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State Name: Virginia

State Plan Amendment (SPA) #: 21-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th Street, Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

July 2, 2021

Karen Kimsey, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

RE: Virginia State Plan Amendment 21-0002

Dear Ms. Kimsey:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Virginia's State Plan Amendment (SPA) 21-0002, Removal of the 21 Out of 60 Day Limit.

The purpose of this SPA is to remove a limit for psychiatric hospitalization that prevented more than 21 days in a hospital in a 60-day period for the same or similar diagnosis or treatment plan. The SPA also updates practitioner terminology as it relates to working titles.

This SPA is acceptable. Therefore, we are approving SPA 21-0002 on July 2, 2021 with an effective date of March 31, 2021. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have any questions concerning this information, please contact me at (816) 426-6417, or your staff may contact Margaret Kosherzenko at Margaret.Kosherzenko@cms.hhs.gov or (215) 861-4288.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc:
Emily McClellan

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0002

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 3/31/2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 438

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ $38,461
b. FFY 2022 $ $38,461

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A&B, Supplement 1, pages 1, 2, 3, 3.1, 4. 4.1, 4.1.1, 4.2, 4.3, 4.4, 7, 8, 9, 9.1, 9.2

Attachment 3.1-C, pages 1, 2

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

10. SUBJECT OF AMENDMENT: Removal of the 21 Out of 60 Day Limit

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Karen Kimsey

14. TITLE: Director

15. DATE SUBMITTED: 3/29/2021

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 7, 2021

18. DATE APPROVED: July 2, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: March 31, 2021

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: James G. Scott

22. TITLE: Director, Division of Program Operations

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY
and MEDICALLY NEEDY

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1. Inpatient Hospital Services.

Inpatient hospital services may be provided in accordance with 42 CFR 440.10.

General

The provision of the following medically necessary services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician. Inpatient acute hospitalizations will be reimbursed only if the stay has been authorized.

Inpatient hospital services provided at general acute care hospitals and free standing psychiatric hospitals.

A. Service Authorizations

1. Service authorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and free-standing psychiatric hospitals. Non-authorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS) or its contractor. Service authorization shall be based on criteria specified by DMAS.

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B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the service authorization requirements specified in subsection A above, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

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4. It is general practice for recipients in a particular locality to use medical resources in another state.

C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

D. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to the life of the mother if the fetus were carried to term.

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E. Mandatory lengths of stay.

a. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

b. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for radical, modified, total, or partial mastectomies may be covered if medically justified and service authorized until the Diagnosis Related Grouping methodology is fully implemented. Nothing in this regulation shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

F. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64 except as allowed under 42 CFR §438.3 (e)(2). Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section.

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G. Addiction and recovery treatment services shall be covered in inpatient facilities.

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H. The admission and length of stay must be medically justified and service authorized via the admission and concurrent review processes. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

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I. Mandatory lengths of stay.

1. Coverage for normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and service authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

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PHYSICIAN'S SERVICES WHETHER FURNISHED IN THE OFFICE, THE PATIENT'S HOME, A HOSPITAL, A SKILLED NURSING FACILITY OR ELSEWHERE.

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

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

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

D. Outpatient psychiatric services.

1. Psychiatric services can be provided by or under the supervision of an individual licensed under state law to practice medicine or osteopathy. Only the following licensed or registered providers are permitted to provide psychiatric services under the supervision of an individual licensed under state law to practice medicine or osteopathy: an LMHP, LMHP-R, LMHP-RP, LMHP-S, or a licensed school psychologist. Medically necessary psychiatric services shall be covered by DMAS or its designee and shall be directly and specifically related to an active written plan designed and signature dated by one of the healthcare professionals listed in this subdivision.

2. Psychiatric services shall be considered appropriate when an individual meets the following criteria:

a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels which have been impaired;

b. Exhibits deficits in peer relations, dealing with authority, is hyperactive, has poor impulse control, is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, abilities to learn, and/or ability to participate in employment, educational, or social activities;

c. Is at risk for developing or requires treatment for maladaptive coping strategies; and

d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

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E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of life to the mother if the fetus was carried to term.

G. Physician visits to inpatient psychiatric hospital patients are restricted to medically necessary authorized (for enrolled providers)/approved (for non-enrolled providers) inpatient hospital days as determined by DMAS or its contractor.

H. [Reserved.]

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

J. [Reserved.]

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K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require service authorization by DMAS. Cornea transplants do not require service authorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant.

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Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere (continued)

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If serviced authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions may be covered, if serviced authorized, for medically necessary indications. Such procedures shall be considered non-cosmetic.

2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated, or are intended solely to preserve, restore, confer or enhance the aesthetic appearance of the breast.

M. Admitting physicians shall comply with the requirements for coverage of out-of-state inpatient hospital services. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia shall only be reimbursed under at least one of the following conditions. It shall be the responsibility of the hospital, when requesting service authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out-of-state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or

4. It is the general practice for recipients in a particular locality to use medical resources in another state.

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N. In compliance with 42 CF441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

O. Service authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computer Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. The referring physician ordering non-emergency outpatient Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT) scans, or Positron Emission Tomography (PET) scans must obtain service authorization from the Department of Medical Assistance Services (DMAS) for those scans. The servicing provider will not be reimbursed for the scan unless proper service authorization is obtained from DMAS by the referring physician.

P. Addiction and recovery treatment services shall be covered in physician services.

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STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

Institutional care.

Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX**.**

Utilization Control: General Acute Care Hospitals (enrolled providers).

A. Prior authorization required. The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) shall not reimburse for services which are not authorized as follows:

1. DMAS shall monitor, consistent with State law, the utilization of all inpatient hospital services. All inpatient hospital stays shall be service authorized prior to admission. Services rendered without such service authorization shall not be covered, except as stated in subdivision 2 of this subsection.

2. If a provider has rendered inpatient services to an individual who later is determined to be Medicaid eligible, it shall be the provider's responsibility to obtain the required authorization prior to billing the DMAS for these services.

3. Regardless of service authorization, DMAS shall review all claims which are suspended for sterilization, hysterectomy, or abortion procedures for the presence of the required federal and state forms prior to reimbursement. If the forms are not attached to the bill and not properly completed, reimbursement for the services rendered will be denied or reduced, according to DMAS policy.

B. To determine that the DMAS enrolled hospital providers are in compliance with the regulations governing hospital utilization control found in 42 CFR 456.50 through 456.145, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit. The hospital shall make all requested records available and shall provide an

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Appropriate place for the auditors to conduct such review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in 42 CFR 456.105 through456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and list of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR 456.141 through 42CFR 456.145.

5. Topic of one on-going Medical Care Evaluation Study to determine the hospital is incompliance with 42 CFR 456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification and written plan of care for each selected stay to determine the hospital's compliance with the 42 CFR 456.60 and 456.80. If any of the required documentation does not meet the requirements found in 42 CFR 456.60 through 456.80, reimbursement may be retracted.

7. The hospital may appeal in accordance with the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) any adverse decision resulting from such audits which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.