimbursed according to the same published fee schedule. All rates are published on the DMAS website at www.dmas.virginia.gov. The Agency's rates, based upon one-hour increments, were set as of January 1, 2024, and shall be effective for 1902(a) state plan authorized services on and after that date. Qualifying overtime for consumer-directed personal care provided under EPSDT will be paid 150% of the fee schedule, and qualifying sick leave for consumer – directed personal care provided under EPSDT will be at 100% of the fee schedule.

16.1.a. Reimbursement for consumer-directed services facilitator services under EPSDT as described per Supplement 1 to Attachment 3.1A&B, pages 6.4.7 & 6.4.8. All governmental and private providers are reimbursed according to the same published fee schedule, located on the DMAS website at www.dmas.virginia.gov. The Agency's rates were set as of July 1, 2022, and shall be effective for services provided on and after that date.

16.2. Private duty nursing services covered under EPSDT as defined per Supplement 1 to Attachment 3.1A&B, page 6.4.8, with provider qualifications on page 6.4.8, are reimbursed based on a 15-minute unit of service in accordance with the State Agency fee schedule. The fee schedule is the same for both governmental and private providers and was set as of July 1, 2022 and shall be effective for services provided on and after that date. The state agency fee schedule is published on the DMAS website at www.dmas.virginia.gov.

16.3 Medical Supplies, Equipment and Appliances (assistive technology) covered under EPSDT, as defined per Supplement 1 to Attachment 3.1 A&B, page 6.4.9, with provider qualifications on page 6.4.10. The service shall be reimbursed based upon the total cost of all AT incurred by the provider.

16.4 Reserved.

16.5 Hospice services, as defined per Attachment 3.1 A&B, Supplement 1, pages 33-37. Hospice services payments are effective October 1 annually and are equivalent to the annual Medicaid hospice rates published by CMS. As of July 1, 2019, room and board will be reimbursed at a rate equal to 100 percent of the skilled nursing facility rate for Medicaid members receiving hospice services who reside in a nursing facility. Hospice services shall be paid according to the location of the service delivery and not the location of the Agency's home office. Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to Medicaid members. During the twelve (12) month period beginning October 1 of each year and ending September 30 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid members during the same period.

Services that are included in the hospice reimbursement are: (a) Routine Home Care where most hospice care is provided - Days 1- 60; (b) Routine Home Care where most hospice care is provided-Days 61 and over; (c) Continuous Home Care; (d) Hospice Inpatient Respite Care; (e) Hospice General Inpatient Care; (f) Service Intensity Add-On (SIA) will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member' s life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.

16.3.1 Effective July 1, 2019, the telehealth originating site facility fee shall be set at 100 percent of the Medicare rate and shall reflect changes annually based on any changes in the Medicare rate.

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16.6. Applied Behavior Analysis Services are reimbursed based on a 15-minute unit of service. The agency's rates were set as of July 1, 2022 and are effective for services on or after that date. All governmental and private providers are reimbursed according to the same published fee schedule, located on the agency's website at the following address: https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/ - go to the header "Search CPT Codes."

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Doula Services

Doula services may be reimbursed from the date of confirmed conception through 180 days (six months) after delivery, contingent on the client maintaining Medicaid eligibility. Virginia will reimburse up to 8 prenatal/postpartum visits and attendance at birth. Any service limits may be exceeded based upon medical necessity. Service authorization is required if more than eight prenatal/postpartum visits are required, and if services are required more than six months after delivery.

Each prenatal/postpartum service visit shall be billed and reimbursed separately. A unit of service is 15 minutes. An initial prenatal visit has a maximum unit capacity of six (6) units to account for assessment while all other visits have a maximum capacity of four (4) units.

During the postpartum period, an additional value-based incentive payment will be made if the Doula performs at least one (1) postpartum service visit and the client is seen by an obstetric clinician for one (1) postpartum visit after a labor and delivery claim. A second additional value-based incentive payment will be made if the Doula performs at least one (1) postpartum service visit (this may be the same postpartum visit used for the first value-based payment) and the newborn is seen by a pediatric clinician for one (1) visit after a labor and delivery claim.

The Agency's fee schedule rates for doula services are set as of January 1, 2022, and are effective for services on or after that date. The rates are the same for both governmental and private providers. All rates are published on the State's website at https://www.dmas.virginia.gov/for-providers/general-information/procedure-fee-files-cpt-codes/.

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§ 6 d Other Practitioners Services

Vaccines administered by pharmacies (pharmacists, pharmacy interns, or pharmacy technicians) shall be reimbursed at the cost of the vaccine plus an administration fee not to exceed $16. Vaccines obtained at no cost to the pharmacy shall be reimbursed for the administration fee only. No dispensing fee will be reimbursed.

Services administered by pharmacists, and pharmacy interns and pharmacy technicians supervised by pharmacists, as defined on page 10 of Supplement 1 to Attachment 3.1-A&B are paid based on codes which are listed in the Agency's fee schedule rate. All rates are published on the agency's website at https://www.dmas.virginia.gov/for-providers/procedure-fee-files-cpt-codes/. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

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17. Supplemental payments for services provided by Type One physicians.

a. A Type One physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, which has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. The methodology for determining the Medicare Equivalent of the Average commercial Rate is described in Supplement 6 to Attachment 4.19-B.

c. Supplemental payments shall be made quarterly, no later than 90 days after the end of the quarter.

d. Effective April 1, 2023, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 238% of Medicare rates.

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

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

1. 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.

2. Effective July 1, 2023, 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 191% 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.

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18. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere, DMAS provides supplemental payments to qualifying nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. 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. . Effective July 1, 2005, a qualifying clinic is a clinic operated by a Community Services Board.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 18 d and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 18 b (1) for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision (2) of this subdivision 18 b by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section will be made annually in a lump sum during the last quarter of the fiscal year.

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18.5. Supplemental payments for services provided by physicians affiliated with Eastern Virginia Medical Center Physicians.

a. In addition to payment for physician services specified elsewhere in the State Plan, DMAS provides supplemental payments to physicians affiliated with Eastern Virginia Medical Center Physicians. A physician affiliated with Eastern Virginia Medical Center Physicians is a physician who is employed by a publicly- funded medical school that is a political subdivision of the Commonwealth of Virginia, who provides clinical services through the faculty practice plan affiliated with the publicly funded medical school, and has entered into contractual arrangements for the assignment of payment in accordance with 42 CFR 447.10.

b. Effective July 1, 2022, the supplemental payment amount shall be the difference between the average commercial rate (ACR) approved by CMS and the payments otherwise made to physicians. The methodology for determining the Medicare Equivalent of the Average Commercial Rate is described in, Supplement 6, Attachment 4.19-B.

c. Supplemental payments shall be made quarterly, no later than 90 days after the end of the quarter.

