



COMMONWEALTH of VIRGINIA
Office of the Governor

Janet Vestal Kelly
Secretary of Health and Human Resources

May 15, 2025

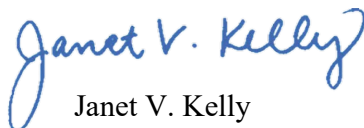
Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Dear Mr. McMillion:

Attached for your review and approval is amendment 25-007, entitled "Tribal Provider Reimbursement" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

This is one of three SPAs that DMAS will be submitting that address services provided by Indian Health Service (IHS) facilities, including facilities operated by a tribe or tribal organization under a Section 638 Agreement with the IHS. SPA 25-006 amends Section 3.1-A&B specifying the scope of covered clinic services, including tribal clinics. SPA 25-007 amends Section 4.19-B and clarifies those services that DMAS will reimburse at the All-Inclusive Rate (AIR) when provided by an IHS or tribal 638 facility. The Department intends to notice a third SPA for public comment and tribal consultation that implements a directive from the Virginia General Assembly limiting the applicability of the AIR to tribal facility services eligible for the 100% FMAP. Please note that each has a different effective date.

Sincerely,


Janet V. Kelly

Attachment

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

Transmittal Summary

SPA 25-007

I. IDENTIFICATION INFORMATION

Title of Amendment: Tribal Provider Reimbursement

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 State Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, provides the Director of the Department of Medical Assistance Services (DMAS) with the full authority of the Board when it is not in session, including authority to administer and amend the State Plan for Medical Assistance.

Purpose: The State Plan is being amended to make the following changes to tribal provider reimbursement:

- Clarify that tribal clinics cannot be reimbursed at the all-inclusive per visit rate (AIR) for non-clinic services, including pharmacy, dental, transportation, and § 1915(c) waiver services.
- Clarify that tribal FQHCs cannot be reimbursed at the all-inclusive per visit rate for pharmacy, transportation, and § 1915(c) waiver services. Dental services provided by Tribal FQHCs are reimbursed through the Alternative Payment Methodology (APM) established in the Medicaid State Plan at Att. 4.19-B, pages 4.6-4.7.
- Clarify the definition of the all-inclusive per visit rate for purposes of reimbursement at the AIR, specifying that it is a bundled, all-inclusive per visit encounter rate and must not be unbundled and billed as separate encounter claims.
- Specify that an Indian Health Service, tribal or urban Indian organization, including a Tribal 638 facility that operates a retail pharmacy, must enroll separately as a pharmacy provider, and that payment for pharmacy services shall align with an existing pharmacy payment methodology and shall not be at the AIR. Drugs provided as part of an outpatient clinic visit are included in the all-inclusive per visit rate for the clinic visit/encounter.

The State Plan is also being amended to make a change needed to reflect new federal requirements for Medicaid reimbursement to tribal clinics, clarifying that these services include

- professional services furnished at the clinic by or under the direction of a physician, or
- services furnished outside the clinic, by clinic personnel under the direction of a physician.

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: The expected decrease in annual aggregate fee-for-service expenditures is \$7,817,289 in state general funds and \$29,477,175 in federal funds in federal fiscal year 2025. The expected decrease in annual aggregate fee-for-service expenditures is \$10,912,457 in state general funds and \$42,122,887 in federal funds in federal fiscal year 2026.

Tribal Notice: Please see attached.

Prior Public Notice: See attached.

Public Comments and Agency Analysis: DMAS received seventy-eight (78) comments that were not in favor of the SPA and that asked DMAS to reconsider the proposed changes. Within these 78 comments, two comments expressed support for implementing the new definition of clinic benefit, one stated that they understood the state’s position on transportation and 1915(c) waiver services, and one requested that the SPA be withdrawn. DMAS also received one comment (via phone) seeking clarification about the SPA process.

DMAS met with the Upper Mattaponi Indian Tribe (UMIT) on March 14, 2025, from 10:00 am-12:00 pm. In attendance from DMAS were: Jeff Lunardi, Chief Deputy Director, Adrienne Fegans, Deputy of Programs and Operations, and Brian Pumphrey, Outside Counsel to DMAS. In attendance from UMIT were: W. Frank Adams, Chief of the Upper Mattaponi Indian Tribe, Owen Adams, Councilperson of the Upper Mattaponi Indian Tribe, Steve Tupponce, Managing Director of UMIT Health Services, and Elliott Milhollin, Counsel to Upper Mattaponi and UMIT Health Services. After the meeting, UMIT sent DMAS an alternative Tribal Provider Reimbursement SPA for consideration and a proposed Reimbursement Agreement.

