



COMMONWEALTH of VIRGINIA

Office of the Governor

Marvin B. Figueroa
Secretary of Health and Human Resources

August 10, 2026

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 26-014, entitled "Removal of Inflation Adjustments" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

Sincerely,

A handwritten signature in black ink, enclosed within an oval border. The signature appears to be "MBF".

Marvin B. Figueroa

Attachment

cc: Steve Ford, Director, Department of Medical Assistance Services
CMS, Region III

Transmittal Summary

SPA 26-014

I. IDENTIFICATION INFORMATION

Title of Amendment: Removal of Inflation Adjustments

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: In accordance with the 2026 Appropriations Act, Item 291.PPPPP, the state plan is being revised to eliminate inflation adjustments for hospitals, freestanding psychiatric facilities, disproportionate share hospitals (DSH) payments, graduate medical education payments, home health, nursing facilities and any other provider rates for FY 2027 and FY 2028. DMAS shall exclude the value of withheld expected FY2027-FY2028 inflation adjustments from future inflation adjustments and hospital and nursing facility rebasings.

Substance and Analysis: The sections of the State Plan that are affected by this amendment are:

- Methods and Standards for Establishing Rates – Inpatient Services
- Methods and Standards for Establishing Rates – Inpatient Hospital Care
- Methods and Standards for Establishing Rates – Other Types of Care
- Methods and Standards for Establishing Rates – Other Types of Care – Establishment of Rate Per Visit
- Methods and Standards for Establishing Rates for Long Term

Impact: The expected decrease in annual fee-for-service aggregate expenditures is \$1,697,130 in state general funds and \$3,011,087 in federal funds in federal fiscal year 2026.

Tribal Notice: Please see attached.

Prior Public Notice: See Attached.

Public Comments and Agency Analysis: DMAS received several comments that were not in favor of the SPA. DMAS has thoroughly considered every comment submitted and has decided to proceed with the SPA without any changes given the department was mandated by the General Assembly to implement the changes in the SPA.



Tribal Notice – Removal of Inflation Adjustments

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

Date Tue 7/28/2026 12:33 PM

To TribalOffice@MonacanNation.com <TribalOffice@monacannation.com>; Ann Richardson <chiefannerich@aol.com>; Pamelathompson4@yahoo.com <Pamelathompson4@yahoo.com>; rappahannocktrib@aol.com <rappahannocktrib@aol.com>; regstew007@gmail.com <regstew007@gmail.com>; Richard.matens@pamunkey.org <Richard.matens@pamunkey.org>; chief <chief@monacannation.gov>; chiefstephenadkins@gmail.com <chiefstephenadkins@gmail.com>; bradbybrown@gmail.com <bradbybrown@gmail.com>; tabitha.garrett@ihs.gov <tabitha.garrett@ihs.gov>; 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>; lorraine.reels-pearson@ihs.gov <lorraine.reels-pearson@ihs.gov>; Holmes, Remedios (IHS/NAS/RIC) <remedios.holmes@ihs.gov>; Lindsey.Taylor@ihs.gov <lindsey.taylor@ihs.gov>; Lyon, Joni (IHS/NAS/AO) <joni.lyon@ihs.gov>; Howard, Joanne <Joanne.howard@cit-ed.org>; chief <Chief@Nansemond.gov>; AssistantChief@Nansemond.gov <AssistantChief@Nansemond.gov>; steven.tupponce@umithealth.com <steven.tupponce@umithealth.com>; owen.adams@umitribe.gov <owen.adams@umitribe.gov>; Jennifer.Floor@ihs.gov <Jennifer.Floor@ihs.gov>

 1 attachment (169 KB)

DMAS Director Steve Ford approved and signed 07.28.2026 - Tribal Notice Letter 7-28-26.pdf;

Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid Director Steve Ford 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 to remove inflation adjustments.

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



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COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

STEVE FORD
DIRECTOR

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

07/28/2026

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to Removal of Inflation Adjustments.

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 in order to eliminate inflation adjustments for hospitals, freestanding psychiatric facilities, disproportionate share hospitals (DSH) payments, graduate medical education payments, home health, nursing facilities and any other provider rates for FY 2027 and FY 2028 in accordance with the 2026 Appropriations Act, Item 291.PPPPP. DMAS shall exclude the value of withheld expected FY2027-FY2028 inflation adjustments from future inflation adjustments and hospital and nursing facility rebasings.

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 August 27, 2026. 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,

A handwritten signature in blue ink, appearing to read "S Ford".

Steve Ford
Director
Department of Medical Assistance Services



Agency

Department of Medical Assistance Services

Board

Board of Medical Assistance Services

[Edit Notice](#)

General Notice

Public Notice - Intent to Amend State Plan - Removal of Inflation Adjustments

Date Posted: 6/30/2026

Expiration Date: 12/30/2026

Submitted to Registrar for publication: YES

[30 Day Comment Forum](#) is underway. Began on 6/30/2026 and will end on 7/30/2026

**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 June 30, 2026

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 — In-Patient Hospital Care (12 VAC 30-70), Other Types of Care (12 VAC 30-80), and Long-Term Care (12 VAC 30-90)*.

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@dmass.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>

Methods & Standards for Establishing Payment Rates-In-Patient Hospital Care (12 VAC 30-70), Other Types of Care (12 VAC 30-80), and Long-Term Care (12 VAC 30-90)

In accordance with the 2026 Appropriations Act, Item 291.PPPPP, the state plan is being revised to eliminate inflation adjustments for hospital rates, freestanding psychiatric facilities, disproportionate share hospitals (DSH) payments, graduate medical education payments, nursing facilities and any other provider rates for FY 2027 and FY 2028. DMAS shall exclude the value of withheld expected FY2027-FY2028 inflation adjustments from future inflation adjustments and hospital and nursing facility rebasings.