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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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18.2 Supplemental payments for services provided by physicians at general acute care non-state government owned hospitals.

a. In addition to payments for physician services specified elsewhere in the State Plan, DMAS shall make supplemental payments for general acute care non-state government owned hospitals. This applies to physician practices employed by or under contract with general acute care non-state government owned hospitals.

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

a. Effective for dates of service on or after July l, 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 ;i 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.

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12 VAC 30-80-35. Fee for service: Ambulatory surgery centers.

A. Definitions: The following words and terms when used in this part shall have the following meaning unless the context clearly indicates otherwise:

"Ambulatory Patient Group (APG)" means a defined group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Disease (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

"APG relative weight" means the relative expected average costs for each APG divided by the relative expected average costs for visits assigned to all APGs.

B. Effective April 5, 2010, the prospective Ambulatory Patient Group (APG)-based payment system described as follows shall apply to Ambulatory Surgery Center (ASC) services:

1. The operating payments for ASC visits shall be determined on the basis of a base rate per visit times the relative weight of the APG to which the visit is assigned.

2. The APG relative weights shall be the weights determined and published periodically by DMAS. The weights shall be updated at least every three years. These values are listed on the DMAS website at the following internet address:

http://www.dmas.virginia.gov/pr-rate_setting.htm

3. The base rate shall be adjusted by the budget neutrality factor (BNF) to ensure that no increase in expenditures occurs as a result of updates to the relative weights. The base period used to adjust the base rate shall be a recent 12-month period prior to the fiscal year that the new base rates will be effective.

4. The operating payment shall represent total allowable amount for a visit including ancillary services.

5. The agency's rates and weights were set as of April 5, 2010 and are effective for services on or after that date subject to provisions in subsections B2 and B3. All rates and weights are published on the agency's website at the web address above. Except as otherwise noted in the plan, state developed ASC fee schedule rates and weights are the same for both governmental and private providers.

C. The Ambulatory Patient Group (APG) grouper used in the ASC payment system for ASCs shall be determined by DMAS. Providers or provider representatives shall be given notice prior to implementing a new grouper.

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Fee for Service Outpatient Hospitals (12 VAC 30-80-36). Enhanced Ambulatory Patient Group Methodology (EAPG)

A. Definitions. The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise:

"Enhanced Ambulatory Patient Group (EAPG)" means a defined group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Disease (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

"EAPG relative weight" means the expected average costs for each EAPG divided by the relative expected average costs for visits assigned to all EAPGs.

"Base year" means the state fiscal year for which data is used to establish the EAPG base rate. The base year will change when the EAPG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Cost" means the reported cost as defined in subsections §2.A and §2.B of page 1.1 of 15 and §2.C of page 2 of 15 of this section.

"Medicare wage index" is published annually in the Federal Register by the Centers for Medicare and Medicaid Services. The indices used in this section shall be those in effect in the base year.

"Cost-to-charge ratio" equals the hospital's total costs divided by the hospital's total charges. The cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

B. Effective January 1, 2014, the prospective Enhanced Ambulatory Patient Group (EAPG) based payment system described as follows shall apply to reimbursement for outpatient hospital services with the exception of laboratory services referred to the hospital but not associated with an outpatient hospital visit, which will be reimbursed according to the laboratory fee schedule:

1. The payments for outpatient hospital visits shall be determined on the basis of a hospital-specific base rate per visit times the relative weights of the EAPGs (and the payment action) assigned for each of the services performed during a hospital visit.

2. The EAPG relative weights shall be the weights determined and published periodically by DMAS and shall be consistent with applicable Medicaid reimbursement limits and policies. The weights shall be updated at least every three years. Except as otherwise noted in the plan, the state-developed weights are the same for both governmental and private providers of outpatient hospital services. The agency's weights were set as of January 1, 2014 and are effective for services provided on or after that date. All rates are published at http://www.dmas.virginia.gov/Content pgs/pr-eapg.aspx.

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3. The statewide base rate shall be equal to the total costs described below divided by the wage- adjusted sum of the EAPG weights for each facility. The wage-adjusted sum of the EAPG weights shall equal the sum of the EAPG weights times the labor percentage times the hospital's Medicare wage index plus the sum of the EAPG weights times the non-labor percentage. The base rate shall be determined for outpatient hospital services at least every three years so that total expenditures will equal the following:

a) When using base years prior to January 1, 2014, for all services, excluding all laboratory services and emergency services described in subdivision 3 c of this subsection, a percentage of costs defined in subsection A as reported in the available cost reports for the base period for each type of hospital as defined in Attachment 4.19-A, Methods and Standards for Establishing Payment Rates-Hospital Services, DRG-Payment Methodology.

(i) Type One Hospitals: Effective January 1, 2014, hospital outpatient operating reimbursement shall be calculated at 90.2 percent of cost and capital reimbursement shall be at 86 percent of cost inflated to the rate year.

(ii) Type Two Hospitals: Effective January 1, 2014, hospital outpatient operating and capital reimbursement shall be calculated at 76 percent of cost inflated to the rate year.

(iii) When using base years after January 1, 2014, the percentages described in subdivision 3 of this subsection shall be adjusted according to subdivision 3 c to 69.8% for Type Two hospitals.

(iv) For critical access hospitals, the operating rate shall be increased by using an adjustment factor or percent of cost reimbursement equal to 100% of cost, effective July 1, 2019.

b) Laboratory services (excluding laboratory services referred to the hospital but not associated with a hospital visit) calculated at the fee schedule in effect for the rate year. Laboratory services are reimbursed based on CPT codes listed in the fee schedules that are published on the DMAS website at the following web address: https://www.dmas.virginia.gov/for-providers/general-information/procedure-fee-files-cpt-codes/

c) Services rendered in emergency departments determined to be non-emergencies as prescribed in Attachment 4.19-B, section 2 D shall be calculated for base years after January 1, 2014 as the cost percentages in subdivision 3(a) of this subsection, adjusted to reflect services paid at the non-emergency reduced rate in the last base year prior to January 1, 2014.

4. Inflation adjustment to base year costs. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with DMAS, shall be used to update the base year costs to the midpoint of the rate year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Corrections made by Global Insight (or its successor), in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year. Inflation shall be applied to the costs identified in subdivision 3(a) of this subsection.

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a. The inflation adjustment for state fiscal year 2017 shall be 50% of the full inflation adjustment calculated according to this section with the exception of 100% of inflation to the Children's Hospital of King's Daughters. There shall be no inflation adjustment for state fiscal year 2018 with the exception of 100% of inflation to the Children's Hospital of King's Daughters.

