# COMMONWEALTH of VIRGINIA

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**MEMORANDUM**

**TO:** **Emily McClellan**
Regulatory Supervisor
Department of Medical Assistance Services

**FROM:** **Davis Creef**
Assistant Attorney General
Office of the Attorney General

**DATE:** **April 6, 2022**

**SUBJECT:** **Emergency Regulation – Private Duty Nursing Services under EPSDT**

You have asked the Office of the Attorney General to review and determine if Department of Medical Assistance Services has the statutory authority to promulgate these regulations and if they comport with applicable state law. I have reviewed the attached emergency regulations posted to the Virginia Regulatory Town Hall that would update the Department's regulations on private duty nursing (PDN) services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, as mandated by the General Assembly in Item 317.MMM (1) and (2) in the 2021 Appropriations Act.

Based on my review, it is this Office's view that the Director of the Department of Medical Assistance Services, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act, and has not exceeded that authority. The proposed regulations will enable the Director to comply with Item 317.MMM (1) and (2) in the 2021 Appropriations Act, consistent with the authority set forth in Virginia Code § 32.1-324.

The authority for the emergency action is found in Virginia Code § 2.2-4011, which provides that Agencies may adopt emergency regulations when Virginia statutory law, the appropriation act, or federal law or regulation requires that the regulation be effective in 280

days or less from its enactment, as directed by Item 317.MMM(2) of the 2021 Appropriation Act.

Accordingly, with the prior approval of the Governor, these regulations will qualify for the "emergency" exemption from Article 2 requirements. Please be advised, however, that under Virginia Code §2.2-4011(A), the Department must state in writing the nature of and necessity for such emergency actions, and this appears to have been accomplished in the "Agency Background Document." In addition, the regulations shall be effective for no more than 18 months. If the Department intends to continue regulating the subject matter governed by this emergency regulation beyond 18 months, it will be necessary to replace these emergency regulations with regulations duly promulgated under Article 2 of the APA.

If you have any questions or need additional information about these regulations, please contact me at 786-6522.

cc: Kim F. Piner, Esq.

Attachment

# Emergency Text

highlight

Action: Private Duty Nursing Services Under EPSDT

Stage: Emergency/NOIRA 2/23/22 10:59 AM [latest]

**12VAC30-50-132 Private Duty Nursing Services Under EPSDT**

A. This section applies to private duty nursing services for eligible individuals in fee-for-service programs. Individuals enrolled with managed care health plans receive private duty nursing services through their plans.

B. Service description. Private duty nursing services are individualized, medically necessary nursing care services consisting of skilled interventions, assessment, monitoring and teaching of those who are or will be involved in nursing care for the individual. Private duty nursing services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit are provided when appropriate and medically necessary to correct and ameliorate a member's health conditions. As opposed to intermittent care provided under Skilled or Home Health Nursing, private duty nursing is provided on a continuous or regularly scheduled basis according to medical necessity. Private duty nursing care provided can be based in the individual's home or any setting in which normal life activities take place. Congregate private duty nursing is defined as private duty nursing provided to two or more individuals who require private duty nursing in the same setting. Services are provided in accordance with 42 CFR 440.80.

C. Service components. Private duty nursing service is the management and administration of the treatment and care of an individual by a licensed nurse, within the scope of practice as outlined by the Virginia Board of Nursing, but is not limited to:

1. Assessments (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity, hydration, level of consciousness, constant observation for comfort and pain management);

2.Administration of treatment related to technological dependence (e.g., ventilator, tracheotomy, bi-level positive airway pressure (BiPAP), intravenous (IV) administration of medications and fluids, feeding pumps, nasal stints, central lines);

3. Monitoring and maintaining parameters/machinery (e.g., oximetry, blood pressure, lab draws, end tidal CO2s, ventilator and tube feeding pumps);

4. Interventions (e.g., medications, suctioning, IV's, hyper alimentation, enteral feeds, ostomy care, tracheostomy care); and

5. Exclusions from DMAS' coverage of skilled PDN services:

a. Not custodial or personal care delivered for the purpose of helping with activities of daily living (ADLs), including dressing, feeding, bathing or transferring from a bed to a chair, and which can safely and effectively be performed by trained non-medical personnel.

b. Monitoring for medically-controlled disorders as part of "maintenance of care".

c. Respite skilled nursing services.

