COMMONWEALTH of VIRGINIA
Office of the Governor

Janet Vestal Kelly
Secretary of Health and Human Resources

August 18, 2025

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Dear Mr. McMillion:

Attached for your review and approval is amendment 25-010, entitled "2025 Non-Institutional Provider Reimbursement Changes" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

Sincerely,

Janet V. Kelly

Janet V. Kelly

Attachment

cc: Cheryl J. Roberts, Director, Department of Medical Assistance Services
CMS, Region III

Transmittal Summary

SPA 25-010

I. IDENTIFICATION INFORMATION

Title of Amendment: 2025 Non-Institutional Provider Reimbursement Changes

II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

Purpose: The 2025 Appropriations Act requires DMAS to make the following changes:

- Item 288.FFFFF.2: The state plan is being revised to update the rates for Private Duty and Skilled Nursing under the Early Periodic Screening, and Diagnosis Treatment (EPSDT) benefit by three percent. (A corresponding rate increase will be provided for these services and for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, and Benefits Planning provided under home and community-based waivers. These increases are not included in the state plan amendment but via waiver documentation.)

- Item 288.GGGGG.2: The state plan is being revised to increase the rates for agency- and consumer-directed personal care under the Early Periodic Screening, and Diagnosis and Treatment (EPSDT) benefit by two percent. (A corresponding rate increase of two percent will be provided for these services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.)

- Item 288.MMMMM: The state plan is being revised to include a provision for payment of medical assistance for FDA approved long-acting injectable or extended-release medications administered for a serious mental illness or substance use disorder in any hospital emergency department. This payment shall be unbundled from the hospital rate.

- Item 288.PPPPP: The state plan is being revised to ensure the reimbursement for a service provided by a licensed certified midwife or licensed midwife shall be in the same amount as the Medicaid reimbursement paid a licensed physician or certified nurse midwife, whichever is higher, for performing such service in the area served.

- Item 288.UUUUU: The state plan is being revised to increase the rates for Office Based Addiction Treatment, Opioid Treatment Services, Partial Hospitalization Services, and Intensive Outpatient Services by 6.5 percent.

- Item 288.WWWWW: The state plan is being revised to provide supplemental payments for dentists employed by or contracted with Virginia Commonwealth University's School of Dentistry. The total supplemental payment shall be based on the average commercial rate as approved by the federal Centers for Medicare and Medicaid (CMS) and all other Medicaid payments subject to such limit made to such dentists. DMAS shall enter into a transfer agreement with Virginia Commonwealth University for such supplemental payments, in which the University shall provide the non-federal share in order to match federal Medicaid funds for the supplemental payments.

- Item 3-5.15: the state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for outpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

Substance and Analysis: The section of the State Plan that is affected by this amendment is "Methods and Standards for Establishing Payment Rate-Other Types of Care"

Impact:

- Item 288.FFFFF.2: The expected increase in annual fee-for-service aggregate expenditures is $16,490 in state general funds and $17,154 in federal funds in federal fiscal year 2025, and $100,995 in state general funds and $103,199 in federal funds in federal fiscal year 2026.

- Item 288.GGGGG.2: The expected increase in annual fee-for-service aggregate expenditures is $109 in state general funds and $112 in federal funds in federal fiscal year 2025, and $660 in state general funds and $673 in federal funds in federal fiscal year 2026.

- Item 288: Item 288.MMMMM: The expected increase in annual fee-for-service aggregate expenditures is $841 in state general funds and $1,980 in federal funds in federal fiscal year 2025, and $3,372 in state general funds and $7,939 in federal funds in federal fiscal year 2026.

- Item 288.PPPPP: The expected increase in annual fee-for-service aggregate expenditures is $2,713 in state general funds and $3,554 in federal funds in federal fiscal year 2025, and $10,850 in state general funds and $14,215 in federal funds in federal fiscal year 2026.

