COMMONWEALTH of VIRGINIA
Office of the Governor

Janet Vestal Kelly
Secretary of Health and Human Resources

September 12, 2024

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 24-0018, entitled "2024 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 24-018

I. IDENTIFICATION INFORMATION

Title of Amendment: 2024 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 2024 Appropriations Act requires DMAS to make the following changes:

- Item 288.BBBB.2: The state plan is being revised to increase reimbursement rates for dental services by three percent.

- Item 288.GGGGG.1: 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.SSSS: The state plan is being revised to update the reimbursement methodology for outpatient rehabilitation services to the Resource Based Relative Value Scale. Any changes to the reimbursement methodology shall be budget neutral. To ensure and maintain budget neutrality, a budget neutrality factor shall be applied to any rate calculations. (Duplicate language related to outpatient rehabilitation services appears on 4.19-B page 4.1 and 4.1.1, so this SPA will also remove the language on page 4.1, so the state plan does not contain duplicative and unnecessary language.)

- Item 288.XXXX: The state plan is being revised to update the rates for consumer-directed facilitation services under EPSDT based on the most recent rebasing estimates as follows: Consumer Directed (CD) Management Training shall be increased to $90.14 per hour in Northern Virginia and to $80.91 per hour in the rest of the state; CD Initial Comprehensive Visit shall be increased to $360.54 per visit in Northern Virginia and to $323.64 per visit in the rest of the state; CD Routine Visit shall be increased to $112.67 per visit in Northern Virginia and to $101.14 per visit in the rest of the state; and CD Reassessment Visit shall be increased to $180.27 per visit in Northern Virginia and to $161.82 per visit in the rest of the state.

- Item 288.YYYY: The state plan is being revised to set the reimbursement rate to 100 percent of the Medicare rural rates or 100 percent of non-rural rates if a rural rate does not exist for specific Durable Medical Equipment (DME) products, including enteral products and supplies and in the following categories in the DMAS fee schedule for Feeding Kits and Tubes and Nutrition Kits/Feeding Tubes.

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.BBBB.2: The expected increase in annual fee-for-service aggregate expenditures is $664,129 in state general funds, $64,314 in special funds, and $1,276,171 in federal funds in federal fiscal year 2024, and $4,083,634 in state general funds, $393,599 in special funds, and $8,184,610 in federal funds in federal fiscal year 2025.

- Item 288.GGGGG.1: The expected increase in annual fee-for-service aggregate expenditures is $104 in state general funds and $109 in federal funds in federal fiscal year 2024, and $625 in state general funds and $651 in federal funds in federal fiscal year 2025.

- Item 288.SSSS: There is no expected increase or decrease in annual fee-for-service aggregate expenditures in federal fiscal year 2024 or 2025.

- Item 288.XXXX: The expected increase in annual fee-for-service aggregate expenditures is $398 in state general funds and $418 in federal funds in federal fiscal year 20242, and $2,800 in state general funds and $2,913 in federal funds in federal fiscal year 2025.

- Item 288.YYYY: The expected increase in annual fee-for-service aggregate expenditures is $7,966 in state general funds, $136 in special funds, and $9,587 in federal funds in federal fiscal year 2024, and $48,024 in state general funds, $815 in special funds, and $58,114 in federal funds in federal fiscal year 2025.

Tribal Notice: Please see attached.

Prior Public Notice: See Attached.

Public Comments and Agency Analysis: Please see attached.

Tribal Notice – Non-Institutional Provider Reimbursement Changes

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

Thu 8/22/2024 7:26 AM

To:TribalOffice@MonacanNation.com <TribalOffice@MonacanNation.com>;Ann Richardson <chiefannerich@aol.com>; pamelathompson4@yahoo.com (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>;Adrian Compton <tribaladmin@monacannation.com>; chiefstephenadkins@gmail.com (chiefstephenadkins@gmail.com) <chiefstephenadkins@gmail.com>;bradbybrown@gmail.com (bradbybrown@gmail.com) <bradbybrown@gmail.com>;tabitha.garrett@ihs.gov (tabitha.garrett@ihs.gov) <tabitha.garrett@ihs.gov>; kara.kearns@ihs.gov (kara.kearns@ihs.gov) <kara.kearns@ihs.gov>;ReBecca.Robinson@ihs.gov <ReBecca.Robinson@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>

1 attachments (264 KB)

08-21-24 Tribal Notice letter, signed by CR.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 non-institutional provider reimbursement changes.