5. Hospital-specific base rate. The hospital-specific base rate per case shall be adjusted for geographic variation. The hospital-specific base rate shall be equal to the labor portion of the statewide base rate times the hospital's Medicare wage index plus the nonlabor percentage of the statewide base rate. The labor percentage shall be determined at each rebasing based on the most recent reliable data. For rural hospitals, the hospital's Medicare wage index used to calculate the base rate shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher. A base rate differential of 5 percent shall be established for freestanding Type Two children's hospitals. The base rate for non cost-reporting hospital shall be the average of the hospital-specific base rates of instate Type Two hospitals.

6. The total payment shall represent the total allowable amount for a visit including ancillary services and capital.

7. The transition from cost-based reimbursement to EAPG reimbursement shall be transitioned over a three and half-year period. DMAS shall calculate a cost-based base rate at January 1, 2014, and at each rebasing during the transition.

(a) Effective for dates of service on or after January 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 75 percent of the cost-based base rate and 25 percent of the EAPG base rate.
b) Effective for dates of service on or after July 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 50 percent of the cost-based base rate and 50 percent of the EAPG base rate.
c) Effective for dates of service on or after July 1, 2015, DMAS shall calculate the hospital-specific base rate as the sum of25 percent of the cost-based base rate and 75 percent of the EAPG base rate.
d) Effective for dates of service on or after July 1, 2016, DMAS shall calculate the hospital-specific base rate as the EAPG base rate.

8. To maintain budget neutrality during the first six years, DMAS shall compare the total reimbursement of hospitals claims based on the parameters in subdivision 3 of this subsection to EAPG reimbursement every six months based on the six months of claims ending three months prior to the potential adjustment. If the percentage difference between the reimbursement target in subdivision 3 of this subsection and EAPG reimbursement is greater than 1 percent, plus or minus, DMAS shall adjust the statewide base rate by the percentage difference the following July I or January 1, The first possible adjustment would be January 1, 2015, using reimbursement between January 1,2014, and October 31, 2014.

C. The Enhanced Ambulatory Patient Group (EAPG) grouper version used for outpatient hospital services shall be determined by DMAS. Providers or provider representatives shall be given notice prior to implementing a new grouper. Except as otherwise noted in the plan, the state-approved EAPG grouper version is the same for both governmental and private providers of outpatient hospital services. The EAPG grouper version was set as of January 1, 2014 and is effective for services provided on or after that date. The grouper version is published at http://www.dmas,virginia.gov/Content pgs/pr-eapg.aspx.

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D. The primary data sources used in the development of the EAPG payment methodology are the DMAS' hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals. The following table identifies key data elements that are used to develop the EAPG payment methodology. DMAS may supplement this data with similar data for Medicaid services furnished by managed care organizations if DMAS determines that it is reliable.

| Data Elements for EAPG Payment Methodology | |
|---|---|
| Data Elements | Source |
| Total charges for each outpatient hospital visit | Claims history file |
| Number of groupable claims lines in each EAPG | Claims history file |
| Total number of groupable claim lines | Claims history file |
| Total charges for each outpatient hospital revenue line | Claims history file |
| Total number of EAPG assignments | Claims history file |
| Cost-to-charge ratio for each hospital | Cost report file |
| Medicare wage index for each hospital | Federal Register |

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§7. Fee-for-service providers: pharmacy. (12VAC30-80-40)

1. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug incredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;

b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;

c) The Federal Uppler Limit (FUL); OR

d) The provider's usual and customary (U&C) charge to the public as identified by the claim charge.

2. Payment for specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursment shall be the lowest of:

a) The National Average Drug Acqusition Cost (NADAC) of the drug;

b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;

c) The Federal Upper Limit (FUL); OR

d) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

3. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acqusition Cost (NADAC) of the drug;

b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;

c) The Federal Upper Limit (FUL); OR

d) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

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4. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;

b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%; OR

c) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

5. 340B covered entities and Federally Qualified Health Centers (FQHCs) that fill Medicaid member prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee. 340B covered entities that fill Medicaid member prescriptions with drugs not purchased under the Section 340B of the Public Health Services Act will be reimbursed in accordance to section 7.1 plus the $10.65 professional dispensing fee as described in section 7.8.

6.Facilities purchasing drugs through the Federal Supply scheduled (FSS) or drug pricing program under 39 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee.

7. Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee. Nominal Price as defined in § 447.502 of the Code of Federal Regulations, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

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8. Payment for pharmacy services will be as described above in sections 7.1 - 7.7; however, shall include the allowed cost of the drug plus only one professional dispensing fee, as defined at 42 CFR § 447.502, per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The professional dispensing fee for all covered outpatient drugs shall be $10.65. The professional dispensing fee shall be determined by a cost of dispensing survey conducted at least every five years.

9. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106 percent of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at the provider's acquisition cost. Covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (AAC).

10. Payment to Indian Health Service, tribal and urban Indian pharmacies. DMAS does not have any Indian Health Service, tribal or urban Indian pharmacies at this time. Payment for pharmacy services will be defined in a state plan amendment if such entity enrolls with DMAS.

11. Investigational drugs are not a covered service under the DMAS pharmacy program.

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9. Home infusion therapy.

a. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accompanied by use of the CMS 1500 claim form.

b. The cost of the active ingredient or ingredients for chemotherapy, pain management and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement rate for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

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10. Supplemental rebate agreement. The Commonwealth complies with the requirements in § 1927 of the *Social Security Act* and 42 CFR 447.500 et seq. with regard to supplemental drug rebates. In addition, the following requirements are met:

a. The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for legend drugs provided to Medicaid recipients, entitled Virginia Supplemental Drug Rebate Agreement Contract and Addendum A, have been authorized by CMS on to be effective April 1, 2012. All amendments to the Supplemental Drug Rebate Agreement Contract shall also be authorized by CMS.

b. Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

c. Prior authorization requirements found in § 1927(d)(5) of the *Social Security Act* have been met.

d. Non-preferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Non-preferred drugs will be made available to Medicaid beneficiaries through prior authorization.

e. Payment of supplemental rebates may result in a product's inclusion on the PDL.

11. Each drug administered in an outpatient hospital setting and reimbursed based on the Enhanced Ambulatory Patient Group methodology as described in Attachment 4.19-B, section 2.5 Enhanced Ambulatory Patient Group (12 VAC 30-80-36) shall be reimbursed separately at a rate greater than zero to be eligible for drug rebate claiming.