D. Provider qualifications.

1. Private duty nursing providers shall meet the following requirements:

a. Demonstrate a prior successful health care delivery;

b. Operate from a business office;

c. Disclose ownership, if requested;

d. Attest to the ability to document and maintain individual case records in accordance with state and federal requirements.

2. Private duty nursing must be provided by a registered nurse (RN) or licensed practical nurse (LPN) employed by (or subcontracted with) and supervised by a private duty nursing provider enrolled with DMAS.

a. The RN must possess the following qualifications:

(1) a license to practice in the Commonwealth of Virginia;

(2) at least one (1) year of related clinical experience as a RN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility; and

(3) a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adults or children is acceptable; and shall submit to a criminal record check obtained through the Virginia State Police. If the individual receiving services is a minor, the RN must also submit to a search of the VDSS Child Protective (CPS) Central Registry. The provider shall not hire any RN with findings of barrier crimes identified in 32.1-162.9:1 of the *Code of Virginia* or founded complaints in the CPS Central Registry.

b. Licensed Practical Nurses shall meet the following requirements:

(1) licensed to practice in the Commonwealth of Virginia;

(2) have at least one (1) year of related clinical experience as a LPN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility;

(3) have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the LPN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable; and

(4) submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider shall not hire any persons who have been convicted of barrier crimes as defined in the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.

3. The RN or LPN must have (i) a documented provider training program or (ii) at least six months of related clinical nursing experience meeting the needs of the individual to receive care. Regardless of whether a nurse has six months of experience or completes a provider training course, the provider agency shall be responsible for assuring all nurses who are assigned to an individual are competent in the care needs of that individual.

4. Nursing services must be provided under the supervision of a licensed, registered nurse in the Commonwealth.

a. As part of direct supervision, the RN supervisor shall make, at a minimum, a visit every 30 days to ensure both quality and appropriateness of nursing services to assess the individual's and the individual's representative's satisfaction with the services being provided, to review the plan of care and to update and verify the most current physician signed orders are in the home. When a delay occurs in the RN supervisor's visits because the individual is unavailable, the reason for the delay shall be documented in the individual's record, and the visit shall occur as soon as the individual is available. Failure to meet this standard may result in DMAS' recovery of payments made. Additional supervisory visits may be required under the following circumstances: (i) at the provider's discretion; (ii) at the request of the individual when a change in the individual's condition has occurred; (iii) any time the health, safety, or welfare of the individual could be at risk; and (iv) at the request of the DMAS staff. The RN is responsible for documentation of the visit's date, time and evaluation.

b. The Supervising RN shall:

(1) Use and foster a person centered planning team approach to nursing services;

(2) Ensure choice of services is made by the individual, legally authorized guardian, or responsible party if a minor;

(3) Ensure personal goals of the individual are respected;

(4) Conduct the initial evaluation visit to initiate EPSDT PDN services in the primary residence;

(5) Regularly evaluate the individual's status and nursing needs and notify the primary care provider if the individual no longer meets criteria for PDN;

(6) Complete the Plan of Care (POC) and update as necessary for revisions;

(7) Assure provision of those services requiring substantial and specialized nursing skill and that assigned nurses have the necessary licensure;

(8) Initiate appropriate preventive and rehabilitative nursing procedures;

(9) Perform an assessment, at least every 30 days (the monthly nursing assessment cannot be made by the nurse providing care in the home); RN Monthly Supervisory Visits shall be completed in the primary residence at least every other visit. Visits may be conducted at school every other visit if necessary;

(10) Coordinate PDN services;

(11) Inform the physician and case manager as appropriate of changes in the individual's condition and needs;

(12) Educate the individual and family/caregiver in meeting nursing and related goals;

(13) Supervise and educate other personnel involved in the individual's care;

(14) Ensure that required documentation is in the individual's agency record;