DMAS has thoroughly considered every comment submitted and the discussion during the March 14th meeting and has decided to proceed with the SPA without any changes.



Outlook

Tribal Notice - State Plan Amendment

From McClellan, Emily (DMAS) <Emily.McClellan@dmas.virginia.gov>

Date Fri 12/20/2024 4:39 PM

To TribalOffice@MonacanNation.com <TribalOffice@MonacanNation.com>; Ann Richardson <chiefannerich@aol.com>; Pam Thompson (pamelathompson4@yahoo.com) <pamelathompson4@yahoo.com>; rappahannocktrib@aol.com (rappahannocktrib@aol.com) <rappahannocktrib@aol.com>; regstew007@gmail.com (regstew007@gmail.com) <regstew007@gmail.com>; Gray, Robert <robert.gray@pamunkey.org>; chief@monacannation.gov <chief@monacannation.gov>; Stephen Adkins (chiefstephenadkins@gmail.com) <chiefstephenadkins@gmail.com>; bradbybrown@gmail.com (bradbybrown@gmail.com) <bradbybrown@gmail.com>; Garrett, Tabitha (IHS/NAS/RIC) (tabitha.garrett@ihs.gov) <tabitha.garrett@ihs.gov>; Kara Kearns (kara.kearns@ihs.gov) <kara.kearns@ihs.gov>; davehennaman@gmail.com <davehennaman@gmail.com>; administrator@nansemond.gov <administrator@nansemond.gov>; info@afwellness.com <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>

 2 attachments (407 KB)

Tribal Notice Letter_Signed by Cheryl Roberts.pdf; Pages 4.9_4.10_7.3_7.4_7.5_from 4.19 B Payment Rates - Other Types of Care - tracked_12_18_24.docx;

Dear Tribal Leaders and Indian Health Programs,

Attached is a letter from Virginia Medicaid Director Cheryl Roberts about changes related to reimbursement of Tribal providers. I have also attached the state plan pages showing the "tracked" changes.

Please let us know if you have any questions.

Thank you! --Emily McClellan

Emily McClellan
Policy Division Director
Department of Medical Assistance Services
emily.mcclellan@dmas.virginia.gov 804-371-4300
Tuesday - Friday 7:00 am - 5:30 pm
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

December 20, 2024

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to Tribal Provider Reimbursement.

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 tribal provider reimbursement:

- Clarify that tribal clinics cannot be reimbursed at the facility rate (all-inclusive rate, or AIR) for non-clinic services, including pharmacy, dental, transportation, and 1915(c) waiver services such as personal care.
- Clarify that tribal FQHCs cannot be reimbursed at the AIR for pharmacy, transportation, and 1915(c) waiver services. Dental services provided by Tribal FQHCs are reimbursed through the Alternative Payment Methodology (APM) established in the Medicaid State Plan at Att. 4.19-B, pages 4.6-4.7.
- Clarify the definition of the per visit rate for purposes of reimbursement at the AIR, specifying that it is a bundled, all-inclusive encounter rate and must not be unbundled and billed as separate encounter claims.
- Specify that an Indian Health Service, tribal or urban Indian organization, including a Tribal 638 facility that operates a retail pharmacy, must enroll separately as a pharmacy provider, and that payment for pharmacy services shall align with an existing pharmacy payment methodology and shall not be at the AIR. Drugs provided as part of an outpatient clinic visit are included in the all-inclusive rate for the encounter.

The SPA will also make a change needed to reflect new federal requirements for Medicaid reimbursement to tribal clinics, clarifying that these services include:

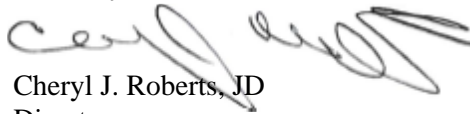
- professional services furnished at the clinic by or under the direction of a physician, or
- services furnished outside the clinic, by clinic personnel under the direction of a physician.