End of Pharmacy Reimbursement Methodology

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11. All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients including those measures specified under 42 USC 1396a(a)(25). (12 VAC 30-80-50)

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E. The single state agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care and services, or on a fee-for-service plus cost of materials. (12VAC 30-80-60)

F. Payment for transportation services shall be according to the following table: (12 VAC 30-80-70)

| TYPE OF SERVICE | PAYMENT METHODOLOGY |
|---|---|
| Taxi services | Rate set by the single state agency |
| Wheelchair van | Rate set by the single state agency |
| Non-emergency ambulance | Rate set by the single state agency |
| Emergency ambulance | Rate set by the single state agency |
| Volunteer Drivers | Rate set by the single state agency |
| Air ambulance | Rate set by the single state agency |
| Mass transit | Rate charged to the public |
| Transportation agreements | Rate set by the single state agency |
| Special emergency transportation | Rate set by the single state agency |

G. Payments for Medicare coinsurance and deductibles for noninstitutional services shall not exceed the allowed charges determined by Medicare in accordance with 42 CFR 447.304(b) less the portion paid by Medicare, other third party payors, and recipient copayment requirements of this Plan. See Supplement 2 for this methodology.

H. Payment for eyeglasses shall be the actual cost of the frames and lenses not to exceed limits set by the single state agency, plus a dispensing fee not to exceed limits set by the single state agency.

I. Expanded prenatal care services to include patient education, homemaker, and nutritional services shall be reimbursed at the lowest of: State Agency fee schedule, Actual Charge, or Medicare (Title XVIII) allowances.

J. Targeted case management for high-risk pregnant women and infants up to age 2 and for community mental health and mental retardation services shall be reimbursed at the lowest of: State Agency fee schedule, Actual Charge, or Medicare (Title **XVIII)** allowances.

12 VAC 30-80-111.

K. Foster Care (FC) Case Management. The Medicaid agency will reimburse providers for the covered services for FC case management for each eligible child at the daily rate agreed upon between the local Community Policy and Management Team (CPMT) in the locality which is responsible for the child's care and the FC case management provider. This daily rate shall be based upon the intensity of the case management needed by the child and be subject to an upper limit set by the Medicaid agency. DMAS shall pay the lesser of the rate negotiated by the CPMT or the maximum rate established by the Department.

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12VAC 30-80-75. Local Education Agency (LEA) providers.
A. Effective for services on or after July 1, 2006, the following methodology will determine the reimbursement for Local Education Agency (LEA) providers.

The methodology described below applies to reimbursement for the following services delivered by LEA providers. These services are described in Supplement 1 to Attachment 3.1 A&B (12VAC 30-50-135) of the Virginia Medicaid State Plan.

Speech therapy;
Audiology and hearing services;
Physician services for Medical Evaluation Services;
Occupational therapy;
Physical therapy;
Psychiatric and psychological services;
Personal care services;
Skilled nursing services; and
Special transportation.

1. Medical services provided by LEA providers for special education students. The following methodology will determine the reimbursement for LEA providers.

a. For each of the IDEA-related school based medical services covered under the State Plan other than special transportation services, the LEA provider's cost of providing the services will be certified and the Federal Financial Participation (FFP) will be paid to LEA providers based on the methodology described in the steps below. For the rate year ending June 30, 2007, cost will be reported on a cash basis; for all succeeding years cost will be reported on an accrual basis. All costs to be certified and used subsequently to determine reconciliation and final settlement amounts as well as interim rates are identified on the CMS approved Medical Services Cost Report. Final payment for each school year is based on actual costs as determined by desk review and/or audit for each LEA provider.

b. Step 1: Develop the Personnel Cost Base for Medical Services/
total salaries and benefits paid as well as contracted (vendor) payments are obtained initially from each LEA's payroll/benefits and financial system for each quarter of the fiscal year. This data will be reported on DMAS Medical Services Cost Report form for all direct service personnel (i.e., all personnel providing medical services covered under the state plan). Total computable personnel costs are reduced by an reimbursement that

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Local Education Agency (LEA) providers.

Effective on and after July 1, 2022, DMAS will use the following methodology to determine the reimbursement for Local Education Agency (LEA) providers delivering the following covered 1905(a) and EPSDT services:

- Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders and EPSDT services provided by licensed practitioners within their scope of practice as defined under state law and regulations and by staff under the supervision of a licensed healthcare professional in accordance with state law
- Nursing services provided by licensed nurses within the scope of practice as defined under state law and regulations
- Mental health services (including Applied Behavior Analysis) provided by qualified professionals within the scope of practice as defined under state law and regulations, and staff under the supervision of a licensed healthcare professional in accordance with state law, and covered as physicians' services or medical or other remedial care
- Personal care services performed by persons under supervision of a licensed health care professional acting within the scope of practice as defined under state law and regulations.
- Medical evaluation services provided by licensed physicians, nurse practitioners and physician assistants within the scope of practice as defined under state law and regulations and covered as physicians' services or medical or other remedial care.
- Transportation services when transportation is listed as a needed service within the child's individualized education program (IEP) plan. The following methodology will determine the direct medical services reimbursement for LEA providers.

All costs described within this methodology are for Medicaid services provided by qualified personnel or qualified health care professionals who have been approved under Attachments 3.1-A and 3.1-B of the Medicaid State Plan.

For providing medical services covered under the State Plan other than specialized transportation services, LEAs will be reimbursed using the following procedure:

- LEAs will submit interim claims through Virginia's Medicaid Management Information System (VAMMIS) for covered medical services provided to enrolled Medicaid members for which they seek cost reimbursement in their annual Direct Medical Services Cost Report. LEAs will receive an interim payment for claims that are submitted and adjudicated in VAMMIS and shown as "paid". Reimbursement for services billed through interim claims will be determined based on the fee-for-service fee schedule published on the DMAS website at https://www.dmas.virginia.gov/media/1522/school-codes-modifiers-and-interim-rates.pdf / LEAs must submit interim claims through VAMMIS no later than five months after the close of the fiscal year in which the costs of providing the services were incurred. Upon completion of the annual cost reconciliation and cost settlement processes performed by each LEA, the LEA's final payment amount will be adjusted based on any over- or underpayments made through the interim claiming process.

- After the conclusion of the applicable fiscal year, each LEA will prepare a Direct Health Care Services Cost Report of the total costs of providing covered medical services to students

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(regardless of students' Medicaid enrollment status). Each LEA will also calculate the proportion of its student population that are enrolled in Medicaid (Medicaid Enrollment Percentage). Each LEA's Direct Medical Services Cost Report and Medicaid Enrollment Percentage, combined with the results of the statewide Random Moment Time Study (RMTS) are used to determine the LEA's gross Medicaid reimbursable amount, also referred to as the Certified Public Expenditure amount. The following steps provide additional detail.

Preparing the Direct Services Cost Report

Step 1: Determine Total Adjusted Salary Cost

Total salaries and benefits paid to the direct medical providers as well as expenditures for contracted direct medical services providers will be obtained from each LEA's payroll/benefits system for each quarter of the fiscal year. This data will be reported on the required DMAS Medical Services Cost Report Form (Cost Report Form), broken down by cost pools as described in Virginia's CMS-Approved "Random Moment Time Study Implementation Plan for Medicaid School-Based Direct Health Care and Administrative Services" (RMTS Implementation Plan) for all qualified direct medical services providers (i.e., all personnel providing direct medical services covered under the state plan). LEA staff are grouped into three cost pools for RMTS.