(15) Ensure that all employees are aware of the requirements to report suspected abuse, neglect, or exploitation immediately to Adult Protective Services or Child Protective Services, as appropriate. A civil penalty may be imposed on mandated reporters who do not report suspected abuse, neglect or exploitation to VDSS as required;

(16) Ensure services are provided in a manner that is in the best interest of the individual and does not endanger the individual's health, safety, or welfare;

(17) Recommend staff changes when needed;

(18) Report to DMAS or it's contractor any unethical or incompetent practices that jeopardize public safety or cause a risk of harm to individuals, including household issues that may jeopardize the safety of the PDN; and

(19) Ensure that all nurses and caregivers are aware that timesheets must be accurate with arrival and departure time of the nurse and that falsifying timesheets is Medicaid fraud.

c. Parents (natural, step-parent, adoptive, foster parent, or other legal guardian), spouses, siblings, grandparents, grandchildren, adult children, or any person living under the same roof with the individual shall not provide skilled PDN services for the purpose of Medicaid reimbursement for the individual.

E. Service limits. Private duty nursing services are limited to the hours of skilled nursing care and medically-necessary supervision as specified in the Plan of Care signed by the child's physician (per Virginia Code § 54.1-2957 and § 54.1-2957.02, signature by a Nurse Practitioner is acceptable in certain circumstances), and limited to the number of hours approved by DMAS or its contractor through DMAS' service authorization form (DMAS-62). Authorization of the number of medically necessary hours is based on assessing individuals' medical and support needs related to respiratory function, cardiovascular access and medications, wound care, feeding, central nervous system function, assessments that require the skills of a medical professional, toileting, and any other additional medical or support needs that require the skills of a licensed clinician. These medical and support needs are encompassed in the DMAS-62, and the number of hours approved will be based on medical needs final score, as detailed in the DMAS-62. Individuals under 21 years of age qualifying under EPSDT shall receive the services described in excess of any State Plan limit, up to 24 hours per day, if services are determined to be medically necessary to correct, ameliorate or maintain the member's health condition, and are prior authorized by the Department or its contractor.

**12VAC30-50-9998 FORMS (12VAC30-50)**

Virginia Uniform Assessment Instrument, UAI, Virginia Long-Term Care Council ~~(1994)~~ (rev. 11/1/2018)

I.V. Therapy Implementation Form, DMAS-354 (eff. 6/1998)

Health Insurance Claim Form, Form HCFA-1500 (eff. 12/1990)

Certificate of Medical Necessity-Durable Medical Equipment and Supplies, DMAS-352 (rev. 7/2010)

Questionnaire to Assess an Applicant's Ability to Independently Manage Personal Attendant Services in the CD-PAS Waiver or DD Waiver, DMAS-95 Addendum ~~(eff. 8/2000)~~ (eff. 8/1/2005)

~~DD Waiver Enrollment Request, DMAS-453 (eff. 1/2001)~~

~~DD Waiver Consumer Service Plan, DMAS-456 (eff. 1/2001)~~

~~DD Medicaid Waiver -- Level of Functioning Survey -- Summary Sheet, DMAS-458 (eff. 1/2001)~~

~~Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services (eff. 8/2000)~~

Comprehensive Outpatient Rehab Facility Participation Agreement (undated; filed 11/2015)

Rehabilitation Hospital Participation Agreement (undated; filed 11/2015)

Medical Necessity Assessment and Private Duty Nursing Service Authorization Form (DMAS 62) (eff. 7/2021)

**12VAC30-80-30 Fee-for-service providers**

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public). Except as otherwise noted in this section, state developed fee schedule rates are the same for both governmental and private individual practitioners. The state agency fee schedule is published on the Department of Medical Assistance Services (DMAS) website at http://www.dmas.virginia.gov/#/searchcptcodes.

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public) except that emergency room services 99282-99284 with a principal diagnosis on the Preventable Emergency Room Diagnosis List shall be reimbursed the rate for 99281. The Preventable Emergency Room Diagnosis List shall be based on the list used for managed care organization clinical efficiency rate adjustments.