- Item 288.UUUUU: The expected increase in annual fee-for-service aggregate expenditures is $6,177 in state general funds and $23,430 in federal funds in federal fiscal year 2025, and $35,208 in state general funds and $133,554 in federal funds in federal fiscal year 2026.

- Item 288.WWWWW: There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025. The expected increase in annual

fee-for-service aggregate expenditures is $854,417 in state general funds and $1,712,833 in federal funds in federal fiscal year 2026.

- Item 3-5.15: There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025. The expected increase in annual fee-for-service aggregate expenditures is $1,361,651 in state general funds and $2,747,310 in federal funds in federal fiscal year 2026.

Tribal Notice: Please see attached.

Prior Public Notice: See Attached.

Public Comments and Agency Analysis: Please see attached.

Outlook

Tribal Notice –2025 Non-Institutional Provider Reimbursement Changes

From Lee, Meredith (DMAS) <Meredith.Lee@dmas.virginia.gov>

Date Thu 8/7/2025 8:46 AM

To TribalOffice@MonacanNation.com <tribaloffice@monacannation.com>; Ann Richardson <chiefannerich@aol.com>; pamelathompson4@yahoo.com <pamelathompson4@yahoo.com>; rappahannocktrib@aol.com <rappahannocktrib@aol.com>; regstew007@gmail.com <regstew007@gmail.com>; Richard.matens@pamunkey.org <richard.matens@pamunkey.org>; Chief Diane Shields <chief@monacannation.gov>; chiefstephenadkins@gmail.com <chiefstephenadkins@gmail.com>; bradbybrown@gmail.com <bradbybrown@gmail.com>; tabitha.garrett@ihs.gov <tabitha.garrett@ihs.gov>; kara.kearns@ihs.gov <kara.kearns@ihs.gov>; administrator@nansemond.gov <administrator@nansemond.gov>; Information <info@afwellness.com>; info@fishingpointhc.com <info@fishingpointhc.com>; contact@Nansemond.gov <contact@nansemond.gov>; brandon.custalow@mattaponination.com <brandon.custalow@mattaponination.com>; admin@umitribe.org <admin@umitribe.org>; Reels-Pearson, Lorraine (IHS/NAS/AO) <lorraine.reels-pearson@ihs.gov>; Holmes, Remedios (IHS/NAS/RIC) <remedios.holmes@ihs.gov>; Lindsey.Taylor@ihs.gov <lindsey.taylor@ihs.gov>

1 attachment (271 KB)

Tribal Notice Letter 08-07-25, signed.pdf;

Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid Director Cheryl Roberts indicating that the Department of Medical Assistance Services (DMAS) plans to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services. This SPA will allow DMAS to make changes to non-institutional provider reimbursement.

If you would like a copy of the SPA documents or proposed text changes, or if you have any questions, please let us know.

Thank you! -- Meredith Lee

Meredith Lee
Policy, Regulations, and Manuals Supervisor
Policy Division
Department of Medical Assistance Services
meredith.lee@dmas.virginia.gov, (804) 371-0552
Hours: 7:00 am - 3:30 pm (Monday-Friday)
www.dmas.virginia.gov

COMMONWEALTH of VIRGINIA

CHERYL J. ROBERTS
DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

August 7, 2025

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to 2025 Non-Institutional Provider Reimbursement Changes.

Dear Tribal Leader and Indian Health Programs:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to amend the Virginia State Plan for Medical Assistance with the Centers for Medicare and Medicaid Services (CMS). Specifically, DMAS is providing you notice about a State Plan Amendment (SPA) that the Agency will file with CMS to make the following changes to the state plan to comply with the 2025 Appropriations Act:

- Item 288.FFFFF.2: The state plan is being revised to update the rates for Private Duty and Skilled Nursing under the Early Periodic Screening, and Diagnosis Treatment (EPSDT) benefit by three percent. (A corresponding rate increase will be provided for these services and for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, and Benefits Planning provided under home and community-based waivers. These increases are not included in the state plan amendment but via waiver documentation.)