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

CardinalCare
Virginia's Medicaid Program

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CHERYL J. ROBERTS
DIRECTOR

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

August 22, 2024

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to 2024 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 2024 Appropriations Act:

- Item 288.BBBB.2: The state plan is being revised to increase reimbursement rates for dental services by three percent.

- Item 288.GGGGG.1: 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.SSSS: The state plan is being revised to update the reimbursement methodology for outpatient rehabilitation services to the Resource Based Relative Value Scale. Any changes to the reimbursement methodology shall be budget neutral. To ensure and maintain budget neutrality, a budget neutrality factor shall be applied to any rate calculations. (Duplicate language related to outpatient rehabilitation services appears on 4.19-B page 4.1 and 4.1.1, so this SPA will also remove the language on page 4.1, so the state plan does not contain duplicative and unnecessary language.)

- Item 288.XXXX: The state plan is being revised to update the rates for consumer-directed facilitation services under EPSDT based on the most recent rebasing estimates as follows: Consumer Directed (CD) Management Training shall be increased to $90.14 per hour in Northern Virginia and to $80.91 per hour in the rest of the state; CD Initial Comprehensive Visit shall be increased to $360.54 per visit in Northern Virginia and to $323.64 per visit in the rest of the state; CD Routine Visit shall be increased to $112.67 per visit in Northern Virginia and to $101.14 per visit in the rest of the state; and CD Reassessment Visit shall be increased to $180.27 per visit in Northern Virginia and to $161.82 per visit in the rest of the state.

- Item 288.YYYY: The state plan is being revised to set the reimbursement rate to 100 percent of the Medicare rural rates or 100 percent of non-rural rates if a rural rate does not exist for specific Durable Medical Equipment (DME) products, including enteral products and supplies and in the following categories in the DMAS fee schedule for Feeding Kits and Tubes and Nutrition Kits/Feeding Tubes.

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 21, 2024. 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 - Non-Institutional Provider Reimbursement Changes

Date Posted: 5/24/2024

Expiration Date: 11/24/2024

Submitted to Registrar for publication: YES

30 Day Comment Forum closed. Began on 5/24/2024 and ended 6/23/2024

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 24, 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, 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 2024 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.BBBB.2, the state plan is being revised to increase reimbursement rates for dental services by three percent.

The expected increase in annual fee-for-service aggregate expenditures is $664,129 in state general funds, $64,314 in special funds, and $1,276,171 in federal funds in federal fiscal year 2024, and $4,083,634 in state general funds, $393,599 in special funds, and $8,184,610 in federal funds in federal fiscal year 2025.

2. In accordance with Item 288.GGGGG.1, 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 $104 in state general funds and $109 in federal funds in federal fiscal year 2024, and $625 in state general funds and $651 in federal funds in federal fiscal year 2025.

3. In accordance with Item 288.SSSS, the state plan is being revised to update the reimbursement methodology for outpatient rehabilitation services to the Resource Based Relative Value Scale. Any changes to the reimbursement methodology shall be budget neutral. To ensure and maintain budget neutrality, a budget neutrality factor shall be applied to any rate calculations.

There is no expected increase or decrease in annual fee-for-service aggregate expenditures in federal fiscal year 2024 or 2025.

4. In accordance with Item 288.XXXX, the state plan is being revised to update the rates for consumer-directed facilitation services under EPSDT based on the most recent rebasing estimates as follows: Consumer Directed (CD) Management Training shall be increased to $90.14 per hour in Northern Virginia and to $80.91 per hour in the rest of the state; CD Initial Comprehensive Visit shall be increased to $360.54 per visit in Northern Virginia and to $323.64 per visit in the rest of the state; CD Routine Visit shall be increased to $112.67 per visit in Northern Virginia and to $101.14 per visit in the rest of the state; and CD Reassessment Visit shall be increased to $180.27 per visit in Northern Virginia and to $161.82 per visit in the rest of the state.

The expected increase in annual fee-for-service aggregate expenditures is $398 in state general funds and $418 in federal funds in federal fiscal year 20242, and $2,800 in state general funds and $2,913 in federal funds in federal fiscal year 2025.

