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State Name: Virginia

State Plan Amendment (SPA) #: 19-008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street, Suite 9400
Philadelphia, Pennsylvania 19107

Regional Operations Group

SWIFT #071220194001

October 9, 2019

Karen Kimsey, Director
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Kimsey:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Virginia's State Plan Amendment (SPA) 19-008, 2019 Non-Institutional Provider Reimbursement Changes. The purpose of this SPA is to increase the practitioner rates for primary care services, increase rates for Emergency Department services, increase the operating rate for Critical Access Hospitals for outpatient services, and increase the rates for personal care in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. This SPA creates a separate service category for psychiatric services and increases practitioner rates for psychiatric services by 21 percent. SPA 19-008 also proposes that the telehealth originating site facility fee be set at 100 percent of the Medicare rate. In addition, the SPA indicates that 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.

This SPA is acceptable. Therefore, we are approving SPA 19-008 with an effective date of July 1, 2019. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis T. McCullough
Director
Division of Medicaid Field Operations Group East (Philadelphia)

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: 19-008

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, 2019

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 447

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 1,175,007
b. FFY 2020 $ 4,700,027

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, page 6.2.1 and 7.2.2
Attachment 4.19-B, Supplement 4, pages 3 and 4

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same as box 8.

10. SUBJECT OF AMENDMENT: 2019 Non-Institutional Provider Reimbursement Changes

GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2019
☐ 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
[redacted] /S/

13. TYPED NAME: Jennifer S. Lee, M.D.

14. TITLE: Director

15. DATE SUBMITTED: 7/2/19

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: July 11, 2019

18. DATE APPROVED: October 7, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Francis T. McCullough

22. TITLE: Director
Division of Medicaid Field Operations Group East Philadelphia

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

16.1 Reimbursement for personal care services: as defined per Attachment 3.1A&B, Supplement 1, page 6.4.3, with provider qualifications on pages 6.4.4-6.4.7 for individuals enrolled in the Medicaid Buy-In program described in Attachment 2.6A, Supplement 8a, p 1-3 (12VAC30-60- 200) or covered under EPSDT. All governmental and private PAS providers are reimbursed according to the same published fee schedule, located on the Agency's website at the following address: www.dmas.virginia.gov The Agency's rates, based upon one-hour increments, were set as of July 1, 2019, and shall be effective for services 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, 2016 and shall be effective for services provided on ~~or~~ and after that date. The state agency fee schedule is published on the DMAS website at http://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 6.4.11, with provider qualifications on page 6.4.12. The service shall be reimbursed based upon the total cost of all AT incurred by the provider.

16.4 There shall be no reimbursement for overtime hours for consumer directed services provided under EPSDT.

16.5 Hospice services, as defined per Attachment 3.1 A&B, Supplement 1, pages 33-37. Hospice services payments are effective October 1st annually and are equivalent to the annual Medicaid hospice rates ~~CMS~~ 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.

16.5.1 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

3. The statewide base rate shall be equal to the total costs described below divided by the wage-adjusted sum of the EAPG weights for each facility. The wage-adjusted sum of the EAPG weights shall equal the sum of the EAPG weights times the labor percentage times the hospital's Medicare wage index plus the sum of the EAPG weights times the nonlabor percentage. The base rate shall be determined for outpatient hospital services at least every three years so that total expenditures will equal the following:

a) When using base years prior to January 1, 2014, for all services, excluding all laboratory services and emergency services described in subdivision 3 c of this subsection, a percentage of costs defined in subsection A as reported in the available cost reports for the base period for each type of hospital as defined in Attachment 4.19-A, Methods and Standards for Establishing Payment Rates-Hospital Services, DRG-Payment Methodology (12VAC30-70-221).

i) Type One Hospitals: Effective January 1, 2014, hospital outpatient operating reimbursement shall be calculated at 90.2 percent of cost and capital reimbursement shall be at 86 percent of cost inflated to the rate year.

ii) Type Two Hospitals: Effective January 1, 2014, hospital outpatient operating and capital reimbursement shall be calculated at 76 percent of cost inflated to the rate year.

iii) When using base years after January 1, 2014, the percentages described in subdivision 3 of this subsection shall be adjusted according to subdivision 3 c to 69.8% for Type Two hospitals.

iv) For critical access hospitals, the operating rate shall be increased by using an adjustment factor or percent of cost reimbursement equal to 100% of cost, effective July 1, 2019.

b) Laboratory services (excluding laboratory services referred to the hospital but not associated with a hospital visit) calculated at the fee schedule in effect for the rate year.

c) Services rendered in emergency departments determined to be nonemergencies as prescribed in Attachment 4.19-B, section 2 D (12VAC30-80-20(D)(1)(b)) shall be calculated at the nonemergency reduced rate reported in the base year for base years prior to January 1, 2014. For base years after January 1, 2014, the cost percentages in subdivision 3(a) of this subsection shall be adjusted to reflect services paid at the non-emergency reduced rate in the last base year prior to January 1, 2014.

4. Inflation adjustment to base year costs. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with DMAS, shall be used to update the base year costs to the midpoint of the rate year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Corrections made by Global Insight (or its successor), in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year. Inflation shall be applied to the costs identified in subdivision 3(a) of this subsection.

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

(3) Pediatric preventive services (defined as Evaluation and Management (E&M) procedures, excluding those listed in 2(e)(1) of this subsection, as defined by the AMA's annual publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21;

(4) Pediatric primary services (defined as evaluation and management (E&M) procedures, excluding those listed in subdivisions 2e(1) and 2e(3) of this subsection, as defined by the AMA's publication of the CPT manual, in effect at the time the service is provided, for recipients under age 21;

(5) Adult primary and preventive services (defined as E&M procedures, excluding those listed in 2e(1) of this subsection, as defined by the AMA's annual publication of the CPT manual, in effect at the time the service is provided, for recipients age 21 and over);

(6) Effective July 1, 2019, psychiatric services as defined by the American Medical Association's annual publication of the CPT manual, in effect at the time the service is provided; and

(7) All other procedures set through the RBRVS process combined.

3. For those services or procedures for which there are no established RVUs DMAS shall approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service (FFS) methodology. The previous FFS methodology refers to the state agency fee schedule in effect prior to the implementation of RBRVS which was implemented and effective July 1, 1995.

4. Fees shall not vary by geographic locality.

C. Effective for dates of service on and after July 1, 2010, through September 30, 2010, fees for all procedures set through the RBRVS process shall be decreased by 3.0% relative to the fees that would otherwise be in effect.

D. Effective for dates of service on and after October 1, 2010, the 3.0% fee decrease in subsection C will no longer be in effect.

E. Effective for dates of service on and after July 1, 2019, rates for adult primary care services shall be increased by 5% and rates for Emergency Department services shall be increased by 1%.

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

F. Effective for dates of service on and after July 1, 2019, rates for psychiatric services shall be increased by 21 percent.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of practitioner services. All rates are published in the DMAS website, and may be found at: http://www.dmas.virginia.gov/ . The fee schedule for rates based on the methodology described in this supplement tied to Medicare's annual update of RBRVS is updated each July 1, based on the methodology described in this supplement.