The expected decrease in annual fee-for-service aggregate expenditures is \$1,697,130 in state general funds and \$3,011,087 in federal funds in federal fiscal year 2026 and \$12,600,620 in state general funds and \$22,386,610 in federal funds in federal fiscal year 2027.

Contact Information

Name / Title:	Meredith Lee / <i>Policy Supervisor</i>
Address:	600 East Broad Street Richmond, 23219
Email Address:	<u>Meredith.Lee@dmass.virginia.gov</u>
Telephone:	(804)371-0552 FAX: (804)768-1680 TDD: (800)343-0634

This general notice was created by Meredith Lee on 06/30/2026 at 7:14am



An official website [Here's how you know](#) 

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VIRGINIA
REGULATORY TOWN HALL

Public comment forums

Regulatory Activity Forums (19)		Guidance Document Forums (4)
Actions (12) Periodic Reviews () Petitions for Rulemaking () General Notices (7)		
Board of Medical Assistance Services		
View Comments	Public Notice - Intent to Amend State Plan - Removal of Inflation Adjustments	General Notice Public Notice - Intent to Amend State Plan - Removal of Inflation Adjustments Closed: 7/30/26 6 comments Last comment: 7/30/26 3:28 pm

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

A. The base amount shall be updated annually ~~be by~~ the DRI-Virginia moving average values as compiled and published by DRIWEFA, Inc. (12 VACJ0-70-351). The updated per-resident amount will then be multiplied by the weighted number of full time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTEs reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

1. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for GME. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

B. Type One hospitals shall be reimbursed 100 percent of Medicaid allowable FFS and MCO GME costs for interns and residents.

1. Type One hospitals shall submit annually separate FFS and MCO GME cost schedules, approved by the agency, using GME per diems and GME RCCs (ratios of cost to charges) from the Medicare and Medicaid cost reports and FFS and MCO days and charges. Type One hospitals shall provide information on managed care days and charges in a format similar to FFS,

2. Interim lump sum GME payment for interns and residents shall be made quarterly based on the total cost from the most recently audited cost report divided by four and will be final settled in the audited cost report for the fiscal year end in which the payments are made.

C. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

D. DMAS will make supplemental payments to hospitals for qualified graduate medical residencies. Residency programs (along with their hospital partners) will submit applications for this funding each year. The applications will be scored and the top applicants will receive funding. Top applicants are determined by the scoring criteria laid out in the application. The supplemental payment for each new qualifying residency slot will be \$100,000 annually, minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose number of residency slots are above the cap set by the Centers for Medicare and Medicaid Services (CMS) or have exceeded the Upper Payment Limit (UPL) set by CMS, the supplemental payments for each qualifying residency slot shall be \$50,000 from the general fund annually. The payments shall be made for up to four (4) years. If the medical specialty requires a residency of fewer than four years, only the number of years required for the specialty will be covered. If a resident does not complete the residency program, the residency payments for the incomplete years may not be transferred to another resident. The primary clinical site must be continuously enrolled as a Medicaid hospital provider to receive payments. Payments to hospitals will be made quarterly. Additional criteria include:

1. Sponsoring institutions or the primary clinical site must be:
 - a. Physically located in Virginia;
 - b. An enrolled hospital provider in Virginia Medicaid and continue as a Medicaid-enrolled provider for the duration of the funding;
 - c. Accredited through either the American Osteopathic Association (AOA) or the American Council for Graduate Medical Education (ACGME).
2. Applications must:
 - a. Be complete and submitted by the posted deadline as noted in the application and on the DMAS website at <https://www.dmas.virginia.gov/for-providers/rate-setting/graduate-medical-education/>;
 - b. Request funding for primary care (care (General Pediatrics, General Internal Medicine, or Family Practice) or high-need specialty residencies; and
 - c. Provide substantiation of the need for the requested primary care or specialty residency.
3. Programs that are awarded funding in the full must attest (by June 1) that the resident(s) have been hired for the start of the academic year and have continued employment with the program each year thereafter.

TN No. 21-015-26-Approval Date September 24, 2021Effective Date 7/1/21 260014

Supersedes

TN No. 49-007 21-015

HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

5. Effective July 1, 2010, DSH payments shall be ~~rebased~~ rebased for all hospitals with the final calculation reduced by a uniform percentage such that the expenditures in FY 2011 do not exceed expenditures in FY 2010 ~~separately~~ separately for Type One and Type Two hospitals. The reduction shall be calculated after determination of ~~eligibility~~ eligibility. Payments determined in FY 2011 shall not be adjusted for inflation in FY 2012.

6. Effective July 1, 2013, DSH payments shall not be rebased for all ~~hospitals~~ hospitals in FY 2014 and shall be frozen at the payment levels for FY 2013 eligible providers.

7. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for DSH payments. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

G. To be eligible for DSH, a hospital shall also meet the requirements in 42 USC § 1396r 4(d). No DSH payment shall exceed any applicable limitations upon such payment established by 42 USC § 1396r 4(g).

H. If making the DSH payments prescribed in the State Plan would exceed the DSH allotment, DMAS shall adjust DSH payments to Type One hospitals. Any DSH payment not made as prescribed in the State Plan as a result of the DSH allotment shall be made upon determination that there is available allotment.

I. Effective July ~~1, 2020~~, a supplemental DSH payment shall be made quarterly for non-state government, public acute care hospitals up to each hospital's hospital-specific DSH (OBRA '93 DSH limit) as determined pursuant to 42 USC § 1396r-4(g). The annual payment total shall be based upon the hospital's disproportionate share limit for the most recent year for which the disproportionate share limit has been calculated subject to the availability of DSH funds under the federal allotment of such funds to the department.