5. In accordance with Item 288.YYYY, the state plan is being revised to set the reimbursement rate to 100 percent of the Medicare rural rates or 100 percent of non-rural rates if a rural rate does not exist for specific Durable Medical Equipment (DME) products, including enteral products and supplies and in the following categories in the DMAS fee schedule for Feeding Kits and Tubes and Nutrition Kits/Feeding Tubes.

The expected increase in annual fee-for-service aggregate expenditures is $7,966 in state general funds, $136 in special funds, and $9,587 in federal funds in federal fiscal year 2024, and $48,024 in state general funds, $815 in special funds, and $58,114 in federal funds in federal fiscal year 2025.

Contact Information

Name / Title:	Meredith Lee / *Policy, Regulations, and Manuals Supervisor*
Address:	Division of Policy and Research 600 East Broad Street, 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 05/24/2024 at 7:41am

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

Currently showing **14** comment forums closed within the last 45 days for the Board of Medical Assistance Services.

Recently closed
Recently opened
Active Forums
More filter options

Regulatory Activity Forums (12) | Guidance Document Forums (2)

Actions (3) | Periodic Reviews () | Petitions for Rulemaking () | General Notices (9)

Board of Medical Assistance Services

View Comments	Public Notice - Intent to Amend State Plan - Non-Institutional Provider Reimbursement Changes	General Notice	Public Notice - Intent to Amend State Plan - Non-Institutional Provider Reimbursement Changes Closed: 6/23/24 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

~~2.D.2. Rehabilitation agencies operated by state agencies for physical therapy, occupational therapy, and speech-language therapy services. The reimbursement methodology for physical therapy, occupational therapy, and speech-language therapy applicable to other rehabilitation agencies is based on Attachment 4.19-B, Supplement 5.~~

~~a. Allocable cost shall be determined as provided in subsections 2.A and 2.B of page 1 and 2C of page 2 of this section.~~

~~b. The following additional procedures shall be followed:~~

~~(1) The CMS-approved cost report determined reimbursable costs for physical therapy, occupational therapy, and speech-language pathology service cost centers. General service costs are stepped down to each service cost center (including any non-reimbursable service cost centers). The cost report shall calculate a ration of cost to charges for each reimbursable service cost center. Cost finding shall be determined according to Medicare principles.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

6.A. 2. Dentists' services: Dental services, dental provider qualifications and dental service limits are identified in Attachment 3.l A&B, Supplement 1, page 16.1 and 16.1.1. Dental services are paid based on procedure codes which are listed in the Agency' fee schedule rate, effective ~~January 1, 2024~~ July 1, 2024. All rates are published on the DMAS website at www.dmas.virginia.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

Dentures. Coverage and service limits for dentures are identified in Attachment 3.lA&B, Supplement 1, page 26.1. Dental services are paid based on procedure codes which are listed in the Agency' fee schedule rate, effective ~~January 1, 2024~~ July 1, 2024. All rates are published on the DMAS website at www.dmas.virginia.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

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

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, and suction machines. Ventilators, non-continuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

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

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

7. Local health services, including services paid to local school districts
8. Laboratory services (Other than inpatient hospital) The agency's rates for clinical laboratory services were set as of July 1, 2014, and are effective for services on or after that date.
9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)
10. X-Ray services.
11. Optometry services
12. Reserved.
13. Home health services: Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3. (12 VAC30-80-180)
14. Physical therapy, occupational therapy, and speech, hearing, language disorders services when rendered to non-institutionalized recipients. Physical therapy, occupational therapy, and speech-language therapy services furnished by state rehabilitation agencies are paid on a cost basis (see sec. 2D, page 4.1). All other services under this section furnished by rehabilitation agencies are paid rates established by Supplement 5.
15. Clinic services, as defined under 42 CFR 440.90, except for services in amblulatory surgery clinics reimbursed under Attachment 4.19-B, page 7.2 (12 VAC 30-80-35).
16. Supplemental payments to state government-owned or operated clinics.
(Repealed effective July 1, 2005)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

16.1 Reimbursement for personal care services for individuals enrolled in the Medicaid Buy-In program described in Attachment 2.6A, Supplement 8a, p 1-3 or for personal care services covered under EPSDT. All governmental and private providers are reimbursed according to the same published fee schedule. All rates are published on the DMAS website at www.dmas.virginia.gov. The Agency's rates, based upon one-hour increments, were set as of ~~January 1, 2024~~ July 1, 2024, and shall be effective for 1902(a) state plan authorized services on and after that date. Qualifying overtime for consumer-directed personal care provided under EPSDT will be paid 150% of the fee schedule, and qualifying sick leave for consumer – directed personal care provided under EPSDT will be at 100% of the fee schedule.