The changes in this SPA will 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 February 18, 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
StreetRichmond,
VA 23219

Please forward this information to any interested party.

Sincerely,

A handwritten signature in black ink, appearing to read "Cheryl J. Roberts, JD". The signature is fluid and cursive, with a large, stylized initial "C".

Cheryl J. Roberts, JD
Director



Tribal Notice - State Plan Amendment

From McClellan, Emily (DMAS) <Emily.McClellan@dmas.virginia.gov>

Date Tue 2/18/2025 4:23 PM

To TribalOffice@MonacanNation.com <TribalOffice@MonacanNation.com>; Ann Richardson <chiefannerich@aol.com>; Pam Thompson (pamelathompson4@yahoo.com) <pamelathompson4@yahoo.com>; rappahannocktrib@aol.com (rappahannocktrib@aol.com) <rappahannocktrib@aol.com>; regstew007@gmail.com (regstew007@gmail.com) <regstew007@gmail.com>; Richard.matens@pamunkey.org <Richard.matens@pamunkey.org>; chief@monacannation.gov <chief@monacannation.gov>; Stephen Adkins (chiefstephenadkins@gmail.com) <chiefstephenadkins@gmail.com>; bradbybrown@gmail.com (bradbybrown@gmail.com) <bradbybrown@gmail.com>; Garrett, Tabitha (IHS/NAS/RIC) (tabitha.garrett@ihs.gov) <tabitha.garrett@ihs.gov>; Kara Kearns (kara.kearns@ihs.gov) <kara.kearns@ihs.gov>; davehennaman@gmail.com <davehennaman@gmail.com>; administrator@nansemond.gov <administrator@nansemond.gov>; info@afwellness.com <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>

 1 attachment (177 KB)

Revised Tribal Notice Letter 2-18-25 (Signed).pdf;

Dear Tribal Leaders and Indian Health Programs,

Attached is a letter from Virginia Medicaid Director Cheryl Roberts about an extension of a comment period for a state plan amendment related to reimbursement of Tribal providers.

Please let us know if you have any questions.

Thank you! --Emily McClellan

Emily McClellan
Policy Division Director
Department of Medical Assistance Services
emily.mcclellan@dmas.virginia.gov 804-371-4300
Tuesday - Friday 7:00 am - 5:30 pm
www.dmas.virginia.gov



T Trust	H Health	R Results	I Integrity	V Vision	E Engagement
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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

February 18, 2025

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to Tribal Provider Reimbursement.

Dear Tribal Leader and Indian Health Programs:

On December 20, 2024, the Department of Medical Assistance Services (DMAS) sent you a letter providing you notice about a State Plan Amendment (SPA) that DMAS will file with the Centers for Medicare and Medicaid Services (CMS) to make changes to tribal provider reimbursement. In that letter, DMAS indicated that the tribal comment period for this SPA would be open through February 18, 2025.

This letter serves as notification that the tribal comment period is being extended through April 25, 2025.

The changes that DMAS will make in the SPA remain the same. Specifically, the SPA will make the following changes to tribal provider reimbursement:

- Clarify that tribal clinics cannot be reimbursed at the facility rate (all-inclusive rate, or AIR) for non-clinic services, including pharmacy, dental, transportation, and 1915(c) waiver services such as personal care.
- Clarify that tribal FQHCs cannot be reimbursed at the AIR for pharmacy, transportation, and 1915(c) waiver services. Dental services provided by Tribal FQHCs are reimbursed through the Alternative Payment Methodology (APM) established in the Medicaid State Plan at Att. 4.19-B, pages 4.6-4.7.
- Clarify the definition of the per visit rate for purposes of reimbursement at the AIR, specifying that it is a bundled, all-inclusive encounter rate and must not be unbundled and billed as separate encounter claims.
- Specify that an Indian Health Service, tribal or urban Indian organization, including a Tribal 638 facility that operates a retail pharmacy, must enroll separately as a pharmacy provider, and

that payment for pharmacy services shall align with an existing pharmacy payment methodology and shall not be at the AIR. Drugs provided as part of an outpatient clinic visit are included in the all-inclusive rate for the encounter.

The SPA will also make a change needed to reflect new federal requirements for Medicaid reimbursement to tribal clinics, clarifying that these services include:

- professional services furnished at the clinic by or under the direction of a physician, or
- services furnished outside the clinic, by clinic personnel under the direction of a physician.