12 VAC 30-70-310. Repealed.

12 VAC 30-70-311. Hospital specific operating rate per case.

A. The hospital's specific operating rate per case shall be equal to the labor portion of the statewide operating rate per case, as determined in 12VAC30-70-331, times the hospital's Medicare wage index plus

B. the nonlabor portion of the statewide operating rate per case.

TN No. ~~20-013 26-0014~~ Approval Date ~~12/2/2020~~

Effective Date ~~07/01/2020~~

Supersedes

TN No. ~~14-017 20-013~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

12 VAC 30-70-351. Updating rates for inflation.

- A. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department shall be used to update the base year standardized operating costs per case, as determined in Attachment 4.19-A, page 13 (12VAC30-70-361), and the base year standardized operating costs per day, as determined in Attachment 4.19-A, page 14 (12VAC30-70-371), to the midpoint of the upcoming state fiscal 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. Thus, 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.
- B. The inflation adjustment for hospital operating rates, disproportionate share hospitals (DSH) payments, and graduate medical education payments shall be eliminated for fiscal year (FY) 2010, with the exception of long stay hospitals.
- C. In FY 2011, hospital operating rates shall be rebased; however the 2008 base year costs shall only be increased 2.58% for inflation. For FY 2011 there shall be no inflation adjustment for graduate medical education (GME) or freestanding psychiatric facility rates. The inflation adjustment shall be eliminated for hospital operating rates, GME payments, and freestanding psychiatric facility rates for FY 2012. The inflation adjustment shall be 2.6 percent for inpatient hospitals, including hospital operation rates, GME payments, DSH payments, and freestanding psychiatric facility rates for FY 2013 and 0.0 percent for the same facilities for FY 2014 and 2015. For FY 2017, the inflation adjustment shall be 50% of the adjustment calculated in subsection A above with the exception of 100% inflation for the Children's Hospital of the King's Daughters.
- D. Effective July 1, 2026 through June 30, 2028, inflation adjustment shall be eliminated for all hospital rates, DSH payments, GME payments, and freestanding psychiatric facilities rates. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

12 VAC 30-70-360. Repealed.

12 VAC 30-70-361. Base year standardized operating costs per case.

A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

TN No. ~~16-007 26-0014~~ Approval Date ~~04/25/17~~

Effective Date ~~07/01/26~~ 16

Supersedes

TN No. ~~16-00714 015~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – IN-PATIENT HOSPITAL CARE

Effective on and after July 1, 1988 and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the Virginia moving average values as compiled and published by Global Insight (or its successor) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988 for all such hospitals shall be adjusted to reflect this change.

Effective on or after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation, shall be based on the percent of change in the Virginia values as compiled by Global Insight (or its successor) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989 for all such hospitals shall be adjusted to reflect this change.

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described in this section, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points, (200 basis points) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992 the conversion to the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992 and their next fiscal year ending on or before May 31, 1993.

Effective July 1, 2009, the escalation factor shall be equal to the allowance for inflation.

Effective July 1, 2010 through June 30, 2012, the escalation factor shall be zero. In addition, ceilings shall remain at the same level as the ceilings for long stay hospitals with fiscal year ends of June 30, 2010.

Effective July 1, 2012, through June 30, 2013, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 2.6 percent.

Effective July 1, 2013, through June 30, 2014, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 00 percent.

The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

Effective July 1, 2026, through June 30, 2028, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 0.0 percent. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

(3) Subsequent to June 30, 1992, the group ceilings shall not be recalculated on allowable costs, but shall be updated by the escalator factor.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

-
- a. The inflation adjustment for state fiscal year 2017 shall be 50% of the full inflation adjustment calculated according to this section with the exception of 100% of inflation to the Children's Hospital of King's Daughters. There shall be no inflation adjustment for state fiscal year 2018 with the exception of 100% of inflation to the Children's Hospital of King's Daughters.
- b. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for hospital rates. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

5. Hospital-specific base rate. The hospital-specific base rate per case shall be adjusted for geographic variation. The hospital-specific base rate shall be equal to the labor portion of the statewide base rate times the hospital's Medicare wage index plus the nonlabor percentage of the statewide base rate. The labor percentage shall be determined at each rebasing based on the most recent reliable data. For rural hospitals, the hospital's Medicare wage index used to calculate the base rate shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher. A base rate differential of 5 percent shall be established for freestanding Type Two children's hospitals. The base rate for non cost-reporting hospital shall be the average of the hospital-specific base rates of in-state Type Two hospitals.

6. The total payment shall represent the total allowable amount for a visit including ancillary services and capital.

7. The transition from cost-based reimbursement to EAPG reimbursement shall be transitioned over a three and half-year period. DMAS shall calculate a cost-based base rate at January 1, 2014, and at each rebasing during the transition.

- (a) Effective for dates of service on or after January 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 75 percent of the cost-based base rate and 25 percent of the EAPG base rate.
- b) Effective for dates of service on or after July 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 50 percent of the cost-based base rate and 50 percent of the EAPG base rate.
- c) Effective for dates of service on or after July 1, 2015, DMAS shall calculate the hospital-specific base rate as the sum of 25 percent of the cost-based base rate and 75 percent of the EAPG base rate.
- d) Effective for dates of service on or after July 1, 2016, DMAS shall calculate the hospital-specific base rate as the EAPG base rate.

