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State Name: Virginia

State Plan Amendment (SPA) #: 10-11

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

OCT 29 2010

Gregg A. Pane, MD, MPA
Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Dr. Pane:

We have reviewed State Plan Amendment (SPA) 10-11, in which you propose to modify your coverage of abortions. In your letter dated May 21, 2010, you assured us that you cover abortions for Medicaid beneficiaries in cases of rape and incest using non-Medicaid funds. In your email note dated October 12, 2010, you assured us that "VA Medicaid beneficiaries are entitled to an induced abortion only in the case where a woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."

Therefore, this SPA is acceptable, and we are approving SPA 10-11 with an effective date of July 1, 2010. Enclosed are the approved SPA pages 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: 10 - 11

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, 2010

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 440

7. FEDERAL BUDGET IMPACT
a. FFY 2010 $ 0
b. FFY 2011 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 3.1-A&B, Pages 3.1, 4.2, 4.5 and 15.2 of 41

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: Abortion Coverage

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2010
☐ 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: Cynthia B. Jones

14. TITLE: Acting Director

15. DATE SUBMITTED: 8/5/10

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: 8/5/10

18. DATE APPROVED: OCT 29 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/10

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Ted Gallagher

22. TITLE: Associate Regional Administrator

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

SMVS

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

4. It is general practice for recipients in a particular locality to use medical resources in another state.

C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

D. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to life of the mother if the fetus were carried to term.

E. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60 day period, for the same or similar diagnosis and/or treatment plan. The 60 day period would begin on the first hospitalization (if there are multiple

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coverage when medically justified. For all admissions that exceed three days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection seven of this section.) Inpatient hospital services will be reviewed for appropriateness of the admission and length of stay.

C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

D. Reimbursement for induced abortions is provided only in those cases in which there would be a substantial endangerment to the life of the mother if the fetus were carried to term.

E. Hospital claims with an admission date prior to the first surgical date, regardless of the number of days prior to surgery, must be medically justified. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for all pre-operative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

F. Reimbursement will not be provided for weekend (Saturday/Sunday) admissions, unless medically justified. Hospital claims with admission dates on Saturday or Sunday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admission will be denied.

G. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for recognized as being capable of providing high quality care in the performance of the requested transplant. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

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B. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment to life to the mother if the fetus were carried to term.

C. Coverage of outpatient observation beds. The following limits and requirements shall apply to DMAS coverage of outpatient observation beds.

1. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment, or;
2. Non-routine observation for underlying medical complications, as explained in documentation attached to the provider's claim for payment, after surgery or diagnostic services shall be covered. Routine use of an observation bed shall not be covered. **Non-covered routine use shall be**:

(a) Routine preparatory services and routine recovery time for outpatient surgical or diagnostic testing services, (e.g., services for routine postoperative monitoring during a normal recovery period (four to six hours)).
(b) Observation services provided in conjunction with emergency room services, unless, following the emergency treatment, there are clear medical complications which must be managed by a physician other than the original emergency physician.
(c) Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

3. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient pre-certification where applicable.

4. When inpatient admission is required following observation services and prior approval has been obtained for the inpatient stay, observation charges must be combined with the appropriate inpatient admission and be shown on the inpatient claim for payment. Observation bed charges and inpatient hospital charges shall not be reimbursed for the same day.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
A. The same service limitations apply to rural health clinics as to all other services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with §4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
A. The same service limitations apply to FQHCs as to all other services.

individual meets the following criteria:

a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels which have been impaired;

b. Exhibits deficits in peer relations, dealing with authority, is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, and/or ability to participate in employment, educational, or social activities;

c. Is at risk for developing or requires treatment for maladaptive coping strategies; and

d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

5. Psychological or psychiatric services may be provided in an office or mental health clinic.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to life of the mother if the fetus were carried to term.

G. Physician visits to inpatient hospital patients, over the age of 21, are limited to a maximum of

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6. Furnished at a safe, effective, and cost effective level suitable for use in the recipient's home environment.

I. Coverage of enteral nutrition (EN) which does not include a legend drug shall be limited to when the nutritional supplement is the sole source form of nutrition, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of EN shall not include the provision of routine infant formulae. A nutritional assessment shall be required for all recipients receiving nutritional supplements.

8. Private duty nursing services. (12 VAC 30-50-170)

A. Not provided.

9. Clinic services. (12 VAC 30-50-180)

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to life of the mother if the fetus were carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. are provided to outpatients;