The changes in this SPA will 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. As noted above, the tribal comment period for this SPA is open through April 25, 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,

A handwritten signature in black ink, appearing to read 'Cheryl J. Roberts', written over a light blue horizontal line.

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 - Reimbursement of Tribal Providers

Date Posted: 12/20/2024

Expiration Date: 7/31/2025

Submitted to Registrar for publication: YES

[126 Day Comment Forum](#) closed. Began on 12/20/2024 and ended 4/25/2025 [1 comments]

**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 December 20, 2024

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, by midnight on April 25, 2025, 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>.

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

This SPA makes the following changes to tribal provider reimbursement:

- Clarifies that tribal clinics cannot be reimbursed at the facility rate (all inclusive rate, or AIR) for non-clinic services, including pharmacy, dental, transportation, and 1915(c) waiver services such as personal care.
- Clarifies that tribal FQHCs cannot be reimbursed at the AIR for pharmacy, transportation, and 1915(c) waiver services. Dental services provided by Tribal FQHCs are reimbursed through the Alternative Payment Methodology (APM) established in the Medicaid State Plan at Att. 4.19-B, pages 4.6-4.7.
- Clarifies the definition of the per visit rate for purposes of reimbursement at the AIR, specifying that it is a bundled, all-inclusive encounter rate and must not be unbundled and billed as separate encounter claims.
- Specifies that an Indian Health Service, tribal or urban Indian organization, including a Tribal 638 facility that operates a retail pharmacy, must enroll separately as a pharmacy provider, and that payment for pharmacy services shall align with an existing pharmacy payment methodology and shall not be at the AIR. Drugs provided as part of an outpatient clinic visit are included in the all-inclusive rate for the encounter.

This SPA also makes a change needed to reflect new federal requirements for Medicaid reimbursement to tribal clinics, clarifying that these services include

- professional services furnished at the clinic by or under the direction of a physician, or
- services furnished outside the clinic, by clinic personnel under the direction of a physician.

The expected decrease in annual aggregate fee-for-service expenditures is \$7,817,289 in state general funds and \$29,477,175 in federal fiscal year 2025. The expected decrease in annual aggregate fee-for-service expenditures is \$10,912,457 in state general funds and \$42,122,887 in federal funds in federal fiscal year 2026.

Contact Information

Name / Title:	Emily McClellan / <i>Regulatory Manager</i>
Address:	Division of Policy and Research 600 E. Broad St., Suite 1300 Richmond, 23219
Email Address:	Emily.McClellan@dmas.virginia.gov
Telephone:	(804)371-4300 FAX: (804)786-1680 TDD: (800)343-0634

This general notice was created by Emily McClellan on 12/20/2024 at 4:40pm

This general notice was last modified by Emily McClellan on 02/18/2025 at 4:28pm

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

REIMBURSEMENT FOR INDIAN HEALTH SERVICE TRIBAL 638 HEALTH FACILITIES

A. Reimbursement for Tribal Health Clinics

1. Outpatient clinic Services services provided by or through facilities of the Indian Health Services (IHS) which includes, at the option of the tribe Tribe, facilities operated by a tribe Tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act, also known as Tribal 638 facilities, are paid at the applicable IHS OMB rate published in the annual Federal Register or Federal Register Notices by IHS.
2. The most current published IHS OMB outpatient per visit rate, also known as the outpatient all-inclusive rate, is paid for up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services (a) furnished at the clinic by or under the direction of a physician or (b) furnished outside of the clinic, by clinic personnel under the direction of a physician. An outpatient visit is defined as a face-to-face or telemedicine contact between any a Medicaid beneficiary and a health care professional, at or through the IHS facility as described above, authorized to provide services under the State Plan and a beneficiary for the provision of Title XIX defined services, as documented in the Medicaid beneficiary's medical record.
3. To be included in the The outpatient all-inclusive per visit rate are certain pharmaceutical/drugs, dental services, is a bundled rate for medical, rehabilitative services, or behavioral health services, and includes any and all ancillary services, and emergency room services provided on-site and medical supplies incidental to the services provided to the Medicaid beneficiary. The per visit rate is a bundled, all-inclusive rate for a single encounter and must not be unbundled and billed as separate encounter claims. Drugs provided as part of an outpatient clinic visit are included in the all-inclusive rate for the encounter.
4. Pharmacy, dental, transportation, and 1915(c) waiver services such as personal care are not considered clinic services and will not be reimbursed at the IHS OMB all-inclusive rate (AIR). If it so qualifies, the tribal provider may enroll and operate as one or more of these provider types and receive the reimbursement rate that aligns with the relevant provider type.