8. To maintain budget neutrality during the first six years, DMAS shall compare the total reimbursement of hospitals claims based on the parameters in subdivision 3 of this subsection to EAPG reimbursement every six months based on the six months of claims ending three months prior to the potential adjustment. If the percentage difference between the reimbursement target in subdivision 3 of this subsection and EAPG reimbursement is greater than 1 percent, plus or minus, DMAS shall adjust the statewide base rate by the percentage difference the following July 1 or January 1. The first possible adjustment would be January 1, 2015, using reimbursement between January 1, 2014, and October 31, 2014.

C. The Enhanced Ambulatory Patient Group (EAPG) grouper version used for outpatient hospital services shall be determined by DMAS. Providers or provider representatives shall be given notice prior to implementing a new grouper. Except as otherwise noted in the plan, the state-approved EAPG grouper version is the same for both governmental and private providers of outpatient hospital services. The EAPG grouper version was set as of January 1, 2014 and is effective for services provided on or after that date. The grouper version is published at <http://www.dmas.virginia.gov/Content/pgs/pr-eapg.aspx>.

TN No. 17-020-26-0014

Approval Date 11-30-17

Effective Date 07-01-17
07-01-26

Supersedes

TN No. 16-008 17-020

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**

2. The HHA's peer group median rate per visit for each peer group at July 1, 1991, shall 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 \$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 on or about July 1, 2010, based on the percent of change in the moving average of Data Resources, Inc., National Forecast Tables for the Home Health Agency Market Basket published by Global Insight (or its successor) for the second quarter of the calendar year in which the fiscal year begins. 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 interim 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 reduce by 50 percent.
- F. Effective July 1, 2010, through June 30, 2016, there shall be no inflation adjustment for home health agencies. Effective July 1, 2017 through June 30, 2018, the annual fee schedule adjustment for inflation shall be reduced by 50%.
- G. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for home health agencies. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

TN No. 17-020 26-0014

Approval Date 11-30-17

Effective Date 07-01-2017

Supersedes

TN No. 17-02014-016

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

-
- c. See 12VAC 30-90-307 for the applicability of case-mix indices.
1. Direct and indirect payment methods.
- a. Effective for services on or after July 1, 2006, the direct patient care operating ceiling shall be set at 117% of the respective peer group day-weighted median of the facilities' case-mix neutralized direct care operating costs per day. The calculation of the medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group direct patient care operating ceilings shall be revised and case-mix neutralized every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.
- b. The indirect patient care operating ceiling shall be set at 107% of the respective peer group day weighted median of the facility's specific indirect operating cost per day. The calculation of the peer group medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.
2. Reimbursement for use of specialized treatment beds. Effective for services on and after January 1, 2005, nursing facilities shall be reimbursed an additional \$10 per day for those recipients who require a specialized treatment bed due to their having at least one stage IV pressure ulcer. Recipients must meet criteria as outlined in 12 VAC30-60-350, and the additional reimbursement must be preauthorized as provided in 12 VAC30-60-40. Nursing facilities shall not be eligible to receive this reimbursement for individuals whose services are reimbursed under the Specialized Care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12 VAC30-90-41B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.
- B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.
1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

J. The reimbursement methodology described in this section shall be utilized for dates of service through June 30, 2014. Effective July 1, 2014, nursing facilities shall be reimbursed the price-based methodology described in 12 VAC 30-90-44 except, effective July 1, 2021, for nursing facilities operated by the Department of Veteran Affairs Services.

12VAC 30-90-41.1 Modifications to Nursing Facility Reimbursement Formula. Repealed. 12VAC30-90-42. Repealed. 12VAC30-90-43. Repealed.

12 VAC 30-90-44. Nursing Facility Price Based Payment Methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates in 12 VAC 30-90-41 to a price-based methodology except for nursing facilities operated by the Department of Veteran Affairs Services. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

a. The department shall calculate the cost per day in the base year for direct and indirect operating costs for each nursing facility. The department shall use existing definitions of direct and indirect costs.

b. The initial base year for calculating the cost per day shall be cost reports ending in calendar year 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent, reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1. Effective July 1, 2021 DMAS shall defer the next scheduled nursing facility rate rebasing for one year in order to utilize cost reports ending in 2021 as the base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations. No adjustments will be made to the base year data for purposes of rate setting after September 1.

c. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost per day by the raw Medicaid facility case-mix that corresponds to the base year by facility.

d. Costs per day shall be inflated to the midpoint of the fiscal year rate period using the moving average Virginia Nursing Home inflation index for the fourth quarter of each year (the midpoint of the fiscal year). Costs in the 2011 base year shall be inflated from the midpoint of the cost report year to the midpoint of fiscal year 2012 by prorating fiscal year 2012 inflation and annual inflation after that. Annual inflation adjustments shall be based on the last available report prior to the beginning of the fiscal year and corrected for any revisions to prior year inflation.

1. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for nursing facilities. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

e. Prices will be established for the following peer groups using a combination of Medicare wage regions and Medicaid rural and bed size modifications based on similar costs.