- Item 288.GGGGG.2: The state plan is being revised to increase the rates for agency- and consumer-directed personal care under the Early Periodic Screening, and Diagnosis and Treatment (EPSDT) benefit by two percent. (A corresponding rate increase of two percent will be provided for these services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.)

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- Item 288.PPPPP: The state plan is being revised to ensure the reimbursement for a service provided by a licensed certified midwife or licensed midwife shall be in the same amount as the Medicaid reimbursement paid a licensed physician or certified nurse midwife, whichever is higher, for performing such service in the area served.

- Item 288.UUUUU: The state plan is being revised to increase the rates for Office Based Addiction Treatment, Opioid Treatment Services, Partial Hospitalization Services, and Intensive Outpatient Services by 6.5 percent.

- Item 288.WWWWW: The state plan is being revised to provide supplemental payments for dentists employed by or contracted with Virginia Commonwealth University's School of Dentistry. The total supplemental payment shall be based on the average commercial rate as approved by the federal Centers for Medicare and Medicaid (CMS) and all other Medicaid payments subject to such limit made to such dentists. DMAS shall enter into a transfer agreement with Virginia Commonwealth University for such supplemental payments, in which the University shall provide the non-federal share in order to match federal Medicaid funds for the supplemental payments.

- Item 3-5.15: the state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for outpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

We realize that the changes in this SPA may impact Medicaid members and providers, including tribal members and providers. Therefore, we encourage you to let us know if you have any comments or questions. The tribal comment period for this SPA is open through September 6, 2025. You may submit your comments directly to Meredith Lee, DMAS Policy Division, by phone (804) 371-0552, or via email: Meredith.Lee@dmas.virginia.gov. Finally, if you prefer regular mail, you may send your comments or questions to:

Virginia Department of Medical Assistance Services
Attn: Meredith Lee
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,

Cheryl J. Roberts, JD
Director

Agency **Department of Medical Assistance Services**

Board **Board of Medical Assistance Services**

Edit Notice

General Notice

Public Notice - Intent to Amend State Plan - 2025 Non-Institutional Provider Reimbursement Changes

Date Posted: 5/30/2025

Expiration Date: 11/30/2025

Submitted to Registrar for publication: YES

30 Day Comment Forum closed. Began on 5/30/2025 and ended 6/29/2025

LEGAL NOTICE
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
NOTICE OF INTENT TO AMEND

(Pursuant to §1902(a)(13) of the *Act (U.S.C. 1396a(a)(13)*)

THE VIRGINIA STATE PLAN FOR MEDICAL ASSISTANCE

This Notice was posted on May 30, 2025

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to provide for changes to the *Methods and Standards for Establishing Payment Rates — Other Types of Care (12 VAC 30-80)*.

This notice is intended to satisfy the requirements of 42 C.F.R. § 447.205 and of § 1902(a)(13) of the *Social Security Act*, 42 U.S.C. § 1396a(a)(13). A copy of this notice is available for public review from Meredith Lee, DMAS, 600 Broad Street, Suite 1300, Richmond, VA 23219, or via e-mail at: Meredith.Lee@dmas.virginia.gov.

DMAS is specifically soliciting input from stakeholders, providers and beneficiaries, on the potential impact of the proposed changes discussed in this notice. Comments or inquiries may be submitted, in writing, within 30 days of this notice publication to Meredith Lee and such comments are available for review at the same address. Comments may also be submitted, in writing, on the Town Hall public comment forum attached to this notice.