~~B. Payments to Tribal 638 Programs~~

~~Virginia Medicaid reimburses Tribal 638 facilities in accordance with the most recently published Federal Register. Encounters/visits are limited to healthcare professionals as approved under the Virginia Medicaid State Plan. A tribal health program selecting to enroll as a FQHC and agreeing to an alternate payment methodology (APM) will be paid using the APM.~~

~~C. B. Alternative Payment Methodology for Tribal Facilities Recognized as FQHCs~~

1. Outpatient health programs or facilities operated by a Tribe or Tribal organization A Tribal 638 facility that choose to be recognized as elects to participate as a FQHCs FQHC in accordance with Section 1905 (I)(2)(B) of the Social Security Act and the Indian Self-Determination Act (Public Law 93-638) will be paid using an alternative payment methodology (APM) for the same services

TN No. ~~21-007-25-0007~~

Approval Date ~~6/22/21~~

Effective Date ~~2/24/21-4/1/25~~

Supersedes

TN No. ~~New Page-21-007~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

listed in Section A.3 above for Tribal 638 clinics. The APM is the IHS OMB outpatient per visit services, that is the published, all-inclusive rate (AIR). The APM/AIR rate is paid for up to five face-to-face encounters/visits per recipient Medicaid beneficiary per day. The per visit rate is a bundled, all-inclusive rate based on a face-to-face visit and must not be unbundled and billed as separate encounter claims. Pharmacy, transportation, and 1915(c) waiver services such as personal care are not considered facility services and will not be reimbursed at the all-inclusive APM/AIR rate. If it so qualifies, the tribal provider may enroll and operate as one or more of these provider types and receive the reimbursement rate that aligns with the relevant provider type.

Dental services provided by Tribal FQHCs are reimbursed through the APM established at Att. 4.19-B, pages 4.6-4.7.

2. Virginia Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal ~~facility~~ FQHC so that the Agency can determine on an annual basis that the published, all-inclusive rate results in payment to the ~~center or clinic~~ Tribal FQHC of an amount which is at least equal to the PPS payment rate. The PPS rate will be established by reference to the current rate applicable to one or more ~~non-tribal non-Tribal~~ FQHCs in the same or adjacent areas with similar caseloads. If such a ~~non-tribal non-Tribal~~ FQHC is not available, the PPS rate will be established by reference to the current rate applicable to one or more ~~non-tribal non-Tribal~~ FQHCs in the same or adjacent areas with a similar scope of services. If there is no ~~non-tribal non-Tribal~~ FQHC in the same or adjacent area with similar caseloads or similar scope of services, the PPS rate will be based on an average rate of ~~non-tribal non-Tribal~~ FQHCs throughout the state. The Tribal facility would not be required to report its costs for the purposes of establishing a PPS rate. The APM is effective for services provided on and after February 24, 2021.

3. The individual Tribal FQHC must agree to receive the APM.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

§7. Fee-for-service providers: pharmacy. (12VAC30-80-40)

1. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ~~ingredient~~ ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;
- c) The Federal ~~Upper~~ Upper Limit (FUL); OR
- d) The provider's usual and customary (U&C) charge to the public as identified by the claim charge.

2. Payment for specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost ~~reimbursement~~ reimbursement shall be the lowest of:

- a) The National Average Drug ~~Acquisition~~ Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;
- c) The Federal Upper Limit (FUL); OR
- d) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

3. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug ~~Acquisition~~ Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;
- c) The Federal Upper Limit (FUL); OR
- d) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

4. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;

b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%; OR

c) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

5. 340B covered entities and Federally Qualified Health Centers (FQHCs) that fill Medicaid member prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee. 340B covered entities that fill Medicaid member prescriptions with drugs not purchased under the Section 340B of the Public Health Services Act will be reimbursed in accordance to section 7.1 plus the \$10.65 professional dispensing fee as described in section 7.8.

