4. b. Early Periodic Screening, Diagnostic and Treatment Services

Screening services are reimbursed on an encounter per diem rate based on the cost of providing the components of the screening examination, and referral where indicated, for qualified providers.

(iii) Reimbursement to those providers dually licensed as Behavioral Health and Residential Child Care Facilities will be reimbursed with standardized per diem rates established for Residential Care Facilities. ~~prospective based on allowable provider specific cost for treatment within each peer group level. Reimbursement will be capped for individual providers within each peer group level based on allowable provider specific cost.~~

~~**Allowable Provider Specific Cost**~~
~~Reimbursement for Behavioral Health Residential Child Care Facilities is limited to those costs required to deliver allowable medically necessary behavioral health treatment services by an efficient ancl economically operated provider. Costs determined to be reasonable and allowable by the Department will be reimbursed up to the level of the peer group ceiling derived from the weighted average cost of providers by peer group. These costs specifically exclude costs for room, board and the minimum supervision required by Social Services licensing regulations.~~

~~**Peer Group Ceiling**~~
~~The peer group ceiling will be derived from the weighted average per patient day treatment costs of all providers, at an assigned occupancy of 90% in the peer group. Patient day is defined as eight (8) continuous hours in residence in the facility in a twentyfour hour period during which the patient receives medical services.~~

~~**Efficiency Allowance**~~
~~When a provider's actual allowable per diem costs are below the peer group ceiling an incentive of 50% of the difference between the provider's allowable cost and the per group ceiling within each level of care (if lower than the peer group ceiling) will be paid, up to a maximum of four dollars ($4) per resident day.~~

~~**Inflation Factor**~~
~~A factor will be assigned to cost as a projection of inflation for subsequent rate setting cycles. Changes in industry wage rate and supply costs compared with CPI are observed and the lesser amount of charge is expressed as a percentage and applied to the allowable reimbursable costs for the six-month reporting period. This inflation factor represents the maximum rate of inflation recognized by the Department for the rate period.~~

Cost Reporting Periods
Cost reports must be filed with ~~the State agency~~ the Department of Human Services (DoHS) annually. ~~Cost reports must be postmarked within sixty {60) days following the end of each six month cost reporting period: January 1 - June 30 and July 1 - December 31. Rates will be calculated and effective for six month periods~~
~~starting three months after their reporting period. Rates will be frozen at the current level {January to June 2001) and will remain at that level for no longer than two rate periods.~~

Provider	Beds	Patient Occupancy Days	Occupancy Percentage	Allowable Treatment Cost	CostPPD Actual
A	9	1,296	80%	$ 77,760	60.00
B	7	1,134	90%	$ 73,710	65.00
C	18	3,078	95%	$153,900	50.00

For this example only, assume 180 days in six month reporting period, actual days will be utilized during actual calculations, and an increase in the inflation factor of 1 %:

Peer Group Ceiling Calculation

Provider	Beds	Possible Days	Patient Days	Allowable Costs	CostsPPD	Cost Adjusted	Allowable Cap Calculation
A	9	1,620	1,296	$77,760	48.00	53.33	$ 69,120
B	7	1,260	1,134	$73,710	58.50	65.00	$ 73,710
C	18	3,240	3,078	$153,900	47.50	52.78	$162,450
Total		6,120	5,508	$305,370			$305,280

Weighted average per patient day allowed treatment cost ($305,280/5,508 days) of$55.42.

Provider	P-PD Cost Cap	Reimbursement or Cap	Lower of PPD	Efficiency Incentive	1%Inflation	Specific Rate
A	60	55.42	55.42	0	0.55	55.97
B	65	55.42	55.42	0	0.55	55.97
C	50	55.42	50.00	0	0.55	50.50

(iv) Payment for Early Intervention services will be through an agreement with the state Title V agency. Payments shall be based on total cost of service provision. The Title V agency must maintain, in auditable form, all records of cost of services for which claims for reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected costs may be used as necessary with a settlement to cost at the end of the fiscal year.

(v) Private duty nursing is reimbursed on a fee-for-service based on units of time. Fees will not exceed the provider's usual and customary charge.

c. Family Planning Services and Supplies

1. Family planning clinic services are reimbursed on a cost basis for the clinic including staffing and cost of supplies dispensed to the recipients.
2. Family planning supplies as ordered by a physician and dispensed by a retail pharmacy are reimbursed as-a pharmacy service.

5 a. Physician’s Services

An upper limit is established using a resource-based relative value for the procedure times a conversion factor as determined by type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the provider’s customary charge for the service to the general public.

Effective for dates of services on or after July 1, 2024 reimbursement for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) RIT and SRIT services as described in EPSDT coverage Supplement 2 to Attachment 3.1-A and 3 .1-B item 4b, Preventive services Supplement 2 to Attachment 3.1-A and 3.1-B, item 13c, and Rehabilitative services Supplement 2 to Attachment 3.1-A and 3.1-B, item 13d will be paid based upon a Medicaid per diem statewide rates established by the West Virginia Department of Human Services (DoHS) as outlined below. RIT and SRIT service providers meeting State and federal standards will be paid at or above the minimum per diem rates consistent with the published rates applicable to the facility type and acuity level of the individual. Providers will provide different intensity and frequency of interventions based on patient's current condition and needs according to the levels of care and facility type outlined by the State.

The RIT and SRIT rates are incorporated in the Managed care organization(s) capitation rates. MCOs are responsible for paying the RIT and SRIT fee a schedule according to program specifications and at or above the West Virginia DoHS established rates.

The per diem rate for treatment is based upon a combined individual, family, and group counseling, discharge planning, treatment planning, physician services, nursing services, medication administration services, skills training and development services, regular and consistently applied assessments, monitoring and oversight. The staff wage models were developed using empirical provider wage data, Bureau of Labor Statistics data, and historical cost reporting data. Empirical data was collected through a 2023 residential treatment facility provider survey sourcing information on staffing titles, FTEs, wages, overtime hours, and benefits expenses. The staff wage model calculation used a base wage from the above-listed sources, adjusted for inflation and overtime hours. A percentage (24.6%) for employee-related expenses based upon the provider data survey and a productivity factor was applied. All parts of the model were combined for a total per hour wage. The number of hours of treatment were multiplied by the total per hour wage to establish treatment hours cost. The cost of a monthly assessment was added to the treatment hours cost to produce the total cost for the treatment component. The total cost of treatment was divided into a daily amount, then modified by an occupancy adjustment based on historical cost reporting data to set the per diem rate.

Additional units of service, beyond the per diem RIT and SRIT rates for the following services, individual therapy, family therapy, group therapy, Behavior Management Services, Crisis Intervention, Mental Health Assessment Administration-non-physician, Skills Training and Development may be reimbursed from the Medicaid fee-for-service fee schedule, with documented medically necessary and any prior authorization approvals where applicable.