2. Dentists' services. Dental services, dental provider qualifications, and dental service limits are identified in 12VAC30-50-190. Dental services are paid based on procedure codes, which are listed in the agency's fee schedule. Except as otherwise noted, state-developed fee schedule rates are the same for both governmental and private individual practitioners.

3. Mental health services.

a. Professional services furnished by nonphysicians as described in 12VAC30-50-150. These services are reimbursed using current procedural technology (CPT) codes. The agency's fee schedule rate is based on the methodology as described in subsection A of this section.

(1) Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists in subdivision A 1 of this section.

(2) Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric, or licensed marriage and family therapists shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

b. Intensive in-home services are reimbursed on an hourly unit of service. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

c. Therapeutic day treatment services are reimbursed based on the following units of service: one unit equals two to 2.99 hours per day; two units equals three to 4.99 hours per day; three units equals five or more hours per day. No room and board is included in the rates for therapeutic day treatment. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

d. Therapeutic group home services (formerly called level A and level B group home services) shall be reimbursed based on a daily unit of service. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

e. Therapeutic day treatment or partial hospitalization services shall be reimbursed based on the following units of service: one unit equals two to three hours per day; two units equals four to 6.99 hours per day; three units equals seven or more hours per day. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

f. Psychosocial rehabilitation services shall be reimbursed based on the following units of service: one unit equals two to 3.99 hours per day; two units equals four to 6.99 hours per day; three units equals seven or more hours per day. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

g. Crisis intervention services shall be reimbursed on the following units of service: one unit equals two to 3.99 hours per day; two units equals four to 6.99 hours per day; three units equals seven or more hours per day. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

h. Intensive community treatment services shall be reimbursed on an hourly unit of service. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

i. Crisis stabilization services shall be reimbursed on an hourly unit of service. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

j. Independent living and recovery services (previously called mental health skill building services) shall be reimbursed based on the following units of service: one unit equals one to 2.99 hours per day; two units equals three to 4.99 hours per day. The agency's rates are set as of July 1, 2011, and are effective for services on or after that date.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME) and supplies.

Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"DMERC" means the Durable Medical Equipment Regional Carrier rate as published by the Centers for Medicare and Medicaid Services at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

"HCPCS" means the Healthcare Common Procedure Coding System, Medicare's National Level II Codes, HCPCS 2006 (Eighteenth edition), as published by Ingenix, as may be periodically updated.

a. Obtaining prior authorization shall not guarantee Medicaid reimbursement for DME.

b. The following shall be the reimbursement method used for DME services:

(1) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10%. For dates of service on or after July 1, 2014, DME items subject to the Medicare competitive bidding program shall be reimbursed the lower of:

(a) The current DMERC rate minus 10%; or

(b) The average of the Medicare competitive bid rates in Virginia markets.

(2) For DME items with no DMERC rate, the agency shall use the agency fee schedule amount. The reimbursement rates for DME and supplies shall be listed in the DMAS Medicaid Durable Medical Equipment (DME) and Supplies Listing and updated periodically. The agency fee schedule shall be available on the agency website at www.dmas.virginia.gov.

(3) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, less shipping and handling, plus 30%. The manufacturer's net charge to the provider shall be the cost to the provider minus all available discounts to the provider. Additional information specific to how DME providers, including manufacturers who are enrolled as providers, establish and document their costs for DME codes that do not have established rates can be found in the relevant agency guidance document.

c. DMAS shall have the authority to amend the agency fee schedule as it deems appropriate and with notice to providers. DMAS shall have the authority to determine alternate pricing, based on agency research, for any code that does not have a rate.

d. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services or durable medical equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled 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 oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous 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.

7. Local health services.

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 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90, except for services in ambulatory surgery clinics reimbursed under 12VAC30-80-35.

16. Supplemental payments for services provided by Type I physicians.

a. In addition to payments for physician services specified elsewhere in this chapter, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

c. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter.

d. Effective May 1, 2017, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 258% of Medicare rates.

