DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

Patrick W. Finnerty, Director
Department of Medicaid Assistance Service
600 East Broad Street, Suite 1300
Richmond, VA 23219

JUN - 2 2010

RE: VA SPA 09-017

Dear Mr. Finnerty:

We have completed our review of State Plan Amendment (SPA) 09-017. This SPA modifies Attachments 4.19-A and 4.19-D of Virginia's Title XIX State Plan. Specifically the 4.19-A amendment effectively freezes rate increases for inpatient hospital services by not providing increases based on any inflationary indices. It also reduces capital reimbursement for certain Type Two hospitals, reduces certain incentive payments for long-stay hospitals, and reduces Disproportionate Share (DSH) payments by increasing the threshold eligibility percentages used to calculate DSH payments. In addition, the amendment rebases freestanding psychiatric hospital costs using 2005 as the base year and eliminates reimbursement for hospital acquired conditions in a manner similar to the Medicare program. In regards to nursing facilities under section 4.19D, the amendment removes a previously approved operating rate reduction factor, but also eliminates inflation adjustments for nursing facilities for the July 1, 2009 through June 30, 2010 year.

We conducted our review of this SPA according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-017 is approved with an effective date of July 1, 2009. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, or require additional information, please call Gary Knight at (304) 347-5723.

Sincerely,

Bill Fox for
Cindy Mann
Director, CMCS

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 09 – 17

2. STATE: Virginia

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

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

4. PROPOSED EFFECTIVE DATE: July 1, 2009

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

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

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

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

7. FEDERAL BUDGET IMPACT
a. FFY 2009 $ [11,131,075.00]
b. FFY 2010 $ [44,524,308.00]

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-A, Pages 7-9, 12, 12.1, 13, and 13.1 of 23, Attach. 4.19-A, Suppl. 3, Pages 3-5 of 15, and Attach. 4.19-D, Pages 26.1 and 26.2 of 61.

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

10. SUBJECT OF AMENDMENT: 2009 Institutional Reimbursement Changes

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: [signature]

13. TYPED NAME: Patrick W. Finnerty

14. TITLE: Director

15. DATE SUBMITTED: 9-25-09

16. RETURN TO

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

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: Rev. 10-02-10

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

SAVE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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 moving average of the Data Resources, Incorporated Health Care Cost HCFA-Type Hospital Market Basket 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 moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia, as developed by Data Resources, Incorporated, 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 above, 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.

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.

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

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(4) Prospective rates for each hospital shall be based upon the hospital's allowable costs plus the escalator factor, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment shall be made to prospective rates.

Capital and education costs approved pursuant to PRM-15 (§400), shall be considered as pass throughs and not part of the calculation. Capital cost is reimbursed the percentage of allowable cost specified in 12VAC30-70-271.

(5) An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 10.5% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report.

Disproportionate share hospitals defined.

The following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

A. Criteria

1. A Medicaid inpatient utilization rate in excess of 10.5% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

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2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subsection A.2 does not apply to a hospital:

   a. at which the inpatients are predominantly individuals under 18 years of age; or

   b. which does not offer nonemergency obstetric services as of December 21, 1987.

B. Payment Adjustment.

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the number of utilization Medicaid inpatient days by the total number of inpatient days. Each hospital with a Medicaid utilization of over 10.5% shall receive a disproportionate share payment adjustment.

2. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 10.5%, times eleven, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 10.5%, times (ii) the lower of the prospective operating cost rate or ceiling.

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care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. "Type Two" hospitals means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Until notification of a change is given, Version 14.0 of this grouper shall be used. DMAS shall notify hospitals when updating the system to later grouper versions.

E. Effective January 1, 2010, DRG cases shall be grouped based on the exclusion of diagnoses and procedures defined as Hospital Acquired Conditions (HAC) from the AP-DRG Grouper used to determine DRG payment for all Medicaid beneficiaries. HACs shall be defined using the criteria published by Medicare in the Federal Register. Any significant changes to the Medicare list of conditions shall be implemented each January 1.

F. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology

Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports

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Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims History File
Outlier adjustment factor	Federal Register

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result in an expenditure for outlier operating payments equal to 5.1% of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

12 VAC 30-70-270. Repealed.

12 VAC 30-70-271. Payment for capital costs.

A. Inpatient capital costs shall be determined on an allowable cost basis and settled at the hospital's fiscal year end. Allowable cost shall be determined following the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VC 30-70-130). Inpatient capital costs of Type One hospitals shall continue to be settled at 100% of allowable cost. For services beginning July 1, 2003, and ending June 30, 2009, inpatient capital costs of Type Two hospitals, except those with Virginia Medicaid utilization rates greater than 50%, shall be settled at 80% of allowable cost. For services beginning July 1, 2009, inpatient capital costs of Type Two hospitals, excluding Type Two hospitals with greater than 50% of Virginia Medicaid utilization, shall be settled at 75% of allowable cost. For hospitals with fiscal years that are in progress and do not begin on July 1, 2003, or July 1, 2009, inpatient capital costs for the fiscal year in progress on those dates shall be apportioned between the time period before and the time period after those dates based on the number of calendar months before and after those dates.

B. The exception to the policy in subsection A of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12 VAC 30-70-321 B, shall be an all-inclusive payment for operating and capital costs. The capital rate per day determined in 12VAC 30-70-321 will be multiplied by the same percentages of allowable cost specified in subsection A of this section.

12 VAC 30-70-280. Repealed.

12 VAC 30-70-281. Payment for direct medical education costs.

A. Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis. Payments for these direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for these direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

C. Effective with cost reporting periods beginning on or after July 1, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis, subject to cost settlement as outlined in subdivision E of this section.

D. The new methodology provides for the determination of a hospital-specific base period per-resident amount to initially be calculated from cost reports with fiscal years

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12 VAC 30-70-320. Repealed.

12 VAC 30-70-321. Hospital specific operating rate per day.

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12 VAC 30-70-341, times the hospital's Medicare wage index plus the non-labor portion of the statewide operating rate per day.

B. For rural hospitals, the hospital's Medicare wage index used in this section shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher.

C. Effective July 1, 2008, and ending after June 30, 2010, the hospital-specific operating rate per day shall be reduced by 2.683 percent.

D. The hospital specific rate per day for freestanding psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases.

E. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC 30-70-271.

F. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals.

G. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from Medicare cost report.

12 VAC 30-70-330. Repealed.

12 VAC 30-70-331. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals and shall be the ratio of the following two numbers:

1. For Type One hospitals the adjustment factor shall be a calculated percentage that causes the type One hospital statewide operating rate per case to equal the type Two hospital statewide operating rate per case;

2. Effective July 1, 2006, for Type Two hospitals the adjustment factor shall be 0.7800:

a. The numerator of the factor is the aggregate total Medicaid operating payments to affected hospitals in hospital fiscal years ending in the base year.

b. The denominator of the factor is the aggregate total Medicaid allowable operating cost as determined from settled cost reports from the same hospitals in the same year.

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12VAC30-70-340. Repealed.

12VAC 30-70-341. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12 VAC 30-70-371, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B or C of this section.

B. The adjustment factor for acute care psychiatric cases and rehabilitation cases shall be the one specified in subsection B of 12 VAC 30-70-331.

C. The adjustment factor for acute care psychiatric cases for Type Two hospitals shall be 0.8400. The adjustment factor for acute care psychiatric cases for Type One hospitals shall be the one specified in subsection B.1 of 12VAC30-70-331 times 0.8400 divided by the factor in subsection B.2 of 12VAC30-70-331.

D. Effective July 1, 2009, for freestanding psychiatric facilities the adjustment factor shall be 1.0000.

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12 VAC 30-70-350. Repealed.

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 12 VAC 30-70-361, and the base year standardized operating costs per day, as determined in 12 VAC 30-70-371, 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. In setting rates effective from July 1, 2003, through June 30, 2004, for Type Two hospitals, the moving average value that would normally be used to represent inflation occurring from the midpoint of SFY 2003 to the midpoint of SFY 2004, shall be replaced by a percentage calculated by DMAS to ensure that the resulting estimated increase in payments to hospitals, by Medicaid, does not exceed $10,863,375 in SFY 2004. After June 30, 2004, the rate-setting basis will revert back to the DRI-Virginia moving average values used according to the previous methodology in effect prior to July 1, 2003.

