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State Name: Virginia

State Plan Amendment (SPA) #: 13-08

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

MAY 22 2014

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RE: State Plan Amendment 13-08

Dear Ms. Jones:

We have completed our review of State Plan Amendment (SPA) 13-08. This SPA modifies Attachments 4.19-A and 4.19-D of Virginia's Title XIX State Plan. Specifically, SPA 13-08 modifies the Indirect Medical Education factor for certain freestanding children's hospitals, eliminates rebasing of DSH payments in 2014 and freezes DSH payments at 2013 levels, and changes the nursing facility capital occupancy requirement from 90% to 88%.

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 13-08 with an effective date of July 1, 2013. 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

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: 13 — 08
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, 2013

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 2013 $ [5,436,540.00]
b. FFY 2014 $ [15,392,995.00]

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-A, Pages 10 and 11 of 23, and Suppl. 1 to Attach. 4.19-D, Pages 4, 18, 21, 33 and 34 of 61

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: 2013 Institutional Reimbursement Changes for Hospitals and Nursing Facilities

GOVERNOR'S REVIEW *(Check One)*

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 9-12-13

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: 09/25/2013

18. DATE APPROVED: MAY 22 2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: [redacted]

22. TITLE: Deputy Director, Policy + Financial Mgt. CMCS

23. REMARKS

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 RATES-INPATIENT SERVICES

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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.

1. For Type Two hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

2. For Type One hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section. Effective April 1, 2012, the operating rate per case used in the formula shall be revised to reflect an adjustment factor of one and case mix adjusted by multiplying the operating rate per case in this subsection by the weight per case for FFS discharges that is determined during rebasing.

D. An additional IME payment not to exceed $200,000 in total shall be apportioned among Type Two Hospitals excluding freestanding children's hospitals with Medicaid NICU 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.

E. An additional IME not to exceed $500,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU days in excess of 4, 500 as reported to the Department of Medical Assistance Services as of March 1, 2005, that do not otherwise receive an additional IME payment under subsection D of this section. These payments shall be total of these days among eligible hospitals as reported by March 1, 2003.

F. Effective July 1, 2013 DMAS shall calculate an IME factor for Virginia freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009. Total payments for IME in combination with other payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 may not exceed the federal uncompensated care cost limit that disproportionate share hospital payments are subject to.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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.

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

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.

E. Emergency regulations effective July 1, 2000, provided for a facility specific fixed capital per diem applicable to services in SFY 2001, that is not to be adjusted at settlement. After SFY 2001, the per diem that would have been applicable to SFY 2001, under the methodology in Article 2 shall be calculated. If there are two provider fiscal years that overlap SFY 2001, this per diem shall be a combination of the two applicable per diem amounts. If the per diem provided in the emergency regulations is lower than the per diem based on Article 2, the difference, multiplied by the days in SFY 2001, shall be paid to the facility. If the per diem provided in the emergency regulations is higher, the difference, multiplied by the days, shall be collected from the facility in the settlement of the provider year settled after the difference is calculated.

Article 2
Plant Cost Component

12VAC30-90-30. Plant cost.

A. This Article describes a capital payment methodology that will be phased out for most nursing facilities by SFY 2012. The terms and timing of the transition to a different methodology are described in Article 1. The methodology that will eventually replace this one for most facilities is described in Article 3.

B. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

C. Effective July 1, 2001, to calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as the occupancy percentage of the daily licensed bed complement during the applicable cost reporting period. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90%, for dates of service on or after July 1, 2013 shall be 88%. For facilities that also provide specialized care services, see subdivision 10 of 12VAC30-90-264 for special procedures for computing the number of patient days required to meet the 90% occupancy requirement.

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are non-reimbursable plant costs.

" Occupancy percentage" means an occupancy percentage of 90% for dates of service on or before June 30, 2013. The occupancy percentage for dates of service on or after July 1, 2013 shall be 88%.

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

A. Fair Rental Value Payment for Capital. Effective for dates of service on or after July 1, 2001, the DMAS shall pay nursing facility capital related costs under a Fair Rental Value (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. FRV 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. 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 the occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see subdivision 10 of 12VAC30-90-264 for special procedures for computing the number of patient days required to meet the occupancy percentage requirement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

Article 4

Operating Cost Component

12VAC30-90-40. Operating cost.

A. Effective July 1, 2001, operating cost shall be the total allowable inpatient cost less plant cost or capital, as appropriate, and NATCEPs costs. See Subpart VII (12 VAC 30-90-170) for rate determination procedures for NATCEPs costs. Operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I (12 VAC 30-90-271). Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs or the actual charges by the Central Criminal Records Exchange for criminal records checks for nursing facility employees (see Appendix I (12 VAC 30-90-272)). For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or the occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period times the Medicaid utilization percentage. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90 percent, for dates of service on or after July 1, 2013 shall be 88 percent. 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 occupancy percentage requirement.

12VAC30-90-41. Nursing facility reimbursement formula.

A. Effective on and after July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group-III (RUG-III) System as defined in Appendix IV (12 VAC 30-90-305 through 307)." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12 VAC 30-90-305 through 307 for details on the Resource Utilization Groups.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the *Social Security Act* as they relate to provision of services, residents' rights and administration and other matters.

A. A new facility shall be defined as follows:

1. A facility that is newly enrolled and new construction has taken place through the COPN process; or

2. A facility that is newly enrolled which was previously denied payments for new admissions and was subsequently terminated from the program.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. A replacement facility or one that has changed location may not be considered a new facility if it serves the same inpatient population. An exception may be granted by DMAS if the provider can demonstrate that the occupancy substantially changed as a result of the facility being replaced or changing location. A decline in the replacement facility's total occupancy of 20 percentage points, in the replacement facility's first cost reporting period, shall be considered to indicate a substantial change when compared to the lower of the old facility's previous two prior cost reporting periods. The replacement facility shall receive the previous operator's operating rates if it does not qualify to be considered a new facility.

D. A change in either ownership or adverse financial conditions (e.g. bankruptcy), or both, of a provider does not change a nursing facility's status to be considered a new facility.

E. Effective July 1, 2001, for all new NFs the occupancy percentage requirement for indirect and capital costs shall be waived for establishing the first cost reporting period interim rate. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90%, for dates of service on or after July 1, 2013 shall be 88%. This first cost reporting period shall not exceed 13 months from the date of the NF's certification.

F. The occupancy percentage 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 occupancy percentage requirement shall be considered as having been satisfied if the new NF achieved the occupancy percentage 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 the occupancy percentage of available bed days for the period of the exception plus the occupancy percentage 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 the occupancy percentage 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.)