16.1.a. Reimbursement for consumer-directed services facilitator services under EPSDT as described per Supplement 1 to Attachment 3.1A&B, pages 6.4.7 & 6.4.8. All governmental and private providers are reimbursed according to the same published fee schedule, located on the DMAS website at www.dmas.virginia.gov. The Agency's rates were set as of ~~July 1, 2022~~ July 1, 2024, and shall be effective for services provided on and after that date.

16.2. Private duty nursing services covered under EPSDT as defined per Supplement 1 to Attachment 3.1A&B, page 6.4.8, with provider qualifications on page 6.4.8, are reimbursed based on a 15-minute unit of service in accordance with the State Agency fee schedule. The fee schedule is the same for both governmental and private providers and was set as of July 1, 2022 and shall be effective for services provided on and after that date. The state agency fee schedule is published on the DMAS website at www.dmas.virginia.gov.

16.3 Medical Supplies, Equipment and Appliances (assistive technology) covered under EPSDT, as defined per Supplement 1 to Attachment 3.1 A&B, page 6.4.9, with provider qualifications on page 6.4.10. The service shall be reimbursed based upon the total cost of all AT incurred by the provider.

16.4 Reserved.

16.5 Hospice services, as defined per Attachment 3.1 A&B, Supplement 1, pages 33-37. Hospice services payments are effective October 1 annually and are equivalent to the annual Medicaid hospice rates published by CMS. As of July 1, 2019, room and board will be reimbursed at a rate equal to 100 percent of the skilled nursing facility rate for Medicaid members receiving hospice services who reside in a nursing facility. Hospice services shall be paid according to the location of the service delivery and not the location of the Agency's home office. Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to Medicaid members. During the twelve (12) month period beginning October 1 of each year and ending September 30 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid members during the same period.

Services that are included in the hospice reimbursement are: (a) Routine Home Care where most hospice care is provided - Days 1- 60; (b) Routine Home Care where most hospice care is provided-Days 61 and over; (c) Continuous Home Care; (d) Hospice Inpatient Respite Care; (e) Hospice General Inpatient Care; (f) Service Intensity Add-On (SIA) will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member' s life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.

16.3.1 Effective July 1, 2019, the telehealth originating site facility fee shall be set at 100 percent of the Medicare rate and shall reflect changes annually based on any changes in the Medicare rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

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

A. Rehabilitation agencies or comprehensive outpatient rehabilitation facilities.

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

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

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

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

~~2.~~1. Payments for the fiscal year ending or in progress on June 30, 2009, shall be settled for private rehabilitation agencies based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of June 30, 2009.

~~4.~~2. Payment for fiscal year ending or in progress on September 30, 2009, shall be settled for community services boards based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of September 30, 2009.

TN No. 10-16 Approval Date 06-15-11 Effective Date 07-01-10
Supersedes
TN No. 09-20

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0018

2. STATE: VA

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

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

4. PROPOSED EFFECTIVE DATE
7/1/2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

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

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

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

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

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
Secretary of Health and Human Resources

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Cheryl J. Roberts

13. TITLE
Agency Director

14. DATE SUBMITTED
August 21, 2024

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

Attn: Policy, Regulations, and Manuals Supervisor

FOR CMS USE ONLY

16. DATE RECEIVED

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.A. 2. Dentists' services: Dental services, dental provider qualifications and dental service limits are identified in Attachment 3.l A&B, Supplement 1, page 16.1 and 16.1.1. Dental services are paid based on procedure codes which are listed in the Agency' fee schedule rate, effective July 1, 2024. All rates are published on the DMAS website at www.dmas.virginia.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

Dentures. Coverage and service limits for dentures are identified in Attachment 3.lA&B, Supplement 1, page 26.1. Dental services are paid based on procedure codes which are listed in the Agency' fee schedule rate, effective July 1, 2024. All rates are published on the DMAS website at www.dmas.virginia.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners.