B. The inflation adjustment for hospital operating rates, disproportionate share hospital payments, and graduate medical education payments shall be zero percent for Fiscal Year (FY) 2010. The elimination of the inflation adjustments shall not be applicable to re-basing in FY 2011.

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.

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B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per day:

1. The operating costs for each per diem case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

2. The standardized operating costs for each per diem case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs.

3. The base year standardized operating costs per day for acute care psychiatric cases shall be calculated by summing the standardized operating costs for acute care psychiatric cases and dividing by the total number of acute care psychiatric days. This calculation shall be repeated separately for freestanding psychiatric cases and rehabilitation cases.

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D. In calculating the DRG relative weights, a threshold of five cases shall be set as the minimum number of cases required to calculate a reasonable DRG relative weight. In those instances where there are five or fewer cases, the department's Medicaid claims data shall be supplemented with Medicaid claims data from another state or other available sources. The DRG relative weights calculated according to this methodology will result in an average case weight that is different from the average case weight before the supplemental claims data was added. Therefore, the DRG relative weights shall be normalized by an adjustment factor so that the average case weight after the supplemental claims data were added is equal to the average case weight before the supplemental claims data were added.

E. The DRG relative weights shall be used to calculate a case-mix index for each hospital. The case-mix index for a hospital is calculated by summing, across all DRGs, the product of the number of groupable cases in each DRG and the relative weight for each DRG and dividing this amount by the total number of groupable cases occurring at the hospital.

12 VAC 30-70-390. Repealed.

12 VAC 30-70-391. Recalibration and re-basing policy.

A. The department recognizes that claims experience or modifications in federal policies may require adjustment to the DRG payment system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the DRG relative weights and hospital case-mix indices) and re-base (review and update the base year standardized operating costs per case and the base year standardized operating costs per day) the DRG payment system at least every three years. Recalibration and re-basing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12 VAC 30-70-490. When re-basing is carried out, if new rates are not calculated before their required effective date, hospitals required to file cost reports and freestanding psychiatric facilities licensed as hospitals shall be settled at the new rates, for discharges on and after the effective date of those rates, at the time the hospitals' cost reports for the year in which the rates become effective are settled.

B. Effective July 1, 2009, rates for freestanding psychiatric facilities shall be re-based using 2005 cost data as the base year. Future re-basings shall be consistent with re-basing for all other hospitals.

Article 3.
Other Provisions for Payment of Inpatient Hospital Services.

12 VAC 30-70-400. Determination of per diem rates.

This section shall be applicable to only those claims for discharges prior to July 1, 1999. Each hospital's revised per diem rate or rates to be used during the transition period (SFY 1997 and SFY 1998) shall be based on the hospital's previous peer group ceiling or ceilings that were established under the provisions of 12 VAC 30-70-10 through 12 VAC 30-70-130, with the following adjustment:

1. All operating ceilings will be increased by the same proportion to effect an aggregate increase in reimbursement of $40 million in SFY 1997. This adjustment incorporates in per diem rates the system-wide aggregate value of payment that otherwise would be made through the payment adjustment fund. This adjustment will be calculated using estimated 1997 rates and 1994 days.

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rates before the sale.

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. Effective July 1, 2005, the total per diem payment to each nursing home shall be increased by $3 per day. This increase in the total per diem payment shall cease, effective July 1, 2006. Effective July 1, 2006, when cost data that include time period before July 1, 2005, are used to set facility specific rates, a portion of the $3.00 per day amount identified above, based on the percentage of patient days in the provider's cost reporting period that fall before July 1, 2005, adjusted for appropriate inflation and multiplied times the providers' Medicaid utilization rate, shall be allocated to the facility specific direct and indirect cost per day prior to comparison to the peer group ceilings. For purposes of this subsection, $1.68 of the $3.00 shall be considered direct costs and $1.32 of the $3.00 shall be considered indirect costs.

