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State Name: Virginia

State Plan Amendment (SPA) #: 10-015

This file contains the following documents in the order listed:

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

Centers for Medicaid, CHIP, and Survey & Certification

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

MAY 3 1 2011

RE: VA SPA 10-015

Dear Dr. Pane:

We have completed our review of State Plan Amendment (SPA) 10-015. This SPA modifies Attachments 4.19-A and 4.19-D of Virginia's Title XIX State Plan. Specifically, SPA 10-015 eliminates the inflation adjustment for inpatient hospitals and nursing facilities, as well as the incentive plan for long-stay hospitals. VA SPA 10-015 also reduces the operating rates at hospitals and nursing facilities by 3%. In addition hospitals will now qualify for DSH at a Medicaid Inpatient Utilization Rate of 14%.

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 approving Medicaid State plan amendment 10-015 with an effective date of July 1, 2010. Enclosed are 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,

/S/

Cindy Mann
Director,
Centers for Medicaid, CHIP, and Survey & Certification

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 10 – 15

2. STATE: Virginia

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

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

4. PROPOSED EFFECTIVE DATE: July 1, 2010

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

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

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

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

7. FEDERAL BUDGET IMPACT
a. FFY 2011 $ (30,606,666.00)
b. FFY 2012 $ (85,131,798.00)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-A, Pages 1.1, 39, 9.1, 9.1.1,10, 10.1, 11, 12, 12.1, 13, and 16 of 23; Attach. 4.19-A, Suppl. 3, Pages 3, and 4 of 15; Attach. 4.19-D, Page 2 of 4, Attach. 4.19-D, Suppl. 1, Pages 1, 2, 17, 18, 26.1, and 34 of

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

10. SUBJECT OF AMENDMENT: Institutional Provider Reimbursement Changes

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2011
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Gregg A. Pane, MD, MPA

14. TITLE: Director

15. DATE SUBMITTED:

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: 05-31-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

CHAPTER 70 - METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES; INPATIENT HOSPITAL CARE.

PART V - INPATIENT HOSPITAL PAYMENT SYSTEM.

Article 1 - Application of Payment Methodologies.

12 VAC 30-70-200. Repealed.

12 VAC 30-70-201. Application of payment methodologies.

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals shall be subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Inpatient hospital facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be reimbursed costs. Facilities may also receive disproportionate share hospital (DSH) payments. The criteria for DSH eligibility and the payment amount shall be based on subsection G of 12VAC30-70-50. If the DSH limit is exceeded by any facility, the excess DSH payments shall be distributed to all other qualifying DBHDS facilities in proportion to the amount of DSH they otherwise receive.

D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

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"Base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" reflects the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases".

"Cost" means allowable cost as defined in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid utilization rate in excess of 14%, 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

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 non-emergency obstetric procedures.

3. Subdivision 2 of this definition 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 non-emergency obstetric services as of December 21, 1987.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

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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 VAC 30-70-130).

B. For hospitals with fiscal years that are in progress and do not begin on July 1 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.

1. Inpatient capital costs apportioned before July 1, 2003, shall be settled at 100% of allowable cost.

2. Effective July 1, 2003 through June 30, 2009, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals shall be settled at 80% of allowable cost.

3. Effective July 1, 2009 through June 30, 2010, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

4. Effective July 1, 2010 through September 30, 2010, inpatient capital costs of Type One hospitals shall be settled at 97% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 72% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 77% of allowable cost.

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5. Effective October 1, 2010 through June 30, 2011, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

6. Effective July 1, 2011, inpatient capital costs of Type One hospitals shall be settled at 96% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 71% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 76% of allowable cost.

C. The exception to the policy in subsection B of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12VAC30-70-321 B, shall be an all-inclusive payment for operating and capital costs. The capital rate per day determined in 12VAC30-70-321 will be multiplied by the same percentage of allowable cost specified in subsection B 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

ending in state fiscal year 1998 or as may be re-based in the future and provided to the public in an agency guidance document. This per-resident amount shall be calculated by dividing a hospital's Medicaid allowable direct GME costs for the base period by its number of interns and residents in the base period yielding the base amount.

E. The base amount shall be updated annually by the DRI-Virginia moving average values as compiled and published by DRI•WEFA, Inc. (12 VAC 30-70-351). The updated per-resident base 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.

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

12 VAC 30-70-290. Repealed.

12 VAC 30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education. Out-of-state cost reporting hospitals are eligible for this payment only if they have Virginia Medicaid utilization in the base year of at least 12 percent of total Medicaid days. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

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1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type One Hospitals = $[1.89 \text{ X } ((1 + r)^{0.405}-1)] \text{ X (IME Factor)}$

An IME factor shall be calculated for each Type One hospital and shall equal a factor that, when used in the calculation of the IME percentage, shall cause the resulting IME payments to equal what the IME payments would be with an IME factor of one, plus an amount equal to the difference between operating payments using the adjustment factor specified in subdivision B 1 of 12VAC30-70-331 and operating payments using an adjustment factor of one in place of the adjustment factor specified in subdivision B 1 of 12 VAC 30-70-331.