This notice is available for public review on the Regulatory Town Hall (**https://townhall.virginia.gov**) on the General Notices page, found at: **https://townhall.virginia.gov/L/generalnotice.cfm**

In accordance with the 2025 Appropriations Act, DMAS will be making the following changes:

Methods & Standards for Establishing Payment Rates-Other Types of Care (12 VAC 30-80)

1. In accordance with Item 288.FFFFF.2, the state plan is being revised to update the rates for Private Duty and Skilled Nursing under the Early Periodic Screening, and Diagnosis Treatment (EPSDT) benefit by

three percent. (A corresponding rate increase will be provided for these services and for Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, and Benefits Planning provided under home and community- based waivers. These increases are not included in the state plan amendment but via waiver documentation.)

The expected increase in annual fee-for-service aggregate expenditures is $16,490 in state general funds and $17,154 in federal funds in federal fiscal year 2025, and $100,995 in state general funds and $103,199 in federal funds in federal fiscal year 2026.

2. In accordance with Item 288.GGGGG.2, the state plan is being revised to increase the rates for agency- and consumer-directed personal care under the Early Periodic Screening, and Diagnosis and Treatment (EPSDT) benefit by two percent. (A corresponding rate increase of two percent will be provided for these services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.)

The expected increase in annual fee-for-service aggregate expenditures is $109 in state general funds and $112 in federal funds in federal fiscal year 2025, and $660 in state general funds and $673 in federal funds in federal fiscal year 2026.

3. In accordance with Item 288.MMMMM, the state plan is being revised to include a provision for payment of medical assistance for FDA approved long-acting injectable or extended-release medications administered for a serious mental illness or substance use disorder in any hospital emergency department. This payment shall be unbundled from the hospital rate.

The expected increase in annual fee-for-service aggregate expenditures is $841 in state general funds and $1,980 in federal funds in federal fiscal year 2025, and $3,372 in state general funds and $7,939 in federal funds in federal fiscal year 2026.

4. In accordance with Item 288.PPPPP, the state plan is being revised to ensure the reimbursement for a service provided by a licensed certified midwife or licensed midwife shall be in the same amount as the Medicaid reimbursement paid a licensed physician or certified nurse midwife, whichever is higher, for performing such service in the area served.

The expected increase in annual fee-for-service aggregate expenditures is $2,713 in state general funds and $3,554 in federal funds in federal fiscal year 2025, and $10,850 in state general funds and $14,215 in federal funds in federal fiscal year 2026.

5. In accordance with Item 288.UUUUU, the state plan is being revised to increase the rates by 6.5 percent for Office Based Addiction Treatment, Opioid Treatment Services, Partial Hospitalization Services, and Intensive Outpatient Services.

The expected increase in annual fee-for-service aggregate expenditures is $6,177 in state general funds and $23,430 in federal funds in federal fiscal year 2025, and $35,208 in state general funds and $133,554 in federal funds in federal fiscal year 2026.

6. In accordance with Item 288.WWWWW, the state plan is being revised to provide supplemental payments for dentists employed by or contracted with Virginia Commonwealth University's School of Dentistry. The total supplemental payment shall be based on the average commercial rate as approved by the federal Centers for Medicare and Medicaid (CMS) and all other Medicaid payments subject to such limit made to such dentists. DMAS shall enter into a transfer agreement with Virginia Commonwealth University for such supplemental payments, in which the University shall provide the non-federal share in order to match federal Medicaid funds for the supplemental payments.

There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025. The expected increase in annual fee-for-service aggregate expenditures is $854,417 in state general funds and $1,712,833 in federal funds in federal fiscal year 2026.

7. In accordance with Item 3-5.15, the state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for outpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025. The expected increase in annual fee-for-service aggregate expenditures is $1,361,651 in state general funds and $2,747,310 in federal funds in federal fiscal year 2026.

Contact Information

Name / Title:	Meredith Lee / *Policy, Regulations, and Manuals Supervisor*
Address:	600 E. Broad St., Suite 1300 Richmond, 23219
Email Address:	**Meredith.Lee@dmas.virginia.gov**
Telephone:	(804)371-0552 FAX: (804)786-1680 TDD: (800)343-0634

This general notice was created by Meredith Lee on 05/30/2025 at 7:38am

Public comment forums

Make your voice heard! Public comment forums allow all Virginia's citizens to participate in making and changing our state regulations.

