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State/Territory Name: VA

State Plan Amendment (SPA) #: 24-0018

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

December 17, 2024

Cheryl J. Roberts, Director
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

RE: TN 24-0018

Dear Director Roberts:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Virginia state plan amendment (SPA) to Attachment 4.19-B of VA-24-0018, which was submitted to CMS on September 23, 2024. This plan amendment updates rates for dental services, Durable Medical Equipment (DME) products, rehabilitation services, and Early Periodic Screening, and Diagnosis and Treatment (EPSDT).

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Jerica Bennett at 410-786-1167 or via email at jerica.bennett@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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: 24-0018

2. STATE: VA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 1,286,285
b. FFY 2025 $ 8,246,288

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, revised pages 4.1.1, 5, 6.2 & 6.2.1
Attachment 4.19-B, Supp 5, revised page 1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same as box #7.

9. SUBJECT OF AMENDMENT
2024 Non-Institutional Provider Reimbursement Changes

10. 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

[redacted]

12. TYPED NAME
Cheryl J. Roberts

13. TITLE
Agency Director

14. DATE SUBMITTED
August 21, 2024

15. RETURN TO
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Policy, Regulations, and Manuals Supervisor

FOR CMS USE ONLY

16. DATE RECEIVED
09/23/2024

17. DATE APPROVED
December 17, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
07/01/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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 July 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 July 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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

(1) 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.

(2) 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.

d. Effective July 1, 2024, enteral products and supplies in the DMAS fee schedule for Feeding Kits and Nutrition Kits/Feeding Tubes shall have reimbursement rates set to 100 percent the Medicare rural rates or 100 percent of non-rural rates if a rural rate does not exist for the specific DME product.

e. Durable medical equipment codes that are subject to the transition rules in 42 CFR 414.210 (g)(9)(vi) shall be paid at the rate that was in effect on December 31, 2023 until that paragraph is amended by federal law. At that time, the durable medical equipment codes that were subject to the transition rules shall be paid at the new rate specified in federal law.

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)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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 July 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, 2024, 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -- OTHER TYPES OF CARE
ESTABLISHMENT OF RATE PER VISIT

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12 VAC 30-80-200. Prospective reimbursement for rehabilitation agencies or comprehensive outpatient rehabilitation facilities.

A. Rehabilitation agencies or comprehensive outpatient rehabilitation facilities.

1. Effective for dates of service on and after July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities, excluding those operated by community services boards or state agencies, shall be reimbursed a prospective rate equal to the lesser of the agency's fee schedule amount or billed charges per procedure. The agency shall develop a statewide fee schedule based on CPT codes to reimburse providers what the agency estimates they would have been paid in FY 2010 minus $371,800. State agencies and community service boards will be reimbursed cost for physical therapy, occupational therapy and speech-language therapy services.

2. Effective for dates of service beginning October 1, 2009, through June 30, 2024, rehabilitation agencies or comprehensive outpatient rehabilitation facilities excluding those operated by state agencies, shall be reimbursed a prospective rate equal to the lesser of the agency's fee schedule amount or billed charges per procedure. The agency shall develop a statewide fee schedule based on CPT codes to reimburse providers what the agency estimates they would have paid in FY 2010 minus $371,800. State agencies will be reimbursed cost for physical therapy, occupational therapy and speech-language therapy services.

3. Effective for dates of service on or after July 1, 2024, rehabilitation agencies or comprehensive outpatient rehabilitation facilities excluding those operated by state agencies, shall be reimbursed a prospective rate equal to the lesser of the agency's fee schedule amount or billed charges per procedure. The agency shall develop a statewide fee schedule based on CPT codes to reimburse providers using the Resource Based Relative Value Scale (RBRVS). Any changes to the reimbursement methodology shall be budget neutral. To ensure and maintain budget neutrality, a budget neutrality factor shall be applied to any rate calculations. State agencies will be reimbursed cost for physical therapy, occupational therapy and speech-language therapy services.

B. Transition reimbursement for rehabilitation agencies subject to the new fee schedule methodology.

1. Payments for the fiscal year ending or in progress on June 30, 2009, shall be settled for private rehabilitation agencies based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of June 30, 2009.

2. Payment for fiscal year ending or in progress on September 30, 2009, shall be settled for community services boards based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of September 30, 2009.