2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type Two Hospitals = $[1.89 \text{ X } ((1 + r)^{0.405}-1)] \text{ X } 0.5695$

In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

D. An additional IME payment not to exceed $1.9 million in total shall be apportioned among Type Two Hospitals with Medicaid NICU utilization in excess of 50 percent and with overall Medicaid utilization in excess of 50 percent as reported to the Department of Medical Assistance Services as of March 1, 2004. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

12 VAC 30-70-300. Repealed.

12 VAC 30-70-301. Payment to disproportionate share hospitals.

A. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis, shall be final, and shall not be subject to settlement except when necessary due to the limit in subsection D of this section.

B. Hospitals qualifying under the 14% inpatient Medicaid utilization percentage shall receive a DSH payment based on the hospital's type and the hospital's Medicaid utilization percentage.

1. Type One hospitals shall receive a DSH payment equal to:

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a. The sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433.

b. Multiplied by the Type One hospital DSH Factor. The Type One hospital DSH factor shall equal a percentage that when applied to the DSH payment calculation yields a DSH payment equal to the total calculated using the methodology outlined in subdivision 1 a of this subsection using an adjustment factor of one in the calculation of operating payments rather than the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times the hospital's Medicaid operating reimbursement, times 1.2074. Out-of-state cost reporting hospitals with Virginia utilization in the base year of less than 12% of total Medicaid days shall receive 50% of the payment described in this subsection.

C. Hospitals qualifying under the 25% low-income patient utilization rate shall receive a DSH payment based on the hospital's type and the hospital's low-income utilization rate.

1. Type One hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times 17, times the hospital's Medicaid operating reimbursement.

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2. Type Two hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

3. Calculation of a hospital's low-income patient utilization percentage is defined in 42 USC § 1396r-4(b)(3).

D. No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and § 1923(g) of the Social Security Act.

E. Each hospital's eligibility for DSH payment and the amount of the DSH payment shall be calculated at the time of each rebasing using the most recent reliable utilization data and projected operating reimbursement data available. The utilization data used to determine eligibility for DSH payment and the amount of the DSH payment shall include days for Medicaid recipients enrolled in capitated managed care programs. In years when DSH payments are not rebased in the way described above, the previous year's amounts shall be adjusted for inflation.

For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recently settled Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

F. 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.

12 VAC 30-70-310. Repealed.

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

A. The hospital specific operating rate per case shall be equal to the labor portion of the statewide operating rate per case, as determined in 12 VAC 30-70-331, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per case.

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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.

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:

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;

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2. For Type Two hospitals the adjustment factor shall be:

a. 0.7800 effective July 1, 2006 through June 30, 2010.

b. 0.7500 effective July 1, 2010 through September 30, 2010.

c. 0.7800 effective October 1, 2010 through June 30, 2011.

d. 0.7400 effective July 1, 2011.

12 VAC 30-70-340. Repealed.

12 VAC 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 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:

1. Type One hospitals shall be the one specified in subdivision B 1 of 12VAC30-70-331 times the factor in subdivision C2 of 12 VAC 30-70-341 divided by the factor in subdivision B 2 of 12VAC30-70-331.

2. Type Two hospitals shall be:

a. 0.7800 effective July 1, 2006, through June 30, 2007.

b. 0.8400 effective July 1, 2007, through June 30, 2010.

c. 0.8100 effective July 1, 2010, through September 30, 2010.

d. 0.8400 effective October 1, 2010, through June 30, 2011.

e. 0.8000 effective July 1, 2011.

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.

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 12VAC30-70-361, and the base year standardized operating costs per day, as determined in 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.

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.

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.

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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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.

C. Effective July 1, 2010, rates for freestanding psychiatric facilities shall not be rebased.

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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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.

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.

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.

Depreciation, capital interest, and education costs approved pursuant to PRM-15 (§400), shall be considered as pass throughs and not part of the calculation. Capital interest 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. Effective for dates of service July 1, 2010 through September 30, 2010, and on or after July 1, 2011, the incentive plan shall be eliminated.

(6) There shall be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.

(7) 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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(4) Reports of field audits are retained by the state agency for at least three years following submission of the report.

(5) Facilities are paid on a cost-related basis in accordance with the methodology described in the Plan.

(6) Modifications to the Plan for reimbursement will be submitted as Plan amendments.

