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State Name: Virginia

State Plan Amendment (SPA) #: 09-18

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

JUN 0 3 2010

Cynthia B. Jones, Acting Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Ms. Jones:

We have reviewed State Plan Amendment (SPA) 09-18, in which you propose modifying your reimbursement methodology for home health and outpatient rehabilitation agencies.

This SPA, as modified by your email notes dated November 19, 2009, and May 11, 2010, is acceptable. Therefore, we are approving SPA 09-18 with an effective date of July 1, 2009. Enclosed are the approved SPA page and signed CMS-179 form.

If you have further questions about this SPA, please contact Jake Hubik at (215) 861-4181.

Sincerely,

/S/

Ted Gallagher
Associate Regional Administrator

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 09 – 18

2. STATE: Virginia

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 433, Subpart D

7. FEDERAL BUDGET IMPACT
a. FFY 2009 $ [142,969.00]
b. FFY 2010 $ [571,876.00]

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-B, Page 4.1 of 15, Attach. 4.19-B, Suppl. 3, Page 1 of 1, and Attach. 4.19-B, Suppl. 5, Page 1 of 2.
SUPP 1 TO ATTACHMENT 3.1 A AP 11, 12, 17, 29, AND 29.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: 2009 Non-Institutional Reimbursement Changes

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2009
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Patrick W. Finnerty

14. TITLE: Director

15. DATE SUBMITTED: 9.25.09

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/28/10

18. DATE APPROVED: JUN 03 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/09

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Teo Gallagher

22. TITLE: Associate Regional Administrator

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

STATE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

D. Other practitioners' services; psychological services, psychotherapy. Limits and requirements for covered services are found under Outpatient Psychiatric Services (see 12VAC30-50-140D).

1. These limitations apply to psychotherapy sessions provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric/licensed marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist. Psychiatric services are limited to an initial availability of 26 sessions without prior authorization. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Psychiatric services are further restricted to no more than three sessions in any given seven day period.

2. Psychological testing is covered when provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialist-psychiatric/marriage and family therapists who are either independently enrolled or under the direct supervision of licensed clinical psychologists.

7. Home Health services. (12 VAC 30-50-160)

A. Service must be ordered or prescribed and directed or performed within the scope of a license of a practitioner of the healing arts. Home health services shall be provided in accordance with in accordance with 42 CFR 440.70 and the guideline found in the Virginia Medicaid Home Health Manual.

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to five visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional services unless authorized by DMAS.

C. Home health aide services provided by a home health agency.

1. Home Health Aides must function under the supervision of a registered nurse.

2. Home Health Aides must meet the certification requirements specified in 42 CFR 484.36.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
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3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. The state assures that this limit is sufficient to meet the service needs of recipients.

D. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility in accordance with 42 CFR 440.110.

1. Service covered only as part of a physician's plan of care.

2. Patients may receive up to five visits for each rehabilitative therapy service ordered annually without authorization. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

E. The following services are not covered under the home health services program:

1. Medical social services;
2. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort whch have no medical necessity, such as television;
3. Community food service delivery arrangements;
4. Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;
5. Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and
6. Services related to cosmetic surgery.

§7.5. Durable medical equipment (DME) and supplies suitable for use in the home. (12 VAC 30-50-165)

A. General requirements and conditions.

1. All medically necessary medical supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.

2. DME providers shall adhere to all applicable DMAS' policies, laws, and regulations for durable medical equipment and supplies. DME providers shall also comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for durable medical equipment or supplies which are regulated by such licensing agency or agencies.

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D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray -- two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once/five years); extractions, orthodontics, tooth guidance appliances, permanent crowns and bridges, endodontics, patient education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare) and described in Agency guidance documents, are covered for all recipients, and require preauthorization or prepayment review by the state agency or its designee as described in Agency guidance documents.

12 VAC 30-50-200. Physical therapy and related services.

11. Physical therapy and related services shall be defined as physical therapy, occupational therapy, and speech-language pathology services. These services shall be prescribed by a physician and be part of a written physician's order/plan of care. Any one of these services may be offered as the sole service and shall not be contingent upon the provision of another service. All practitioners and providers of services shall be required to meet State and Federal licensing and/or certification requirements. Services shall be provided according to guidelines found in the Virginia Medicaid Rehabilitation Manual.

11a. Physical Therapy provided in accordance with 42 CFR 440.110.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective with dates of service on and after October 24, 1995, DMAS will provide for the direct reimbursement to enrolled rehabilitation providers for physical therapy services, when such services are rendered to patients residing in nursing facilities (NFs). Such reimbursement shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

11b. Occupational Therapy provided in accordance with 42 CFR 440.110.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective with dates of service on and after October 24, 1995, DMAS will provide for the direct reimbursement to enrolled rehabilitation providers for occupational therapy services, when such services are rendered to patients residing in nursing facilities (NFs). Such reimbursement shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13. Other diagnostic screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. **(12VAC30-50-225)** Rehabilitative services provided accordance with 42 CFR 440.110.