The following definitions shall apply to direct peer groups. The Northern Virginia peer group shall be defined as localities in the Washington DC-MD-VA MSA as published by the Centers for Medicare and Medicaid Services (CMS) for skilled nursing facility rates. The Other MSA peer group includes localities in any MSA defined by CMS other than the Northern Virginia MSA and non-MSA designations. The Rural peer groups are non-MSA areas of the state divided into Northern and Southern Rural peer groups based on drawing a line between the following points on the Commonwealth of Virginia map with the coordinates: 37.4203914 Latitude, 82.0201219 Longitude and 37.1223664 Latitude, 76.3457773 Longitude.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

- C. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.
- D. The NATCEPs interim reimbursement rate determined in subsection C of this section shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.
- E. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs that is properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in subsection C of this section times the Medicaid patient days from the DMAS MMR-240.
- F. Disallowance of non-reimbursable NATCEPs costs shall be reflected in the year in which the non-reimbursable costs were claimed.
- G. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in 12VAC30-90-55 A.
- H. Effective July 1, 2014, prospective NATCEPs per diem rates for each facility shall be the NATCEPs per diem rate in the base year inflated to the rate year based on inflation in 4.19-D, Supp. 1, p. ~~26.2~~ 26.1-26.7 (12 VAC 30-90-44). To calculate the NATCEPs per diem rate, NATCEPs costs in the base year shall be converted to a per diem amount by dividing allowable NATCEPs cost by the actual number of NF's patient days. In non-rebasing years, the prospective rate calculation shall be revised annually using costs from the next available year. The NATCEPs reimbursement rate determined above shall be added to the prospective operating cost, criminal records checks and plant cost components.

12 VAC 30-90-171 to 12 VAC 30-90-179. Reserved.

Subpart VIII
Criminal Records Checks for Nursing Facility Employees

12VAC30-90-180. Criminal records checks.

- A. This section implements the requirements of § 32.1-126.01 of the Code of Virginia and Chapter 994 of the Acts of Assembly of 1993 (Item 313 T).

TN No. 14-019 26-
0014

Approval Date 05-04-15

Effective Date 7/01/1426

Supersedes
TN No. 14-019 01-04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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- operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 4.19-D, Supp 1, page 21 (12 VAC 30-90-41).
4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:
- a. Statewide ceiling. The statewide routine operating ceiling shall be \$415 as of July 1, 2002. This routine operating ceiling amount shall be adjusted for inflation based on 4.19-D, Supp 1, page 21 (12VAC 30-90-41). Effective July 1, 2016, the routine operating ~~ceiling~~ ceiling shall be \$573.09 as of SFY 15 and shall be adjusted for inflation ~~based based~~ based on 4.19-D, supp 1, page ~~26.2~~ 26.1 (12 VAC 30-90-44) to the upcoming state fiscal year, the ~~prospective~~ prospective rate year.
- b. The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after the January 1 for which the normalization is calculated. Effective July 1, 2016, the normalized wage index for the FFY following the base year shall be applied to the SFY ceiling.
5. Facility-specific prospective routine operating base cost per day: The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted for inflation based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). Effective July 1, 2016, the routine operating base cost per day in subdivision 1 shall be adjusted for inflation based on 4.19-D, Supp 1, page ~~26.2~~ 26.1 (12 VAC 30-90-44) to the upcoming state fiscal year, the prospective rate year.
6. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report available at the time the interim rates must be set, except that failure to submit a cost report timely may result in adjustment to interim rates as provided elsewhere. Effective July 1, 2016, this section is no longer applicable.
7. Ancillary costs. Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:
- a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. Effective for specialized care days on or after January 15, 2007, reimbursement for reasonable costs shall be subject to a ceiling. The ceiling shall be \$238.81 per day for calendar year 2004 (150% of average costs) and shall be inflated to the appropriate provider fiscal year. For cost report years beginning in each calendar year, ancillary ceilings will be inflated based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). See NHPS, Appendix III, page 2 (12VAC30-90-290) for the cost reimbursement limitations. Effective July 1, 2016, the ancillary ceiling of \$300.38 in SFY 15, inclusive of kinetic therapy devices, shall be adjusted for inflation to the prospective rate year based on 4.19-D, Supp 1, page ~~26.2~~ 26.1 (12 VAC 30-90-44).

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2. STATE

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

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY _____ \$ _____

b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT *(If Applicable)*

9. SUBJECT OF AMENDMENT

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

15. RETURN TO

12. TYPED NAME

13. TITLE

14. DATE SUBMITTED

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

A. The base amount shall be updated annually by the DRI-Virginia moving average values as compiled and published by DRIWEFA, Inc. (12 VACJ0-70-351). The updated per-resident amount will then be multiplied by the weighted number of full time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTEs reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

1. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for GME. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

B. Type One hospitals shall be reimbursed 100 percent of Medicaid allowable FFS and MCO GME costs for interns and residents.

1. Type One hospitals shall submit annually separate FFS and MCO GME cost schedules, approved by the agency, using GME per diems and GME RCCs (ratios of cost to charges) from the Medicare and Medicaid cost reports and FFS and MCO days and charges. Type One hospitals shall provide information on managed care days and charges in a format similar to FFS.

2. Interim lump sum GME payment for interns and residents shall be made quarterly based on the total cost from the most recently audited cost report divided by four and will be final settled in the audited cost report for the fiscal year end in which the payments are made.

C. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

D. DMAS will make supplemental payments to hospitals for qualified graduate medical residencies. Residency programs (along with their hospital partners) will submit applications for this funding each year. The applications will be scored and the top applicants will receive funding. Top applicants are determined by the scoring criteria laid out in the application. The supplemental payment for each new qualifying residency slot will be \$100,000 annually, minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose number of residency slots are above the cap set by the Centers for Medicare and Medicaid Services (CMS) or have exceeded the Upper Payment Limit (UPL) set by CMS, the supplemental payments for each qualifying residency slot shall be \$50,000 from the general fund annually. The payments shall be made for up to four (4) years. If the medical specialty requires a residency of fewer than four years, only the number of years required for the specialty will be covered. If a resident does not complete the residency program, the residency payments for the incomplete years may not be transferred to another resident. The primary clinical site must be continuously enrolled as a Medicaid hospital provider to receive payments. Payments to hospitals will be made quarterly. Additional criteria include:

1. Sponsoring institutions or the primary clinical site must be:
 - a. Physically located in Virginia;
 - b. An enrolled hospital provider in Virginia Medicaid and continue as a Medicaid-enrolled provider for the duration of the funding;
 - c. Accredited-through either the American Osteopathic Association (AOA) or the American Council for Graduate Medical Education (ACGME).
2. Applications must:
 - a. Be complete and submitted by the posted deadline as noted in the application and on the DMAS website at <https://www.dmas.virginia.gov/for-providers/rate-setting/graduate-medical-education/>;
 - b. Request funding for primary care (care (General Pediatrics, General Internal Medicine, or Family Practice) or high-need specialty residencies; and
 - c. Provide substantiation of the need for the requested primary care or specialty residency.
3. Programs that are awarded funding in the full must attest (by June 1) that the resident(s) have been hired for the start of the academic year and have continued employment with the program each year thereafter.