1. Pool 1 is for Administrative Only staff and therefore is excluded from Direct Services cost reporting.
2. Pool 2: Nursing, Psychological and Medical Services. This pool includes staff who meet DMAS provider qualifications to perform Medicaid-covered mental and behavioral health services (such as psychologists, social workers, counselors), behavior analysis services (such as behavior analysts and behavior technicians), medical services (such as physicians and nurses) and personal care assistance services. This pool also includes personnel who perform Medicaid billing.
3. Pool 3: Therapy Services. This pool includes staff who meet DMAS provider qualifications to perform Medicaid-covered speech-language pathology and therapy services, occupational therapy services, physical therapy services and audiology services.

Each LEA will report on the Cost Report Form all sources of federal funding, and the total computable personnel costs will be reduced by the amount of that federal funding reported. The personnel cost base will not include any costs applied to staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. Additionally, any staff members whose compensation is included in the cognizant agency's calculation of the LEA's Indirect Cost Rate are also excluded from being claimed as direct expenditures in all cost pools. The application of Step 1 will result in a Total Adjusted Salary Cost for each LEA.

Step 2: Determine Percentage of Time Spent Delivering Medical Services Using a Time Study

The percentage of time spent delivering covered direct medical services to students with an individualized education plan or individualized family services plan (IEP) and to students without an IEP (non-IEP), and the percentage of time spent performing general and administrative (G&A) activities is calculated using the methodology described in the RMTS Implementation Plan. (The methodology used ensures that a sufficient number of direct medical service personnel will be sampled to ensure time study results that

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will have a confidence level of at least 95 percent with a precision of plus or minus five percent overall.) Time spent in G&A activities will be reallocated to direct medical services as follows: The percentage of total time that direct services providers spend in G&A activities will be subtracted from the percentage of total time spent in providing direct medical services (IEP and non-IEP figured separately) divided by 1.0. The quarterly RMTS percentages are captured, and calculated statewide by cost pool, then applied to each LEA's allowable costs for each cost pool (i.e. all LEAs reimbursement is determined using the same, statewide percentages by pool)..

LEA staff are available for random sampling on all scheduled working days and hours, and only on their scheduled working days and hours, including days and hours when students are not in attendance. This method ensures that the full salary and benefit costs claimed for staff are accurately quantified by the RMTS and recognizes that important work activities in support of direct medical services (such as documentation, evaluation report writing, service delivery planning, etc.) and Medicaid Administrative Activities (such as Medicaid training, health services program planning, and care coordination activities) occur on days and hours when students are not in attendance. As outlined in the RMTS Implementation Plan and the LEA RMTS Coordinator Instruction Manual, each LEA's RMTS Coordinator is responsible for submitting and maintaining accurate work schedules for RMTS participants. The use of a single "district" calendar indicating school days and hours is not permitted. This ensures the integrity of the time study and accuracy of its use for cost allocation. This also means that during school vacation periods and other schedule variations, staff who are not scheduled to work will not be available for sampling, while staff who are scheduled to work will continue to be sampled.

**RMTS Sampling Periods:**

**Effective on 7/1/2024:** The sampling periods are defined as:

- Quarter 1 = July 1 – September 30
- Quarter 2 = October 1 – December 31
- Quarter 3 = January 1 – March 31
- Quarter 4 = April 1 – June 30

**Effective until 6/30/2024:** The sampling periods are defined as:

- Quarter 1 = July 1 – September 30 *
- Quarter 2 = October 1 – December 31
- Quarter 3 = January 1 – March 31
- Quarter 4 = April 1 – June 30

* No time study conducted during this period.

Step 3: Determine Personnel Cost of Delivering Medical Services

The percentages of time spent delivering direct medical services (from Step 2), determined quarterly, will be multiplied by the applicable cost pool's personnel cost base as determined in Step 1 and used to allocate personnel cost to direct medical services provided to all students pursuant to an IEP, and to direct medical services provided that are unrelated to an IEP (referred to as non-IEP). Quarterly personnel costs are

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summed for the fiscal year and reported on the DMAS Medical Services Cost Report Form.

For claims submitted after the effective date of this SPA, and prior to the CMS approval of the RMTS Implementation Plan, cost will be identified in accordance with a methodology that utilizes the quarterly results of the prospectively approved RMTS and applies them to prior period claims. In other words, in anticipation of a retro-active approval, DMAS has adjusted the RMTS beginning 10/01/2022 so that the time LEA staff spend performing reimbursable Non-IEP direct services is isolated and captured, allowing DMAS to calculate the resulting Non-IEP time percentage per cost pool and apply these results to LEA costs effective as of 07/01/2022. For the quarter 07/01/2022-09/30/2022 and the quarter 07/01/2023-09/30/2023, DMAS plans to apply the average percentages from Q2, Q3 and Q4 of FY2023. Then, as indicated in Step 2 above, DMAS will begin conducting RMTS during all 4 quarters of the year to be used to allocate each quarter's costs as of 07/01/2024.

Step 4: Determine Non-Personnel Costs of Delivering Medical Services

Non-personnel costs directly related to the delivery of covered IEP and non-IEP direct medical services will be detailed as line items on the DMAS Medical Services Cost Report Form by each LEA. This includes materials and supplies, purchased services, and medical equipment. These costs are allowable if used exclusively for the delivery of health care services for which the LEA is including allowable personnel costs. Total computable non-personnel costs are reduced by any reimbursement that is from federal funding source.

Step 5: Determine Indirect Costs of Delivering Medical Services

Indirect cost related to the delivery of direct medical services will be determined separately for IEP and non-IEP by multiplying each LEA's unrestricted indirect rate assigned by the cognizant agency (the Virginia Department of Education or VDOE) by direct salary and benefit costs of delivering direct medical services as determined under Step 3 and non-personnel costs of delivering direct medical services as determined in Step 4. The indirect cost rate is not applied to contractor costs.

Indirect rate X (Direct salary and benefit costs + Non-personnel costs)

No costs that are included and reimbursed through the application of the indirect cost rate may be claimed directly by the LEA in any cost category of the Medical Services Cost Report. No additional indirect cost is recognized outside of the indirect cost determined by Step 5.

Step 6: Total Cost of Delivering Medical Services

Total Medical Services Costs will be determined by adding costs from steps 3, 4 and 5 for each, IEP and non-IEP, as separate calculations.

Determining the Medicaid Enrollment Rate for IEP and non-IEP

Step 7: Allocate Total Medical Services Cost to Medicaid.