6. Facilities purchasing drugs through the Federal Supply ~~scheduled~~ scheduled (FSS) or drug pricing program under 39 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee.

7. Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee. Nominal Price as defined in § 447.502 of the Code of Federal Regulations, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

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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**

8. Payment for pharmacy services will be as described above in sections 7.1 - 7.7; however, shall include the allowed cost of the drug plus only one professional dispensing fee, as defined at 42 CFR § 447.502, per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The professional dispensing fee for all covered outpatient drugs shall be \$10.65. The professional dispensing fee shall be determined by a cost of dispensing survey conducted at least every five years.

9. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106 percent of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at the provider's acquisition cost. Covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act or drugs purchased through the Federal Supply schedule (FSS) or drug pricing program under 39 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8 for Medicaid members must bill Medicaid their actual acquisition cost (AAC).

10. An Indian Health Service, Tribal or urban Indian organization, including Tribal 638 facility that operates a retail pharmacy must enroll separately as a pharmacy. Payment to Indian Health Service, tribal and urban Indian pharmacies. DMAS does not have any accepts enrollment of Indian Health Service, tribal Tribal or urban Indian pharmacies, at this time however payment for pharmacy services would not be at the IHS OMB outpatient per visit rate, also known as the outpatient all-inclusive rate (AIR). Payment for pharmacy services will be defined in a state plan amendment if If such entity enrolls with DMAS, payment will align with one of the following:

- a) Paragraph 1 of this section when the drugs are obtained at a standard market price
- b) Paragraph 5 of this section when drugs are obtained under Section 340B of the Public Health Services Act
- c) Paragraph 6 of this section when the drugs are obtained through Federal Supply schedule (FSS)

11. Investigational drugs are not a covered service under the DMAS pharmacy program.

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER ____ _	2. STATE ____
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3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI
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TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE 04/01/2025
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5. FEDERAL STATUTE/REGULATION CITATION
--


6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY _____ \$ _____ b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
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8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

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
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11. SIGNATURE OF STATE AGENCY OFFICIAL 
12. TYPED NAME
13. TITLE
14. DATE SUBMITTED

15. RETURN TO

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE- OTHER TYPES OF CARE**REIMBURSEMENT FOR INDIAN HEALTH SERVICE TRIBAL 638 HEALTH FACILITIES****A. Reimbursement for Tribal Health Clinics**

1. Outpatient clinic services provided by facilities of the Indian Health Services (IHS) which includes, at the option of the Tribe, facilities operated by a Tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act, also known as Tribal 638 facilities, are paid at the applicable IHS OMB rate published in the annual Federal Register or Federal Register Notices by IHS.
2. The most current published IHS OMB outpatient per visit rate, also known as the outpatient all-inclusive rate, is paid for up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services (a) furnished at the clinic by or under the direction of a physician or (b) furnished outside of the clinic, by clinic personnel under the direction of a physician. An outpatient visit is defined as a face-to-face or telemedicine contact between a Medicaid beneficiary and a health care professional authorized to provide services under the State Plan for the provision of Title XIX defined services, as documented in the Medicaid beneficiary's medical record.
3. The outpatient all-inclusive per visit rate is a bundled rate for medical, rehabilitative, or behavioral health services, and includes any and all ancillary services and medical supplies incidental to the services provided to the Medicaid beneficiary. The per visit rate is a bundled, all-inclusive rate for a single encounter and must not be unbundled and billed as separate encounter claims. Drugs provided as part of an outpatient clinic visit are included in the all-inclusive rate for the encounter.
4. Pharmacy, dental, transportation, and 1915(c) waiver services such as personal care are not considered clinic services and will not be reimbursed at the IHS OMB all-inclusive rate (AIR). If it so qualifies, the tribal provider may enroll and operate as one or more of these provider types and receive the reimbursement rate that aligns with the relevant provider type.