TN No. 26-0014

Approval Date _____

Effective Date 7/1/26

Supersedes

TN No. 21-015

HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

5. Effective July 1, 2010, DSH payments shall be rebased for all hospitals with the final calculation reduced by a uniform percentage such that the expenditures in FY 2011 do not exceed expenditures in FY 2010 separately for Type One and Type Two hospitals. The reduction shall be calculated after determination of eligibility. Payments determined in FY 2011 shall not be adjusted for inflation in FY 2012.

6. Effective July 1, 2013, DSH payments shall not be rebased for all hospitals in FY 2014 and shall be frozen at the payment levels for FY 2013 eligible providers.

7. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for DSH payments. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

G. To be eligible for DSH, a hospital shall also meet the requirements in 42 USC § 1396r 4(d). No DSH payment shall exceed any applicable limitations upon such payment established by 42 USC § 1396r 4(g).

H. If making the DSH payments prescribed in the State Plan would exceed the DSH allotment, DMAS shall adjust DSH payments to Type One hospitals. Any DSH payment not made as prescribed in the State Plan as a result of the DSH allotment shall be made upon determination that there is available allotment.

I. Effective July 1, 2020, a supplemental DSH payment shall be made quarterly for non-state government, public acute care hospitals up to each hospital's hospital-specific DSH (OBRA '93 DSH limit) as determined pursuant to 42 USC § 1396r-4(g). The annual payment total shall be based upon the hospital's disproportionate share limit for the most recent year for which the disproportionate share limit has been calculated subject to the availability of DSH funds under the federal allotment of such funds to the department.

12 VAC 30-70-310. Repealed.

12 VAC 30-70-311. Hospital specific operating rate per case.

A. The hospital's specific operating rate per case shall be equal to the labor portion of the statewide operating rate per case, as determined in 12VAC30-70-331, times the hospital's Medicare wage index plus

B. the nonlabor portion of the statewide operating rate per case.

TN No. 26-0014
Supersedes
TN No. 20-013

Approval Date

Effective Date 07/01/26

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

12 VAC 30-70-351. Updating rates for inflation.

- A. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department shall be used to update the base year standardized operating costs per case, as determined in Attachment 4.19-A, page 13 (12VAC30-70-361), and the base year standardized operating costs per day, as determined in Attachment 4.19-A, page 14 (12VAC30-70-371), to the midpoint of the upcoming state fiscal 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. Thus, 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.
- B. The inflation adjustment for hospital operating rates, disproportionate share hospitals (DSH) payments, and graduate medical education payments shall be eliminated for fiscal year (FY) 2010, with the exception of long stay hospitals.
- C. In FY 2011, hospital operating rates shall be rebased; however the 2008 base year costs shall only be increased 2.58% for inflation. For FY 2011 there shall be no inflation adjustment for graduate medical education (GME) or freestanding psychiatric facility rates. The inflation adjustment shall be eliminated for hospital operating rates, GME payments, and freestanding psychiatric facility rates for FY 2012. The inflation adjustment shall be 2.6 percent for inpatient hospitals, including hospital operation rates, GME payments, DSH payments, and freestanding psychiatric facility rates for FY 2013 and 0.0 percent for the same facilities for FY 2014 and 2015. For FY 2017, the inflation adjustment shall be 50% of the adjustment calculated in subsection A above with the exception of 100% inflation for the Children's Hospital of the King's Daughters.
- D. Effective July 1, 2026 through June 30, 2028, inflation adjustment shall be eliminated for all hospital rates, DSH payments, GME payments, and freestanding psychiatric facilities rates. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

12 VAC 30-70-360. Repealed.

12 VAC 30-70-361. Base year standardized operating costs per case.

A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

TN No. 26-0014
Supersedes
TN No. 16-007

Approval Date _____

Effective Date 07/01/26

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – IN-PATIENT HOSPITAL CARE

Effective on and after July 1, 1988 and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the Virginia moving average values as compiled and published by Global Insight (or its successor) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988 for all such hospitals shall be adjusted to reflect this change.

Effective on or after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation, shall be based on the percent of change in the Virginia values as compiled by Global Insight (or its successor) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989 for all such hospitals shall be adjusted to reflect this change.

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described in this section, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points, (200 basis points) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992 the conversion to the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992 and their next fiscal year ending on or before May 31, 1993.

Effective July 1, 2009, the escalation factor shall be equal to the allowance for inflation.

Effective July 1, 2010 through June 30, 2012, the escalation factor shall be zero. In addition, ceilings shall remain at the same level as the ceilings for long stay hospitals with fiscal year ends of June 30, 2010.

Effective July 1, 2012, through June 30, 2013, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 2.6 percent.

Effective July 1, 2013, through June 30, 2014, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 00 percent.

The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

Effective July 1, 2026, through June 30, 2028, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 0.0 percent. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

(3) Subsequent to June 30, 1992, the group ceilings shall not be recalculated on allowable costs, but shall be updated by the escalator factor.

