Table of Contents

State Name: Virginia

State Plan Amendment (SPA) #: 11-11

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

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

NOV 17 2011

RE: VA SPA 11-011

Dear Dr. Pane:

We have completed our review of State Plan Amendment (SPA) 11-011. This SPA modifies Attachments 4.19-A and 4.19-B of Virginia's Title XIX State Plan. Specifically, SPA 11-011 implements regulations for provider preventable conditions and related payment adjustments for Medicaid.

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 11-011 with an effective date of August 18, 2011. 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 and CHIP Services

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: 11 — 11

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, 2011

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 447

7. FEDERAL BUDGET IMPACT
a. FFY 2011 $ 0.00
b. FFY 2012 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Preprint Pages 57 and 58
Page 5 of 23 (4.19A)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: Provider Preventable Conditions

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: NOV 17 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: August 18, 2011

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS: Per verbal change made to Block #8

FORM CMS-179 (07/92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

---

§1. General. The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in §1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

1. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

2. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

3. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

4. Reimbursement for services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.
   a. No payment shall be made for services for the following Never Events: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
   b. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
   c. Reductions in provider payment may be limited to the extent that the following apply:

      i. The identified provider-preventable conditions would otherwise result in an increase in payment.
      ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

   d. Providers or members may request full payment based on lack of access to services for Medicaid members.
   e. In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

§2. Services which are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision 2c of subsection D below. The upper limit for reimbursement shall be no higher than payments for Medicare patients in accordance with 42 CFR 447.321. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be noncovered as a component of payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform CMS-approved cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

4. Each hospital's total yearly reduction amount is equal to their respective state fiscal '03 and '04 forecast reimbursement as described above in 3.a. and 3.b., times 3.235857 percent for state fiscal '03, and 3.235857 percent, for the first two quarters of state fiscal '04 and 2.88572 percent for the last two quarters of state fiscal year '04, not to be reduced by more than $500,000 per year.

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in 4 above. Payment reduction offsets not covered by claims remittance by May 15, 2003 and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30.

F. Provider Preventable Conditions.

Effective July 1, 2012, reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

1. Payments for Hospital Acquired Conditions (HACs) shall be adjusted in the following manner. For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by DMAS. For example, an inpatient claim with 45 covered days identified with an HAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

2. No payment shall be made for inpatient services for the following Never Events: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; (iii) surgical or other invasive procedure performed on the wrong patient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

3. No reduction in payment for a provider preventable condition shall be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

4. Reductions in provider payment may be limited to the extent that the following apply:

   a. The identified provider-preventable conditions would otherwise result in an increase in payment.

   b. The Commonwealth can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

5. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

6. In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

12 VAC 30-70-205. REPEALED.

Article 2.
Prospective (DRG-Based) Payment Methodology.

12 VAC 30-70-210. Repealed.

12 VAC 30-70-211. Reserved.

12 VAC 30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

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. [RESERVED]

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, cons-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, include Type One hospitals. The following table identified 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