A. Intensive physical rehabilitation

1. Medicaid covers intensive inpatient rehabilitation services as defined in subsection A.4 of this section in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in subsection A.4 of this section in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21-day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in 4.19-A

4. An intensive rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech-language pathology, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of physical medicine and rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

6. To receive continued intensive rehabilitation services, the patient must demonstrate an ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team. This shall be evidenced by regular attendance in planned activities and demonstrated progress toward the established goals.

7. Intensive rehabilitation services shall be considered for termination regardless of the preauthorized length of stay when any of the following conditions are met:

a. No further potential for improvement is demonstrated. The patient has reached his maximum progress and a safe and effective maintenance program has been developed.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of VIRGINIA
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13d.1 Intensive rehabilitative services provided accordance with 42 CFR 440.110

A. Physical Therapy

1. Physical therapy services are provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

2. "Qualified physical therapist" is an individual who is—

(i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and licensed by the State.

B. Occupational Therapy:

1. Occupational therapy services are provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

2. A "qualified occupation therapist" is an individual who is—

(i) Registered by the American Occupational Therapy Association; or

(ii) A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

C. **Services for individuals with speech, hearing, and language disorders are provided by the appropriate individual as follows:**

1. A ``speech pathologist'' is an individual who meets one of the following conditions:

(i) Has a certificate of clinical competence from the American Speech and Hearing Association.

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate.

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

2. A "qualified audiologist" means an individual with a master's or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:

(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, and the individual is licensed by the State as an audiologist to furnish audiology services.

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

e. Payment for direct medical education costs of nursing schools, paramedical programs, and graduate medical education for interns and residents:
   (1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.
   (2) Effective with cost reporting periods beginning on or after July 1, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12 VAC 30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

3. Rehabilitation agencies operated by Community Services Boards. For the reimbursement methodology applicable to other rehabilitation agencies, see Attachment 4.19-B, Supplement 5 (12 VAC 30-80-200). Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

4. Rehabilitation hospital outpatient services.

(The next page is 4.3 of 15)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

2. The HHA's peer group median rate per visit for each peer group at July 1, 1991, shall be the interim peer group rate for calculating the update through January 1, 1992. The interim peer group rate shall be updated by 100 percent of historical inflation from July 1, 1991, through December 31, 1992, and shall become the final interim peer group rate which shall be updated by 50 percent of the forecasted inflation to the end of December 31, 1993, to establish the final peer group rates. The lower of the final peer group rates or the Medicare upper limit at January 1, 1993, will be effective for payments from July 1, 1993, through December 1993.

3. Separate rates shall be provided for the initial assessment, follow-up, and comprehensive visits for skilled nursing and for the initial assessment and follow-up visits for physical therapy, occupational therapy, and speech therapy. The comprehensive rate shall be 200 percent of the follow-up rate, and the initial assessment rates shall be fifteen dollars ($15.00) higher than the follow-up rates. The lower of the peer group median or Medicare upper limits shall be adjusted as appropriate to assure budget neutrality when the higher rates for the comprehensive and initial assessment visits are calculated.

D. The fee schedule shall be adjusted annually beginning July 1, 2010, based on the percent of change in the moving average the National Forecast Tables for the Home Health Agency Market Basket published by Global Insight (or its successor) for the quarter ending at the mid-point of the rate year. The report shall be the latest published report prior to the fiscal year. The method to calculate the annual update shall be:

1. All subsequent year peer group rates shall be calculated utilizing the previous final peer group rate established on July 1.

2. The annual July 1 update shall be compared to the Medicare upper limit per visit in effect on each January 1, and the HHA's shall receive the lower of the annual update or the Medicare upper limit per visit as the final peer group rate.

E. Effective July 1, 2009, the previous inflation increase effective January 1, 2009, shall be reduced by 50 percent.

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

12VAC30-80-200. Prospective reimbursement for rehabilitation agencies.

A. Effective for dates of service on and after July 1, 2009, rehabilitation agencies, including comprehensive outpatient rehabilitation facilities and excluding those operated by community services boards and 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.

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

C. Rehabilitation services furnished by community service boards or state agencies shall be reimbursed costs based on annual cost reporting methodology and procedures.

D. Beginning with state fiscal years beginning on and after July 1, 2009, rates shall be adjusted using the Virginia-specific nursing home input price index contracted for by the agency. The agency shall use the percent moving average for the quarter ending at the midpoint of the rate year from the most recently available index prior to the beginning of the rate year.