TN No. 26-0014

Approval Date _____

Effective Date 07-01-26

Supersedes

TN No. 14-017

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

-
- a. The inflation adjustment for state fiscal year 2017 shall be 50% of the full inflation adjustment calculated according to this section with the exception of 100% of inflation to the Children's Hospital of King's Daughters. There shall be no inflation adjustment for state fiscal year 2018 with the exception of 100% of inflation to the Children's Hospital of King's Daughters.
- b. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for hospital rates. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

5. Hospital-specific base rate. The hospital-specific base rate per case shall be adjusted for geographic variation. The hospital-specific base rate shall be equal to the labor portion of the statewide base rate times the hospital's Medicare wage index plus the nonlabor percentage of the statewide base rate. The labor percentage shall be determined at each rebasing based on the most recent reliable data. For rural hospitals, the hospital's Medicare wage index used to calculate the base rate shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher. A base rate differential of 5 percent shall be established for freestanding Type Two children's hospitals. The base rate for non cost-reporting hospital shall be the average of the hospital-specific base rates of in-state Type Two hospitals.

6. The total payment shall represent the total allowable amount for a visit including ancillary services and capital.

7. The transition from cost-based reimbursement to EAPG reimbursement shall be transitioned over a three and half-year period. DMAS shall calculate a cost-based base rate at January 1, 2014, and at each rebasing during the transition.

- (a) Effective for dates of service on or after January 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 75 percent of the cost-based base rate and 25 percent of the EAPG base rate.
- b) Effective for dates of service on or after July 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 50 percent of the cost-based base rate and 50 percent of the EAPG base rate.
- c) Effective for dates of service on or after July 1, 2015, DMAS shall calculate the hospital-specific base rate as the sum of 25 percent of the cost-based base rate and 75 percent of the EAPG base rate.
- d) Effective for dates of service on or after July 1, 2016, DMAS shall calculate the hospital-specific base rate as the EAPG base rate.

8. To maintain budget neutrality during the first six years, DMAS shall compare the total reimbursement of hospitals claims based on the parameters in subdivision 3 of this subsection to EAPG reimbursement every six months based on the six months of claims ending three months prior to the potential adjustment. If the percentage difference between the reimbursement target in subdivision 3 of this subsection and EAPG reimbursement is greater than 1 percent, plus or minus, DMAS shall adjust the statewide base rate by the percentage difference the following July 1 or January 1. The first possible adjustment would be January 1, 2015, using reimbursement between January 1, 2014, and October 31, 2014.

C. The Enhanced Ambulatory Patient Group (EAPG) grouper version used for outpatient hospital services shall be determined by DMAS. Providers or provider representatives shall be given notice prior to implementing a new grouper. Except as otherwise noted in the plan, the state-approved EAPG grouper version is the same for both governmental and private providers of outpatient hospital services. The EAPG grouper version was set as of January 1, 2014 and is effective for services provided on or after that date. The grouper version is published at <http://www.dmas.virginia.gov/Content/pgs/pr-eapg.aspx>.

TN No. 26-0014

Approval Date _____

Effective Date 07-01-26

Supersedes

TN No. 17-020

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**

2. The HHA's peer group median rate per visit for each peer group at July 1, 1991, shall 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 \$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 on or about July 1, 2010, based on the percent of change in the moving average of Data Resources, Inc., National Forecast Tables for the Home Health Agency Market Basket published by Global Insight (or its successor) for the second quarter of the calendar year in which the fiscal year begins. 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 interim 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 reduce by 50 percent.
- F. Effective July 1, 2010, through June 30, 2016, there shall be no inflation adjustment for home health agencies. Effective July 1, 2017 through June 30, 2018, the annual fee schedule adjustment for inflation shall be reduced by 50%.
- G. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for home health agencies. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

TN No. 26-0014

Approval Date _____

Effective Date 07-01-26

Supersedes

TN No. 17-020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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- c. See 12VAC 30-90-307 for the applicability of case-mix indices.
1. Direct and indirect payment methods.
- a. Effective for services on or after July 1, 2006, the direct patient care operating ceiling shall be set at 117% of the respective peer group day-weighted median of the facilities' case-mix neutralized direct care operating costs per day. The calculation of the medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group direct patient care operating ceilings shall be revised and case-mix neutralized every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.
 - b. The indirect patient care operating ceiling shall be set at 107% of the respective peer group day weighted median of the facility's specific indirect operating cost per day. The calculation of the peer group medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.
2. Reimbursement for use of specialized treatment beds. Effective for services on and after January 1, 2005, nursing facilities shall be reimbursed an additional \$10 per day for those recipients who require a specialized treatment bed due to their having at least one stage IV pressure ulcer. Recipients must meet criteria as outlined in 12 VAC30-60-350, and the additional reimbursement must be preauthorized as provided in 12 VAC30-60-40. Nursing facilities shall not be eligible to receive this reimbursement for individuals whose services are reimbursed under the Specialized Care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12 VAC30-90-41B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.
- B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.
- 1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

J. The reimbursement methodology described in this section shall be utilized for dates of service through June 30, 2014. Effective July 1, 2014, nursing facilities shall be reimbursed the price-based methodology described in 12 VAC 30-90-44 except, effective July 1, 2021, for nursing facilities operated by the Department of Veteran Services.

12VAC 30-90-41.1 Modifications to Nursing Facility Reimbursement Formula. Repealed. 12VAC30-90-42. Repealed. 12VAC30-90-43. Repealed.