DMAS will ensure that LEAs only receive reimbursement for costs related to the provision of direct medical services when the services are provided to Medicaid-enrolled students by applying student

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Medicaid enrollment rates that are calculated separately for each LEA, and also separately for services provided related to an IEP and those that are non-IEP. This is accomplished by matching LEA student enrollment data to DMAS Medicaid enrollment data for the two (IEP and non-IEP) student populations in order to create a count of all Medicaid-enrolled students also enrolled in the LEA. The procedure used for determining the Medicaid Enrollment Rate (MER) is as follows:

Medicaid Enrollment Rate (MER) related to IEP Health Care Services

Statistics for this section are based on the VDOE certified, unduplicated Special Education Child Count as of December 1 of the applicable fiscal year. LEAs will upload their VDOE certified child count list of students to an online system that LEA staff can securely use to view their results of a system-generated list of students that are both enrolled in special education with their LEA and enrolled in Medicaid. For each "matched" student listed, the LEA must indicate those students to be included in the calculation of MER. The LEAs report the finalized list of matched students with the parental consent in place. The cost report system calculates the resulting MER to be used in the calculation of the allowable expenditures related to providing IEP medical services to children enrolled with Medicaid.

The calculation of MER for services related to an IEP:

| | | |
|---|---|---|
| Unduplicated count of LEA students as of December 1 of the applicable fiscal year:<br>• That are included in the LEA's VDOE-certified Special Education Child Count,<br>• For whom the LEA is seeking reimbursement, and<br>• Who were matched to the DMAS December 1 enrollment data and determined to be actively enrolled in Medicaid | Divided by | Unduplicated December 1 Special Education Child Count of LEA students, certified by VDOE |

Medicaid Enrollment Percentage related to Non-IEP

Statistics for this section are based on the LEA's total enrollment as of December 1 of the cost report year. LEAs upload their December 1 division-wide enrollment roster to a DMAS online system that LEA staff can securely use to view their results of a system-generated list of students that are both enrolled the LEA and in Medicaid. For each "matched" student listed, the LEA must indicate in the system whether parental consent for sharing the student's records (for interim claims purposes) was in place.

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The calculation of MER for services not related to an IEP:

| | | |
|---|---|---|
| Unduplicated count of all LEA students as of December 1 of the applicable fiscal year:<br>• For whom the LEA is seeking reimbursement, and<br>• Who were matched to the DMAS December 1 enrollment data and determined to be actively enrolled in Medicaid | Divided by | Unduplicated count of all LEA students, certified by VDOE |

The cost report system calculates the resulting Medicaid enrollment rate to be used in the calculation of the allowable expenditures related to providing non-IEP medical services to children enrolled with Medicaid.

Step 8. Cost Settlement of Medical Services
DMAS shall issue a settlement notice at the conclusion of the reconciliation process that denotes the amount due to or from the LEA. The LEAs receive 95% of the FFP from the settlement for direct medical services. (The State retains 5% of the FFP reimbursement to school divisions for medical and transportation services. The State will settle with each provider, using one of the methods described below for either under- or overpayment associated with school-based services. Settlement will be limited to recovery or payment of only the Federal Financial Participation associated with total computable cost.

i. If payments made to the LEA through the interim claims process for services delivered during the applicable fiscal year exceed the Certified Public Expenditure amount reported by the LEA, DMAS will recoup the overpayment through offset of future claim payments or through a repayment plan approved by DMAS. All FFP associated with the overpayment will be returned to CMS within one year.

ii. If the certified costs exceed interim payments made during the applicable fiscal year, DMAS will pay the difference to the LEA provider via EFT or paper check.

For providing specialized transportation services covered under the State Plan as a direct medical service, LEAs will be reimbursed using the following procedure:

School based specialized transportation is defined as a medically necessary service (as outlined in the IEP of an enrolled Medicaid beneficiary) provided in a specially-adapted vehicle that has been physically-adjusted or designed (e.g., wheelchair lifts, ramps, etc.,). Costs associated with specialized transportation will be included in a Specialized Transportation Cost Report, which is submitted on a quarterly basis. The approved quarterly payments based on the methodology below will be considered final. Specialized transportation is not subject to cost settlement.

Specialized Transportation may be claimed as a direct service when the following conditions are met:

- The child has a formal written IEP;

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- Specialized transportation is documented in the IEP as a medically necessary service and;
- The child receives a medically necessary Medicaid-covered IEP service in school on the day that the specialized transportation cost is claimed.
- The service billed only represents the costs associated with the trip on the specially adapted transportation for direct medical services (or administrative claiming) as listed in the IEP (e.g., the 1-way trip).

Step 1: Develop Specialized Transportation Non-Personnel Cost
Non-personnel costs directly related to the delivery of specialized transportation services will be detailed as line items on the Quarterly Specialized Transportation Cost Report by each LEA. This includes costs of fuel, repairs and maintenance, rentals and contract vehicle use. These costs are allowable if used exclusively for the delivery of specialized transportation services and the LEA must maintain supporting documentation to that effect. Non-personnel costs are reduced by any reimbursement that is not from state or local funding sources. All cost is reported on an accrual basis. All non-personnel costs except contract vehicle costs are eligible for the additional application of the LEA's indirect cost rate. Contractor costs for transportation (same as contractor costs for other medical services) are not eligible to have the LEA indirect cost rate applied.

Step 2: Develop Specialized Transportation Personnel Cost
Quarterly salaries and benefits paid for employees directly involved in the delivery of specialized transportation services are obtained from each LEA's payroll/benefits systems and reported on the Quarterly Specialized Transportation Cost Report Form. These costs are allowable if used exclusively for the delivery of specialized transportation services and the LEA must maintain supporting documentation to that effect. Personnel costs are reduced by any reimbursement that is not from state or local funding sources. All cost is reported on an accrual basis.

Step 3: Develop Specialized Transportation Contract Cost
Quarterly contract cost (vendor payments) for specialized transportation services are obtained from each LEA's financial system and reported on the Quarterly Specialized Transportation Cost Report Form. These costs are allowable if used exclusively for the delivery of specialized transportation services and the LEA must maintain supporting documentation to that effect. Contract costs are reduced by any reimbursement that is not from state or local funding sources. All cost is reported on an accrual basis.

Step 4: Capital Cost
Quarterly depreciation costs for capital assets used in the provision of specialized transportation will be included when the value of the item is over $5,000 and the estimated useful life is at least 2 years. Straight line, monthly depreciation are applied. These costs are allowable if used exclusively for the delivery of specialized transportation services and the LEA must maintain supporting documentation to that effect. Costs are reduced by any reimbursement that is not from state or local funding sources. All cost is reported on an accrual basis.