(7) Covered cost will include such items as:

(a) Cost of meeting certification standards.

(b) Routine services which include items expense providers normally incur in the provision of services.

(c) The cost of such services provided by related organizations except as modified in the payment system supplement 4.19-D.

(8) Bad debts, charity and courtesy allowances shall be excluded from allowable cost.

(9) Effective for facility cost reporting periods beginning on or after October 1, 1978, the reimbursable amount will be determined prospectively on a facility by facility basis, except that facilities operated by the Department of Behavioral Health And Developmental Services and facilities operated by the Departement of Veterans Services shall be reimbursed retrospectively. The prospective rate will be based on the prior period's actual cost (as determined by an annual cost report and verified by audit as set forth in Section d. (3) above) plus an inflation factor. Payments will be made to facilities no less than monthly.

(10) The payment level calculated by the prospective rate will be adequate to reimburse in full such actual allowable costs that an economically and efficiently operated facility must incur. In addition, an incentive plan will be established as described in the payment system supplement 4.19-D.

(11) Upper limits for payment within the prospective payment system shall be as follow:

(a) Allowable cost shall be determined in accordance with Medicare principles as defined in PRM-15, except as may be modified in this plan.

(b) Reimbursement for operating costs will be limited to regional ceilings.

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Part II -- Nursing Home Payment System

Subpart I: General

12 VAC 30-90-20. Nursing home payment system; generally.

A. Effective July 1, 2001, the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in this part.

B. Three separate cost components are used: plant or capital, as appropriate, cost; operating cost; and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

C. Effective July 1, 2001, in determining the ceiling limitations, there shall be direct patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA MSA, for NFs with less than 61 beds in the rest of the state, and for NFs with more than 60 beds in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Centers for Medicare and Medicaid Services (CMS). A nursing facility located in a jurisdiction that CMS adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of CMS' final rule.

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D. Institutions for mental diseases providing nursing services for individuals age 65 and older operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be exempt from the prospective payment system as defined in Articles 1 (12 VAC 30-90-29), 3 (12 VAC 39-90-35 et seq.), 4 (12 VAC 39-90-40 et seq.), 6 (12 VAC 30-90-60 et seq.), and 8 (12 VAC 30-90-80 et seq.) of this subpart, as are mental retardation/intellectual disability facilities operated by DBHDS as are facilities operated by the Department of Veterans Services. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare principles of reimbursement and Medicaid principles of reimbursement in effect on June 30, 2000, except that those that are defined as skilled nursing facilities (SNFs) and are operated by DBHDS shall not be subject to the routine cost limits that are normally required and applicable under Medicare principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) shall be reimbursed retrospectively on the basis of reasonable costs but limited to the highest rate paid to a state ICF/ID institution, approved each July 1 by DMAS.

E. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see 12 VAC 30-90-270) and must be identifiable and verifiable by contemporaneous documentation. All matters of reimbursement which are part of the DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

12 VAC 30-90-21 through 12 VAC 30-90-28. Reserved.

Subpart II
Rate Determination Procedures

Article 1. Transition to new capital payment methodology.

12 VAC 30-90-29.

A. This section provides for a transition to a new capital payment methodology. The methodology that will be phased out for most facilities is described in Article 2. The methodology that will be phased in for most facilities is described in Article 3. The terms and timing of the transition are described in this article.

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TABLE 1
R.S. MEANS COMMERCIAL CONSTRUCTION COST
LOCATION FACTORS (2000)

Zip Code	PRINCIPAL CITY	Location Factor
220-221	Fairfax	0.90
222	Arlington	0.90
223	Alexandria	0.91
224-225	Fredericksburg	0.85
226	Winchester	0.80
227	Culpeper	0.80
228	Harrisonburg	0.77
229	Charlottesville	0.82
230-232	Richmond	0.85
233-235	Norfolk	0.82
236	Newport News	0.82
237	Portsmouth	0.81
238	Petersburg	0.84
239	Farmville	0.74
240-241	Roanoke	0.77
242	Bristol	0.75
243	Pulaski	0.70
244	Staunton	0.76
245	Lynchburg	0.77
246	Grundy	0.70

"Rental rate" means for a prospective year a rate equal to two percentage points plus the yield on US Treasury Bonds with maturity over 10 years, averaged over the most recent three calendar years for which data are available, as published by the Federal Reserve [(Federal Reserve Statistical Release H.15 Selected Interest Rates (www.Federalreserve.gov/releases/)]. The rate will be published and distributed to providers annually. Changes in the rental rate shall be effective for the providers' fiscal year beginning on or after July 1st. Rental rates may not fall below 9% or exceed 11% and will be updated annually on or about July 1st each year. Effective July 1, 2010, through September 30, 2010, the floor for the nursing facility rental rates may not fall below 8.75%. Effective October 1, 2010, through June 30, 2011, the floor for the nursing facility rental rates may not fall below 9.0%. Effective July 1, 2011, through June 30, 2012, the floor for the nursing facility rental rates may not fall below 8.5%.

