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MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **USHA KODURU**
Assistant Attorney General

DATE: **July 29, 2016**

SUBJECT: **Exempt final regulation to add coverage of behavioral therapy services 12VAC 30-141-500**

I have reviewed the attached exempt final regulation to add behavioral therapy services, including applied behavior analysis, for recipients in the Family Access to Medical Insurance Security Plan program. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to amend the regulation and if the regulation comports with state and federal law.

Based on my review and pursuant to the 2016 Acts of the Assembly, Item 305.G, the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, in accordance with Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA") and has not exceeded that authority. It is my view that the amendment of this regulation is exempt from the procedures of Article 2 of the APA pursuant to Va. Code § 2.2-4006(A). This will amend the State Plan; therefore, approval by the Centers for Medicare and Medicaid Services will be required.

If you have any questions about this matter, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

12VAC30-141-500. Benefits reimbursement.

A. Reimbursement for the services covered under FAMIS fee-for-service and MCHIPs shall be as specified in this section.

B. Reimbursement for physician services, surgical services, clinic services, prescription drugs, laboratory and radiological services, outpatient mental health services, early intervention services, emergency services, home health services, immunizations, mammograms, medical transportation, organ transplants, skilled nursing services, well baby and well child care, vision services, durable medical equipment, disposable medical supplies, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, school-based health services, behavioral therapy services including but not limited to applied behavior analysis, and certain community-based mental health services shall be based on the Title XIX rates.

C. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population. MCHIP rates will be determined annually and published 30 days prior to the effective date.

D. Exceptions.

1. Prior authorization is required after five visits in a fiscal year for physical therapy, occupational therapy and speech therapy provided by home health providers and outpatient rehabilitation facilities and for home health skilled nursing visits. Prior authorization is required after 26 visits for outpatient mental health visits in the first year of service and prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging, including Magnetic Resonance Angiography (MRA), Computerized 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. Prior authorization for dental services will be based on the Title XIX prior authorization requirements for dental services.

2. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each hospital. Reimbursement shall not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made shall be final and there shall be no retrospective cost settlements.

3. Reimbursement for outpatient hospital services shall be based on the Title XIX rates in effect for each hospital. Payments made will be final and there will be no retrospective cost settlements.

4. Reimbursement for inpatient mental health services other than by free standing psychiatric hospitals will be based on the Title XIX rates in effect for each hospital. Reimbursement will not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made will be final and there will be no retrospective cost settlements.

5. Reimbursement for outpatient rehabilitation services will be based on the Title XIX rates in effect for each rehabilitation agency. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for outpatient substance abuse treatment services will be based on rates determined by DMAS for children ages six through 18 years. Payments made will be final and there will be no retrospective cost settlements.

7. Reimbursement for prescription drugs will be based on the Title XIX rates in effect. Reimbursements for Title XXI do not receive drug rebates as under Title XIX.

8. Reimbursement for covered prescription drugs for noninstitutionalized FAMIS recipients receiving the fee-for-service benefits will be subject to review and prior authorization when their current number of prescriptions exceeds nine unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12VAC30-50-210 A 7.