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Step 5: Determine Indirect Cost
Indirect cost is determined by multiplying each LEA's unrestricted indirect rate assigned by the cognizant agency (VDOE) by total Non-Personnel and Personnel specialized transportation cost, as determined under Steps 1, 2 and 4. The indirect cost rate is not applied to contract costs or contract vehicle use.

Step 6: Total specialized transportation services cost is determined by adding costs from steps 1, 2, 3, 4 and

Step 7: Allocate Total Specialized Transportation Cost to Direct Medical Services Provided to Medicaid-enrolled students.

a. *Determine the percentage of LEA's specialized transportation population with medically necessary specialized transportation directed by an IEP.* This will be determined for the quarter based on the number of students receiving medically necessary transportation directed by an IEP to the total number of ALL students transported in a specialized transportation vehicle.

b. *Allocate costs to students receiving medically necessary transportation directed by an IEP.* This will be determined for the quarter by multiplying total specialized transportations costs from step 6 by the percentage of specialized transportation population with medically necessary specialized transportation directed by an IEP from step 7(a).

c. *Determine the Medicaid Enrollment Rate (MER) for Specialized Transportation*. This will be determined for the quarter based on the ratio of the number of students receiving medically necessary specialized transportation directed by an IEP who are enrolled in Medicaid to the total number of students receiving specialized transportation directed by an IEP (regardless of Medicaid status).

d. *Determine percentage of one-way trips provided on a day when the student received Medicaid-covered IEP services*. This will be determined for the quarter based on the number of one-way trips that were provided to a Medicaid enrolled specialized transportation IEP student from step 7(c) on a day when the student received a Medicaid covered IEP service to the total number of one-way trips provided to these same students in the quarter.

e. *Allocate costs to one-way trips provided on a day when Medicaid-covered IEP services were provided.* This will be calculated by multiplying the cost of providing medically necessary transportation directed by an IEP from step 7(b) by the percentage of one-way trips provided on a day when the student received Medicaid-covered IEP services from step 7(d).

f. *Allocate Specialized Transportation Cost to Medicaid.* This will be determined for the quarter by multiplying the stepped-down allowable cost of specialized transportation provided on a day when Medicaid-covered IEP services were provided from step 7(e) by the MER for Specialized Transportation from step 7(c).

Step 8. Reimbursement for Specialized Transportation Services
DMAS shall reimburse LEA's quarterly transportation costs based on the Quarterly Specialized Transportation Cost Report. The LEAs receive 95% of the FFP from the reimbursement for specialized transportation

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services. (The State retains 5% of the FFP reimbursement to school divisions for medical and transportation services.)

Supporting Documentation
DMAS requires LEAs to maintain adequate supporting documentation for all reimbursable services, program costs, and eligibility data. These documents are required to be available upon request for audit.

State Monitoring
DMAS utilizes multiple levels of review to monitor the school-based services program. The agency's contractor performs oversight activities throughout the year to monitor compliance with Federal and State requirements. DMAS conducts site review audits of LEA's on a cyclical basis. The objective of these audits is to review procedures and supporting documents to ensure compliance with Federal and State requirements. In addition, LEA provider claims are subject to audit by DMAS' Program Integrity Division.

Awareness of Federal Audit and Documentation Regulations: The Virginia State Medicaid agency and any contractors used to help administer any part of the school services program are aware of federal regulations listed below for audits and documentation:
42 CFR § 431.107 Required provider agreement
42 CFR § 447.202 Audits
45 CFR § 75.302 Financial management and standards for financial management systems

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12 VAC 30-80-96. Fee-for-service: Early Intervention (under EPSDT).

A. Payment for Early Intervention (EI) services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004, as set forth in Supplement 1 to Attachment 3.1-A&B, page 6.1 of 41, for individuals younger than 21 years of age shall be the lower of the state agency fee schedule or actual charge (charge to the general public). All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of January 1, 2024, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov .

B. There shall be separate fees for:

1. certified Early Intervention professionals who are also licensed as either a physical therapist, occupational therapist, speech pathologist, or registered nurse and certified Early Intervention specialists who are also licensed as either a physical therapy assistant or occupational therapy assistant and

2. all other certified Early Intervention professionals and certified Early Intervention specialists.

C. Provider travel time shall not be included in billable time for reimbursement.

D. Local Education Agency (LEA) providers provide Medicaid-covered school health services for which they are reimbursed on a cost basis pursuant to Attachment 4.19-B, pages 9a through 9f of 15. LEAs may also be certified as, and enrolled to provide, Early Intervention services. LEAs providing such services shall be reimbursed for EI services on a fee-for-service basis in the same manner as other EI providers. The fee- for-service rate is the same regardless of the setting in which LEAs provide EI services.

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**(n.b. this page follows J.1 [now K] on Page 9 of 15, of Attachment 4.19-B)**

J. 2. Targeted case management for Early Intervention (Part C) Children.

a. Targeted case management for children from birth to age three who have developmental delay who are in need of early intervention is reimbursed at the lower of the state agency fee schedule or actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

b. Case management may not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services, and intensive in-home services for children and adolescents.

c. Case management defined for another target group shall not be billed concurrently with this case management service except for case management services for high risk infants provided under 12 VAC 30-50-410. Providers of early intervention case management shall coordinate services with providers of case management services for high risk infants, pursuant to 12 VAC 30-50-410, to ensure that services are not duplicated.

d. Each entity receiving payment for services as defined in Section 3.1-A will be required to furnish the following to the Medicaid agency, upon request:

i. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and,

ii. cost information by practitioner.

Future rate updates will be based on information obtained from the providers. DMAS monitors the provision of Targeted Case Management through Post-Payment Review (PPR). PPRs ensure that paid services were rendered appropriately, in accordance with State and Federal policies and program requirements, provided in a timely manner, and paid correctly.

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Reimbursement for preventive nutritional therapy as defined per Supplement 3 to Attachment 3.1A&B page 2 of 8 under Preventative Services shall be paid at the lowest of: The State Agency Fee Schedule, actual charges or Medicare (Title XXVIII) allowances. Nutritional providers are defined per Supplement 3, Attachment 3.1 A&B, pages 1 and 2.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of preventive nutritional therapy services. The agency's fee schedule (rate) was last updated on January 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at www.dmas.virginia.gov

Payment for preventive nutritional therapy shall be limited to CPT code 97802 (4 units in 12 months) and CPT code 97803 (2 units in 12 months). The payment unit of service is a time-based code where 1 unit is equivalent to 15 minutes.

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L. Early discharge Follow-up Visit for Mothers and Newborns. The early discharge follow-up visit for mothers and newborns covered under the provisions of Supplement 1 to 3.1A&B, Item 13c (12 VAC 30-50-220. 13c. A) shall be reimbursed at the lower of the State Agency Fee Schedule or actual charges. Providers qualified for reimbursement of this service are those hospitals, physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The service must be delivered either by the appropriate professional who is an employee of the participating provider or is under contract with the participating billing providers listed above. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health.