K. Effective July 1, 2008, and ending after June 30, 2009, the operating rate for nursing facilities shall be reduced by 1.329 percent.

L. Effective July 1, 2009, through June 30, 2010, there will be no inflation adjustment for nursing facility operating rates and ceilings and specialized care operating rates and ceilings. Exempt from this are government-owned nursing facilities with Medicaid utilization of 85% or greater in provider fiscal year 2007.

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

12 VAC 30-90-41.2. Limits on Application of Inflation Factor to Indirect and Direct Care Costs.

A. Effective on and after July 1, 2003, and for only State Fiscal Year 2004 (ending June 30, 2004), the adjustment for inflation of nursing facility direct care rates and ceilings as referenced at 12 VAC 30-90-41.B above shall be calculated in a manner to ensure that the increase in payments does not exceed $8,768,125 in General Funds and $8,813,838 in Non-General Funds.

B. Effective on July 1, 2003, and for only State Fiscal Year 2004 (ending June 30, 2004), the adjustment for inflation of nursing facility indirect care rates and ceilings as referenced at 12VAC30-90-41.B shall be calculated in a manner to ensure that the increase in payments does not exceed $2,325,094 in General Funds and $2,337,216 in Non-General funds.

C. The provision of this section 12VAC30-90-41.2 shall supersede, for the duration of July 1, 2003, through June 30, 2004, the applicable provisions in 12VAC 30-90-41. The application of this section 12 VAC 30-90-41.2 shall end on June 30, 2004, and on July 1, 2004, the applicable provisions in 12 VAC 30-90-41 shall resume in effect.

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12VAC30-90-42. Repealed.

12VAC30-90-43. Repealed.

12VAC30-90-44 to 12VAC30-90-49. Reserved.

Article 5
Allowable Cost Identification

12VAC30-90-50. Allowable costs.

A. Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270).

B. Certification. The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

OS Notification

State/Title/Plan Number:	**Virginia 09-017**	
Type of Action:	**SPA Approval**	
Required Date for State Notification:	**June 6, 2010**	
Fiscal Impact in Millions:	**FY 2009**	**4.19A ($8,630,395)**
		4.19D ($2,500,680)
	FY 2010	**4.19A ($34,521,587)**
		4.19D ($10,002,721)

Number of Potential Newly Eligible People: 0
Eligibility Simplification: No
Provider Payment Increase: No
Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

4.19A Effective July 1, 2009, this amendment 1) freezes operating rates for inpatient hospital services by not providing increases based on inflationary indices; 2) reduces capital reimbursements for Type Two hospitals from 80% to 75% of cost, except for those with VA Medicaid utilization rates greater than 50% (Type Two hospitals are defined as hospitals that weren't state-owned teaching hospitals on January 1, 1996); 3) reduces incentive payments for long-stay hospitals 4) reduces DSH payments for long-stay hospitals by increasing the threshold eligibility percentages used to calculate DSH payments; 5) removes additional 2% added to inflation for the escalator used to increase ceilings for long-stay hospital payments; 6) rebases freestanding psych hospital to 100% of 2005 cost inflated forward and subject to no FY10 inflation; and, 7) eliminates reimbursement for hospital acquired conditions similar to Medicare's 10/1/2008 initiative with significant changes to Medicare HACs implemented each January 1.

4.19D Effective July 1, 2009, this amendment removes a previously approved operating rate reduction factor (1.329 % in effect for the July 1, 2008 through June 30, 2009 year), but also eliminates inflation adjustments for nursing facilities for the July 1, 2009 through June 30, 2010 year.

This plan amendment is a result of legislative state budget actions for SFY 2009-2010. Non-Federal funds are generated from state general fund appropriations. The public notice requirements have been met and the revisions do not present any known UPL issues since the SPA reduces reimbursements. CMS asked about compliance with 1902(a)(30) and the State in its written reply makes an assurance that payments will comply with the statutory requirements- The State supported this claim by pointing out that no providers have declined to participate in the program as a result of the proposed changes and that these changes were fully vetted through the