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"Required occupancy percentage" means an occupancy percentage of 90%.

"SFY" means State Fiscal Year (July 1st through June 30th.)

A. Fair Rental Value (FRV) Payment for Capital. Effective for dates of service on or after July 1, 2001, DMAS shall pay nursing facility capital related costs under a FRV methodology. The payment made under this methodology shall be the only payment for capital related costs, and no separate payment shall be made for depreciation or interest expense, lease costs, property taxes, insurance, or any other capital related cost, including home office capital costs. This payment is considered to cover costs related to land, buildings and fixed equipment, major movable equipment, and any other capital related item. This shall be the case regardless of whether the property is owned or leased by the operator. The Department shall review the operation and performance of the FRV methodology every two years.

B. RV Rate Year. The FRV payment rate shall be a per diem rate determined each year for each facility, using the most recent available data from settled cost reports, or from other verified sources as specified herein. The per diem rate shall be determined prospectively and shall apply for the entire fiscal year. Each provider shall receive a new capital per diem rate each year effective at the start of the provider's fiscal year except that the capital per diem rate shall also be revised for the rental rate changes effective July 1, 2010, through June 30, 2012. Data elements that are provider specific shall be revised at that time and shall rely on the settled cost report and schedule of assets of the previous year. Data elements that are not provider specific, including those published by RSMeans and the rental rate, shall be determined annually on or about July 1st and shall apply to provider fiscal years beginning on or after July 1st. That is, each July 1st DMAS shall determine the RSMeans values and the rental rate, and these shall apply to all provider fiscal years beginning on or after July 1st.

12 VAC 30-90-37 Calculation of FRV Per Diem Rate for Capital. Calculation of FRV Rental Amount. Change of Ownership.

A. Calculation of FRV Per Diem Rate for Capital. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of actual patient days or 90 percent of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see 12 VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the 90 percent occupancy requirement.

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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.

M. Effective July 1, 2010, through June 30, 2012, there shall be no inflation adjustment for nursing facility and specialized care operating rates. Nursing facility and specialized care ceilings shall be frozen at the same level as the ceilings for nursing facilities with provider fiscal year ends of June 30, 2010.

N. Effective July 1, 2010, through September 30, 2010, the operating rate for nursing facilities shall be reduced 3% below the rates otherwise calculated. Effective July 1, 2011, through June 30, 2012, the operating rate for nursing facilities shall be reduced 3% below the rates otherwise calculated.

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

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F. The 90% occupancy requirement for indirect and capital costs shall be applied to the first and subsequent cost reporting periods' actual indirect and capital costs for establishing such NFs second and future cost reporting periods' prospective reimbursement rates. The 90% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 90% occupancy at any point in time during the first cost reporting period. The Department may grant an exception to the minimum occupancy requirement for reimbursement purposes for beds taken out of service for renovation. In this case, the occupancy requirement shall be calculated as 90% of available bed days for the period of the exception plus 90% of licensed bed days for the remainder of the cost report year. The provider must notify DMAS and the Division of Long Term Care Services Office of Licensure and Certification in advance and present a plan including a reasonable timetable for when the beds will be placed back into service. The provider must keep the appropriate documentation of available beds and days during the renovation period which will provide the evidence of the beds and days taken out of service for renovation purposes. This supporting documentation along with a copy of the provider's letter to the Division of Long Term Care Services Office of Licensure and Certification notifying them of the number-of-beds not in use for the defined period-of-time should be submitted with the filing of the provider's cost report, as applicable.

G. A new NFs interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by DMAS, or the appropriate operating ceilings or charges.

H. Effective July 1, 2001, on the first day of its second cost reporting period, a new nursing facility's interim plant or capital, as appropriate, rate shall be converted to a per diem amount by dividing its allowable plant/capital costs for its first cost reporting period by 90% of the potential number of patient days for all licensed beds during the first cost reporting period.

I. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned CMI based upon its peer group's normalized average Medicaid CMI for direct patient care. An expanded NF receiving new NF treatment shall receive the CMI calculated for its last semiannual period prior to obtaining new NF status.

12 VAC 30-90-61 through 12 VAC 30-90-64. Reserved.

12VAC30-90-65. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in 12 VAC 30-90-60 E, F, and H.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If indirect costs are below the ceiling, an efficiency incentive shall be paid at settlement of the first year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable indirect operating cost and the peer group ceiling used to set the interim rate. (Refer to 12 VAC 30-90-41 F.)