B. Alternative Payment Methodology for Tribal Facilities Recognized as FQHCs

1. A Tribal 638 facility that elects to participate as a FQHC in accordance with Section 1905 (I)(2)(B) of the Social Security Act and the Indian Self-Determination Act (Public Law 93-638) will be paid using an alternative payment methodology (APM) for the same services

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

listed in Section A.3 above for Tribal 638 clinics. The APM is the IHS OMB outpatient per visit all-inclusive rate (AIR). The APM/AIR rate is paid for up to five face-to-face encounters/visits per Medicaid beneficiary per day. The per visit rate is a bundled, all-inclusive rate based on a face-to-face visit and must not be unbundled and billed as separate encounter claims. Pharmacy, transportation, and 1915(c) waiver services such as personal care are not considered facility services and will not be reimbursed at the all-inclusive APM/AIR rate. If it so qualifies, the tribal provider may enroll and operate as one or more of these provider types and receive the reimbursement rate that aligns with the relevant provider type.

Dental services provided by Tribal FQHCs are reimbursed through the APM established at Att. 4.19-B, pages 4.6-4.7.

2. Virginia Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal FQHC so that the Agency can determine on an annual basis that the published, all-inclusive rate results in payment to the Tribal FQHC of an amount which is at least equal to the PPS payment rate. The PPS rate will be established by reference to the current rate applicable to one or more non-Tribal FQHCs in the same or adjacent areas with similar caseloads. If such a non-Tribal FQHC is not available, the PPS rate will be established by reference to the current rate applicable to one or more non-Tribal FQHCs in the same or adjacent areas with a similar scope of services. If there is no non-Tribal FQHC in the same or adjacent area with similar caseloads or similar scope of services, the PPS rate will be based on an average rate of non-Tribal FQHCs throughout the state. The Tribal facility would not be required to report its costs for the purposes of establishing a PPS rate. The APM is effective for services provided on and after February 24, 2021.

3. The individual Tribal FQHC must agree to receive the APM.

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§7. Fee-for-service providers: pharmacy. (12VAC30-80-40)

1. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;
- c) The Federal Upper Limit (FUL); OR
- d) The provider's usual and customary (U&C) charge to the public as identified by the claim charge.

2. Payment for specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;
- c) The Federal Upper Limit (FUL); OR
- d) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

3. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

- a) The National Average Drug Acquisition Cost (NADAC) of the drug;
- b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%;
- c) The Federal Upper Limit (FUL); OR
- d) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

4. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus a \$10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be lowest of:

-The National Average Drug Acquisition Cost (NADAC) of the drug;

-When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%; OR

-The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

5. 340B covered entities and Federally Qualified Health Centers (FQHCs) that fill Medicaid member prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee. 340B covered entities that fill Medicaid member prescriptions with drugs not purchased under the Section 340B of the Public Health Services Act will be reimbursed in accordance to section 7.1 plus the \$10.65 professional dispensing fee as described in section 7.8.

6. Facilities purchasing drugs through the Federal Supply schedule (FSS) or drug pricing program under 39 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee.

7. Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a \$10.65 professional dispensing fee. Nominal Price as defined in § 447.502 of the Code of Federal Regulations, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

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State of VIRGINIA

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

8. Payment for pharmacy services will be as described above in sections 7.1 - 7.7; however, shall include the allowed cost of the drug plus only one professional dispensing fee, as defined at 42 CFR § 447.502, per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The professional dispensing fee for all covered outpatient drugs shall be \$10.65. The professional dispensing fee shall be determined by a cost of dispensing survey conducted at least every five years.

9. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106 percent of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at the provider's acquisition cost. Covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act or drugs purchased through the Federal Supply schedule (FSS) or drug pricing program under 39 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8 for Medicaid members must bill Medicaid their actual acquisition cost (AAC).

10. An Indian Health Service, Tribal or urban Indian organization, including Tribal 638 facility that operates a retail pharmacy must enroll separately as a pharmacy. DMAS accepts enrollment of Indian Health Service, Tribal or urban Indian pharmacies, however payment for pharmacy services would not be at the IHS OMB outpatient per visit rate, also known as the outpatient all-inclusive rate (AIR). If such entity enrolls with DMAS, payment will align with one of the following:

- a) Paragraph 1 of this section when the drugs are obtained at a standard market price
- b) Paragraph 5 of this section when drugs are obtained under Section 340B of the Public Health Services Act
- c) Paragraph 6 of this section when the drugs are obtained through Federal Supply schedule (FSS)

11. Investigational drugs are not a covered service under the DMAS pharmacy program.