17. Supplemental payments for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this chapter, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2015, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 178% of Medicare rates as defined in the

supplemental payment calculation for Type I physician services. Payments shall be made on the same schedule as Type I physicians.

18. Supplemental payments for services provided by physicians affiliated with Eastern Virginia Medical Center.

a. In addition to payments for physician services specified elsewhere in this chapter, the Department of Medical Assistance Services provides supplemental payments to physicians affiliated with Eastern Virginia Medical Center for furnished services provided on or after October 1, 2012. A physician affiliated with Eastern Virginia Medical Center is a physician who is employed by a publicly funded medical school that is a political subdivision of the Commonwealth of Virginia, who provides clinical services through the faculty practice plan affiliated with the publicly funded medical school, and who has entered into contractual arrangements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective November 1, 2018, the supplemental payment amount shall be the difference between the Medicaid payments otherwise made for physician services and 145% of the Medicare rates. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

c. Supplemental payments shall be made quarterly, no later than 90 days after the end of the quarter.

19. Supplemental payments for services provided by physicians at freestanding children's hospitals serving children in Planning District 8.

a. In addition to payments for physician services specified elsewhere in this chapter, DMAS shall make supplemental payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 with more than 50% Medicaid inpatient utilization in fiscal year 2014. This applies to physician practices affiliated with Children's National Health System.

b. The supplemental payment amount for qualifying physician services shall be the difference between the Medicaid payments otherwise made and 178% of Medicare rates but no more than $551,000 for all qualifying physicians. The methodology for determining allowable percent of Medicare rates is based on the Medicare equivalent of the average commercial rate described in this chapter.

c. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter. Any quarterly payment that would have been due prior to the approval date shall be made no later than 90 days after the approval date.

20. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in this chapter, DMAS provides supplemental payments to qualifying nonstate government-owned or government-operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist, or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or government-operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 20 d of this subsection and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 20 b (1) of this subsection for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision 20 b (2) of this subsection by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section will be made annually in a lump sum during the last quarter of the fiscal year.

d. To determine the aggregate upper payment limit referred to in subdivision 20 b (3) of this subsection, Medicaid payments to nonstate government-owned or government-operated clinics will be divided by the "additional factor" whose calculation is described in 12VAC30-80-190 B 2 in regard to the state agency fee schedule for Resource Based Relative Value Scale. Medicaid payments will be estimated

using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

21. Personal assistance services (PAS) or personal care services for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200 or covered under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and respite services covered under EPSDT. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the DMAS website at http://www.dmas.virginia.gov. The agency's rates, based upon one-hour increments, were set as of July 1, 2020, and shall be effective for services on and after that date.

22. Private duty nursing services covered under EPSDT 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 and after that date. The state agency fee schedule is published on the DMAS website at https://www.dmas.virginia.gov/for-providers/general-information/procedure-fee-files-cpt-codes/

~~22.~~ 23. Supplemental payments to state-owned or state-operated clinics.

a. Effective for dates of service on or after July 1, 2015, DMAS shall make supplemental payments to qualifying state-owned or state-operated clinics for outpatient services provided to Medicaid patients on or after July 1, 2015. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist, or other medical professional acting within the scope of his license to an eligible individual.

b. The amount of the supplemental payment made to each qualifying state-owned or state-operated clinic is determined by calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 19 b of this subsection and the amount otherwise actually paid for the services by the Medicaid program.

c. Payments for furnished services made under this section shall be made annually in lump sum payments to each clinic.

d. To determine the upper payment limit for each clinic referred to in subdivision 19 b of this subsection, the state payment rate schedule shall be compared to the Medicare resource-based relative value scale nonfacility fee schedule per Current Procedural Terminology code for a base period of claims. The base period claims shall be extracted from the Medical Management Information System and exclude crossover claims.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility. As of July 1, 2019, payments for hospice services in a nursing facility are 100% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

C. Effective July 1, 2019, the telehealth originating site facility fee shall be increased to 100% of the Medicare rate and shall reflect changes annually based on changes in the Medicare rate. Federally qualified health centers and rural health centers are exempt from this reimbursement change.