See our public comment policy

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Board of Medical Assistance Services

View Comments	Public Notice - Intent to Amend State Plan - 2025 Non-Institutional Provider Reimbursement Changes	**General Notice** Public Notice - Intent to Amend State Plan -2025 Non-Institutional Provider Reimbursement Changes Closed: 6/29/25 0 comments

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. 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, including acute care hospitals and critical access hospitals, and excluding public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, and 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Virginia

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 based on 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~~ July 1, 2025
- Substance Use Care Coordination, which is reimbursed based on a monthly unit, rate set as of ~~April 1, 2017~~ July 1, 2025
- 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~~ July 1, 2025
- 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

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~~ July 1, 2025, 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

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.
4. Podiatry
5. Nurse-midwife services
5.1. Effective July 1, 2025, reimbursement for services provided by a licensed certified midwife or licensed midwife shall be in the same amount as the reimbursement paid to a licensed physician or certified nurse midwife, whichever is higher, for performing such service in the area served.

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.

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~~ July 1, 2025, 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~~ July 1, 2025 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 RATE-
OTHER TYPES OF CARE

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21. Supplemental Payments for Dental Services

A. Effective July 1, 2025, DMAS shall make supplemental payments for dentists employed by or contracted with Virginia Commonwealth University's (VCU) School of Dentistry.

B. The total supplemental payment shall be based on the average commercial rate as approved by the federal Centers for Medicare and Medicaid (CMS) and all other Medicaid payments subject to such limit made to such dentists. 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 (ACR) described on the Medicaid.gov website at https://www.medicaid.gov/medicaid/financial-management/payment-limit-demonstrations/index.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

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

E. Effective July 1, 2025, a provision for payment shall be made for FDA approved long-acting injectable or extended-release medications administered for serious mental illness or substance use disorder in any hospital emergency department. This payment shall be unbundled from the hospital payment rate.

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: 25-0010

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
7/1/2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 46,230
b. FFY 2026 $ 4,719,723

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, revised pages 4.4, 6.02, 6.03, 6.1, 6.2.1& 7.2.4 and Attachment 4.19-B, new page 7.1.3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, pages 4.4, 6.02, 6.03, 6.1, 6.2.1& 7.2.4

9. SUBJECT OF AMENDMENT
2025 Non-Institutioanl 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

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Cheryl J. Roberts

13. TITLE
Agency Director

14. DATE SUBMITTED
August 7, 2025

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

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

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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6. Supplemental Outpatient Payments for Private 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 hospitals, including acute care hospitals and critical access hospitals, and excluding public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, and long-term acute care 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Virginia

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 based on 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 July 1, 2025
- Substance Use Care Coordination, which is reimbursed based on a monthly unit, rate set as of July 1, 2025
- 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 July 1, 2025
- 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

Section 6 A (3), continued.

(m) Community ARTS rehabilitation services. Per diem rates for partial hospitalization (ASAM Level 2.5) described in Attachment 3.1A&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 July 1, 2025, 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

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.
4. Podiatry
5. Nurse-midwife services
5.1. Effective July 1, 2025, reimbursement for services provided by a licensed certified midwife or licensed midwife shall be in the same amount as the reimbursement paid to a licensed physician or certified nurse midwife, whichever is higher, for performing such service in the area served.

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.

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, 2025, 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, 2025 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.

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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

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21. Supplemental Payments for Dental Services

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B. The total supplemental payment shall be based on the average commercial rate as approved by the federal Centers for Medicare and Medicaid (CMS) and all other Medicaid payments subject to such limit made to such dentists. 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 (ACR) described on the Medicaid.gov website at https://www.medicaid.gov/medicaid/financial-management/payment-limit-demonstrations/index.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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.

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