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**State Name:** Virginia

**State Plan Amendment (SPA)#:** 14-017

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Nine (9) SPA Pages

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 SERVICES

**Financial Management Group**

JUN 02 2015

Mrs. Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond, VA 23219

RE: State Plan Amendment 14-017

Dear Ms. Jones:

We have completed our review of State Plan Amendment (SPA) 14-017. This SPA modifies Attachment 4.19-A of Virginia's Title XIX State Plan. Specifically, the SPA makes amendments to disproportionate share hospital reimbursement to better estimate uncompensated care and be more sustainable moving forward.

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 state plan amendment 14-017 effective July 1, 2014. 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 yours,

/S/

Timothy Hill
Director

Enclosures

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

GH 5/19/2015

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 14-0017

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, 2014

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 477

7. FEDERAL BUDGET IMPACT
a. FFY 2014 $ 0
b. FFY 2015 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, pp 10.1,10.2,11, & 11.1 of 23; Attachment 4.19-A, Supplement 3, pp 1,3,4,5 of 15.

3.1, GH 5/19/2015

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: Disproportionate Share Hospital Payment Method

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2014
☐ 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: 9/3/14

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: JUN 02 2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Kristen Fan

22. TITLE: Deputy Director, FMG

23. REMARKS

FORM CMS-179 (07/92)

*Instructions on Back*

Save

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"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days and nonpaid/denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth. Effective July 1, 2014, the definition for Medicaid utilization percentage is defined in Attachment 4.19-A, Page 10.1 (12 VAC 30-70-301.B).

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

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12 VAC 30-70-300. Repealed.

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

A. Definitions. The following words and terms shall have the following meanings unless the context clearly indicates otherwise:

"Uncompensated care costs" or "UCC" means unreimbursed costs incurred by hospitals from serving self-pay, charity or Medicaid patients without regard to disproportionate share adjustment payments.

B. 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 and shall be final subject to provisions in subsections E, G and H.

C. Effective July 1, 2014, in order to qualify for DSH payments, DSH eligible hospitals shall have a total Medicaid inpatient utilization rate equal to 14 percent or higher in the base year using Medicaid days eligible for Medicare DSH defined in 42 USC § 1396r-4(b)(2) or a low income utilization rate defined in 42 USC § 1396r-4(b)(3) in excess of 25 percent. Eligibility for out of state cost reporting hospitals shall be based on total Medicaid utilization or on total Medicaid neonatal intensive care unit (NICU) utilization equal to 14 percent or higher.

D. Effective July 1, 2014, the DSH reimbursement methodology for all hospitals except Type One hospitals shall be the following:

1. Each hospital's DSH payment shall be equal to the DSH per diem multiplied by each hospital's eligible DSH days in a base year. Days reported in provider fiscal years in state FY 2011 (available from the Medicaid cost report through the Hospital Cost Report Information System (HCRIS) as of July 30, 2013) will be the base year for FY 2015 prospective DSH payments. DSH shall be recalculated annually with an updated base year. Future base year data shall be extracted from Medicare cost report summary statistics available through HCRIS as of October 1 prior to next year's effective date.

2. Eligible DSH days are the sum of all Medicaid inpatient acute, psychiatric and rehabilitation days above 14 percent for each DSH hospital subject to special rules for out-of-state cost reporting hospitals. Eligible DSH days for out-of-state cost reporting hospitals shall be the higher of the number of eligible days based on the calculation in the first sentence times Virginia Medicaid utilization (Virginia Medicaid days as a percent of total Medicaid days) or the Medicaid NICU days above 14 percent times Virginia NICU Medicaid utilization (Virginia NICU Medicaid days as a percent of total NICU Medicaid days). Eligible DSH days for out-of-state cost reporting hospitals who qualify for DSH but who have less than 12 percent Virginia Medicaid utilization shall be 50 percent of the days that would have otherwise been eligible DSH days.

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3. Additional eligible DSH days are days that exceed 28 percent Medicaid utilization for Virginia Type Two hospitals, excluding Children's Hospital of the Kings Daughters (CHKD).

4. The DSH per diem shall be calculated in the following manner:

a. The DSH per diem for Type Two hospitals is calculated by dividing the total Type Two DSH allocation by the sum of eligible DSH days for all Type Two DSH hospitals. For purposes of DSH, Type Two hospitals do not include CHKD or any hospital whose reimbursement exceeds its federal uncompensated care cost limit. The Type Two Hospital DSH allocation shall equal the amount of DSH paid to Type Two hospitals in state FY 2014 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act adjusted for the state fiscal year.

b. The DSH per diem for state inpatient psychiatric hospitals is calculated by dividing the total state inpatient psychiatric hospital DSH allocation by the sum of eligible DSH days. The state inpatient psychiatric hospital DSH allocation shall equal the amount of DSH paid in state FY 2013 increased annually by the percent change in the federal allotment, including any reductions as a result of the Affordable Care Act, adjusted for the state fiscal year.

c. The DSH per diem for CHKD shall be three times the DSH per diem for Type Two hospitals.

5. Each year, the department shall determine how much Type Two DSH has been reduced as a result of the Affordable Care Act and adjust the percent of cost reimbursed for outpatient hospital reimbursement.

E. Effective July 1, 2014, the DSH reimbursement methodology for Type One hospitals shall be to pay its uncompensated care costs up to the available allotment. Interim payments shall be made based on estimates of the UCC and allotment. Payments shall be settled at cost report settlement and at the conclusion of the DSH audit.

F. Prior to July 1, 2014, 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.

3. 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.

a. 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.

b. 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.

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

4. 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.

a. 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.

b. In years when DSH payments are not rebased in the way described above, the previous year's amounts shall be adjusted for inflation.

c. 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.

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

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

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

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

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

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

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The state agency will pay the reasonable cost of in-patient hospital services provided under the Plan. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of medical assistance.

I. For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the state agency will apply the standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine service costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routine service charges or patient days as well as Title XVIII inpatient routine service cost.

II. For each hospital not participating in the Program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

III. For either participating or nonparticipating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services that the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary, HHS on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in paragraphs (a) and (b) above.

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural - 0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban- 0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Centers for Medicare and Medicaid Services (CMS) in determining routine cost limitations.

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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 shal be adjusted to reflect this change.

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

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

Effective July 1, 2013, through June 30, 2014, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 0,0 percent.

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

(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. Effective for dates of service July 1, 2010 through September 30, 2010, 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.

Prior to July 1, 2014, the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share pay. Effective July 1, 2014, the payment methodology for DSH is defmed in 12 VAC 30-70-301 beginning on page 10.1 of Attachment 4.19-A.

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 defmed 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 8% 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.

3. No payments made under subdivision 1 or 2 of this subsection shall exceed any applicable limitations upon such payments established by federal law or regulations.