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12 VAC 30-80-95.

M.1. Effective January 1, 2008, payment for hearing aids for individuals younger than 21 years of age shall be the actual cost of the device not to exceed limits set by the single state agency, plus a fixed dispensing and fitting fee not to exceed limits set by the single state agency.

M.2. All private and governmental providers are reimbursed according to the same methodology. Limitations set by the state agency are effective January 1, 2008, and for services provided on and after that date. The limitations are published at the following address (state agency website): http://www.dmas.virginia.gov/pr-fee_files.htm.

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**12 VAC 30-80-110**

Reimbursement for Targeted Case Management for Seriously Mentally Ill Adults and Emotionally Disturbed Children and for Youth At Risk of Serious Emotional Disturbance.

1. Targeted case management services for seriously mentally ill adults and emotionally disturbed children defined in § 2 of Supplement 2 to Attachment 3.1-A or for youth at risk of serious emotional disturbance defined in § 3 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of serious emotional disturbance may not be billed when it is an integral part of another Medicaid service including, but not limited to, intensive community treatment services , and intensive in-home services for children and adolescents.

3. Case management defined for another target group shall not be billed concurrently with these case management services.

4. Each provider receiving payment for these services will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of these services furnished Medicaid members; and,
    b. Cost information by practitioner furnishing these services.
5. Rate updates will be based on utilization and cost information obtained from the providers.

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**12 VAC 30-80-110**

Reimbursement Targeted Case Management for Individuals with Intellectual Disability.

1. Targeted case management for individuals with intellectual disability defined in § 4 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for individuals with intellectual disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with this case management service

4. Each provider receiving payment for this service will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of this service furnished Medicaid members; and,
    b. Cost information by practitioner furnishing this service.
5. Rate updates will be based on utilization and cost information obtained from the providers

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**12 VAC 30-80-110**

Reimbursement for Targeted Case Management for Individuals with Developmental Disability

1. Targeted case management for individuals with developmental disability defined in § 5 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of July 1, 2022, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for individuals with developmental disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with this case management service.

4. Each entity receiving payment for this service will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of this service furnished Medicaid members; and,
    b. Cost information by practitioner furnishing this service.
5. Rate updates will be based on information obtained from the providers.

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**12 VAC 30-80-110**

Reimbursement for Targeted Case Management for Individuals with Developmental Disability

1. Targeted case management for individuals with developmental disability defined in § 5 of Supplement 2 to Attachment 3.1-A, shall be reimbursed at the lower of the State Agency Fee Schedule or the actual charge (charge to the general public). The unit of service is monthly. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of August 2, 2016, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for individuals with developmental disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with this case management service.

4. Each entity receiving payment for this service will be required to furnish the following to the Medicaid agency, upon request:
    a. Data on the hourly utilization of this service furnished Medicaid members; and,
    b. Cost information by practitioner furnishing this service.
5. Rate updates will be based on information obtained from the providers.

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Reimbursement for Targeted Case Management for Individuals with Traumatic Brain Injuries

Targeted case management for individuals with traumatic brain injuries, as described in Attachment 3.1 A & B, Supplement 2, page 48, shall be reimbursed through a state-developed fee schedule rate. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2023, and are effective for services on or after that date. All rates are published on the DMAS website at www.dmas.virginia.gov.

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B. Outpatient hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid using the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals, less five percent. The five percent is for the cost of the additional manual processing of the claims. Outpatient hospitals that are not enrolled shall submit claims on DMAS invoices.

C. Non-enrolled providers of non-institutional services shall be paid on the same basis as enrolled in-state providers of non-institutional services. Non-enrolled providers of physician, dental, podiatry, optometry, and clinical psychology services, etc., shall be reimbursed the lesser of the charges submitted, of the DMAS rates for the services.

D. All non-enrolled non-institutional providers shall be reviewed every two years for the number of Medicaid recipients they have served. Those providers who have had no claims submitted in the past twelve months shall be declared inactive.

E. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

§5. Refund of Overpayments

A. Providers reimbursed on the basis of a fee plus cost of materials.

1. When DMAS determines an overpayment has been made to a provider, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputed in whole or in part DMAS's determination of the overpayment.

2. If the provider cannot refund the total amount of the overpayment within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

3. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, it a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services [the "director"] may approve a repayment schedule of up to 36 months.

4. A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be

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repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

5. If during the time an extended repayment schedule is in effect, the provider withdraws from the Program, the outstanding balance shall become immediately due and payable.

6. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

7. In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

8. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

9. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to §32.1-313 of the Code of Virginia from the date the director's determination becomes final.

10. The director's determination shall be deemed to be final on (i) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (ii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iii) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

B. Providers reimbursed on the basis of reasonable costs.

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1. When the provider files a cost report indicating that an overpayment has occurred, fill refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputed in whole or in part DMAS's determination of the overpayment.

2. If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, an underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

3. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

4. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, it a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services [the "director"] may approve a repayment schedule of up to 36 months.

5. A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

6. If during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

7. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

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8. In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

9. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

10. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to §32.1-313 of the Code of Virginia from the date the director's determination becomes final.

11. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

§6. EPSDT. (Repealed per SPA 97-03, 4/23/1997).

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EPSDT. (Repealed per SPA 97-03, 4/23/1997).

§7. Dispute resolution for state-operated providers. (12 VAC 30-80-150)

A. Definitions.

DMAS means the Department of Medical Assistance Services.

Division Director means the Director of a division of DMAS.

State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This shall be the sole procedure available to state-operated providers.

The appropriate DMAS Division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

(3) Informal review. The state-operated provider shall submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a

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Resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations.

D. Division Director's action. The Division Director shall consider any recommendation of his designee and shall render a decision.

E. DMAS Director review. A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after the receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

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§29 Medication-Assisted Treatment (MAT) Pursuant to section 1905(a)(29) of the Social Security Act

The state will cover all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

The reimbursement for unbundled MAT prescribed drugs and biologicals used to treat opioid use disorder (OUD) will be reimbursed using the same methodology as described for covered outpatient legend and non-legend drugs located in Attachment 4.19-B, pages 7.3, 7.4, and 7.5 for prescribed drugs that are dispensed or administered.

The reimbursement for individual, family and group therapy is referenced in Attachment 4.19-B Page 6.01, Reimbursement for outpatient substance use disorder services: Other Providers, including Licensed Mental Health Professionals (LMHP) (42 CFR 447, Subpart F).

The induction of medication for OUD is reimbursed per encounter; and is limited to 3 encounters per 12 months; rate set as of April 1, 2017.