12 VAC 30-90-44. Nursing Facility Price Based Payment Methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates in 12 VAC 30-90-41 to a price-based methodology except for nursing facilities operated by the Department of Veteran Services. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

a. The department shall calculate the cost per day in the base year for direct and indirect operating costs for each nursing facility. The department shall use existing definitions of direct and indirect costs.

b. The initial base year for calculating the cost per day shall be cost reports ending in calendar year 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent, reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1. Effective July 1, 2021 DMAS shall defer the next scheduled nursing facility rate rebasing for one year in order to utilize cost reports ending in 2021 as the base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations. No adjustments will be made to the base year data for purposes of rate setting after September 1.

c. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost per day by the raw Medicaid facility case-mix that corresponds to the base year by facility.

d. Costs per day shall be inflated to the midpoint of the fiscal year rate period using the moving average Virginia Nursing Home inflation index for the fourth quarter of each year (the midpoint of the fiscal year). Costs in the 2011 base year shall be inflated from the midpoint of the cost report year to the midpoint of fiscal year 2012 by prorating fiscal year 2012 inflation and annual inflation after that. Annual inflation adjustments shall be based on the last available report prior to the beginning of the fiscal year and corrected for any revisions to prior year inflation.

1. Effective July 1, 2026, through June 30, 2028, inflation adjustments shall be eliminated for nursing facilities. The department shall exclude the value of the withheld expected FY 2027 and FY 2028 inflation adjustments from future inflation adjustments and rebasings.

e. Prices will be established for the following peer groups using a combination of Medicare wage regions and Medicaid rural and bed size modifications based on similar costs.

The following definitions shall apply to direct peer groups. The Northern Virginia peer group shall be defined as localities in the Washington DC-MD-VA MSA as published by the Centers for Medicare and Medicaid Services (CMS) for skilled nursing facility rates. The Other MSA peer group includes localities in any MSA defined by CMS other than the Northern Virginia MSA and non-MSA designations. The Rural peer groups are non-MSA areas of the state divided into Northern and Southern Rural peer groups based on drawing a line between the following points on the Commonwealth of Virginia map with the coordinates: 37.4203914 Latitude, 82.0201219 Longitude and 37.1223664 Latitude, 76.3457773 Longitude.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

- C. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.
- D. The NATCEPs interim reimbursement rate determined in subsection C of this section shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.
- E. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs that is properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in subsection C of this section times the Medicaid patient days from the DMAS MMR-240.
- F. Disallowance of non-reimbursable NATCEPs costs shall be reflected in the year in which the non-reimbursable costs were claimed.
- G. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in 12VAC30-90-55 A.
- H. Effective July 1, 2014, prospective NATCEPs per diem rates for each facility shall be the NATCEPs per diem rate in the base year inflated to the rate year based on inflation in 4.19-D, Supp. 1, p. 26.1-26.7 (12 VAC 30-90-44). To calculate the NATCEPs per diem rate, NATCEPs costs in the base year shall be converted to a per diem amount by dividing allowable NATCEPs cost by the actual number of NF's patient days. In non-rebasing years, the prospective rate calculation shall be revised annually using costs from the next available year. The NATCEPs reimbursement rate determined above shall be added to the prospective operating cost, criminal records checks and plant cost components.

12 VAC 30-90-171 to 12 VAC 30-90-179. Reserved.

Subpart VIII
Criminal Records Checks for Nursing Facility Employees

12VAC30-90-180. Criminal records checks.

- A. This section implements the requirements of § 32.1-126.01 of the Code of Virginia and Chapter 994 of the Acts of Assembly of 1993 (Item 313 T).

TN No. 26-0014
Supersedes
TN No. 14-019

Approval Date _____

Effective Date 7/01/26

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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- operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 4.19-D, Supp 1, page 21 (12 VAC 30-90-41).
4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:
 - a. Statewide ceiling. The statewide routine operating ceiling shall be \$415 as of July 1, 2002. This routine operating ceiling amount shall be adjusted for inflation based on 4.19-D, Supp 1, page 21 (12VAC 30-90-41). Effective July 1, 2016, the routine operating ceiling shall be \$573.09 as of SFY 15 and shall be adjusted for inflation based on 4.19-D, supp 1, page 26.1 (12 VAC 30-90-44) to the upcoming state fiscal year, the prospective rate year.
 - b. The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after the January 1 for which the normalization is calculated. Effective July 1, 2016, the normalized wage index for the FFY following the base year shall be applied to the SFY ceiling.
 5. Facility-specific prospective routine operating base cost per day: The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted for inflation based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). Effective July 1, 2016, the routine operating base cost per day in subdivision 1 shall be adjusted for inflation based on 4.19-D, Supp 1, page 26.1 (12 VAC 30-90-44) to the upcoming state fiscal year, the prospective rate year.
 6. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report available at the time the interim rates must be set, except that failure to submit a cost report timely may result in adjustment to interim rates as provided elsewhere. Effective July 1, 2016, this section is no longer applicable.
 7. Ancillary costs. Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:
 - a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. Effective for specialized care days on or after January 15, 2007, reimbursement for reasonable costs shall be subject to a ceiling. The ceiling shall be \$238.81 per day for calendar year 2004 (150% of average costs) and shall be inflated to the appropriate provider fiscal year. For cost report years beginning in each calendar year, ancillary ceilings will be inflated based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). See NHPS, Appendix III, page 2 (12VAC30-90-290) for the cost reimbursement limitations. Effective July 1, 2016, the ancillary ceiling of \$300.38 in SFY 15, inclusive of kinetic therapy devices, shall be adjusted for inflation to the prospective rate year based on 4.19-D, Supp 1, page 26.1 (12 VAC 30-90-44).

TN No. 26-0014

Approval Date _____

Effective Date 07-01-26

Supersedes

TN No. 16-007