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

(1) Respiratory therapies. The DME for oxygen therapy shall have supplies or components under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, and suction machines. Ventilators, non-continuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(2) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

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

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

7. Local health services, including services paid to local school districts
8. Laboratory services (Other than inpatient hospital) The agency's rates for clinical laboratory services were set as of July 1, 2014, and are effective for services on or after that date.
9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)
10. X-Ray services.
11. Optometry services
12. Reserved.
13. Home health services: Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by Supplement 3. (12 VAC30-80-180)
14. Physical therapy, occupational therapy, and speech, hearing, language disorders services when rendered to non-institutionalized recipients. Physical therapy, occupational therapy, and speech-language therapy services furnished by state rehabilitation agencies are paid on a cost basis (see sec. 2D, page 4.1). All other services under this section furnished by rehabilitation agencies are paid rates established by Supplement 5.
15. Clinic services, as defined under 42 CFR 440.90, except for services in amblulatory surgery clinics reimbursed under Attachment 4.19-B, page 7.2 (12 VAC 30-80-35).
16. Supplemental payments to state government-owned or operated clinics.
(Repealed effective July 1, 2005)

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OTHER TYPES OF CARE

16.1 Reimbursement for personal care services for individuals enrolled in the Medicaid Buy-In program described in Attachment 2.6A, Supplement 8a, p 1-3 or for personal care services covered under EPSDT. All governmental and private providers are reimbursed according to the same published fee schedule. All rates are published on the DMAS website at www.dmas.virginia.gov. The Agency's rates, based upon one-hour increments, were set as of July 1, 2024, and shall be effective for 1902(a) state plan authorized services on and after that date. Qualifying overtime for consumer-directed personal care provided under EPSDT will be paid 150% of the fee schedule, and qualifying sick leave for consumer – directed personal care provided under EPSDT will be at 100% of the fee schedule.

16.1.a. Reimbursement for consumer-directed services facilitator services under EPSDT as described per Supplement 1 to Attachment 3.1A&B, pages 6.4.7 & 6.4.8. All governmental and private providers are reimbursed according to the same published fee schedule, located on the DMAS website at www.dmas.virginia.gov. The Agency's rates were set as of July 1, 2024, and shall be effective for services provided on and after that date.

16.2. Private duty nursing services covered under EPSDT as defined per Supplement 1 to Attachment 3.1A&B, page 6.4.8, with provider qualifications on page 6.4.8, are reimbursed based on a 15-minute unit of service in accordance with the State Agency fee schedule. The fee schedule is the same for both governmental and private providers and was set as of July 1, 2022 and shall be effective for services provided on and after that date. The state agency fee schedule is published on the DMAS website at www.dmas.virginia.gov.

16.3 Medical Supplies, Equipment and Appliances (assistive technology) covered under EPSDT, as defined per Supplement 1 to Attachment 3.1 A&B, page 6.4.9, with provider qualifications on page 6.4.10. The service shall be reimbursed based upon the total cost of all AT incurred by the provider.

16.4 Reserved.

16.5 Hospice services, as defined per Attachment 3.1 A&B, Supplement 1, pages 33-37. Hospice services payments are effective October 1 annually and are equivalent to the annual Medicaid hospice rates published by CMS. As of July 1, 2019, room and board will be reimbursed at a rate equal to 100 percent of the skilled nursing facility rate for Medicaid members receiving hospice services who reside in a nursing facility. Hospice services shall be paid according to the location of the service delivery and not the location of the Agency's home office. Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to Medicaid members. During the twelve (12) month period beginning October 1 of each year and ending September 30 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care days) for any given hospice provider may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid members during the same period.

Services that are included in the hospice reimbursement are: (a) Routine Home Care where most hospice care is provided - Days 1- 60; (b) Routine Home Care where most hospice care is provided-Days 61 and over; (c) Continuous Home Care; (d) Hospice Inpatient Respite Care; (e) Hospice General Inpatient Care; (f) Service Intensity Add-On (SIA) will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member' s life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.

16.3.1 Effective July 1, 2019, the telehealth originating site facility fee shall be set at 100 percent of the Medicare rate and shall reflect changes annually based on any changes in the Medicare rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

A. Rehabilitation agencies or comprehensive outpatient rehabilitation facilities.

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

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

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

B. Transition reimbursement for rehabilitation agencies subject to the new fee schedule methodology.
1. Payments for the fiscal year ending or in progress on June 30, 2009, shall be settled for private rehabilitation agencies based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of June 30, 2009.
2. Payment for fiscal year ending or in progress on September 30, 2009, shall be settled for community services boards based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of September 30, 2009.