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State Name: Virginia

State Plan Amendment (SPA) #: 14-02

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT #022020144042

MAY 15 2014

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

Dear Ms. Jones:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Virginia's State Plan Amendment (SPA) 14-02, Enhanced Ambulatory Patient Group (EAPG) for Outpatient Hospital Reimbursement. This SPA proposes to implement a prospective payment methodology for outpatient hospital services. The EAPG methodology is a more efficient and predictable reimbursement for Virginia to pay hospitals that furnish services to Medicaid recipients in an outpatient hospital setting.

This SPA is acceptable. Therefore, we are approving SPA 14-02 with an effective date of January 1, 2014. Enclosed are the approved SPA pages and a copy of the signed Form CMS-179.

If you have any questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

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: 14-02

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: January 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 447

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-B, pp. 2 and 4, of 15; pp. 7.2.1, 7.2.2, 7.2.3, 7.2.4 of 15; and pp. 7.3 and 8.1 of 15 AND 4.1.1 of 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Replace: Attach. 4.19-B, pp. 2, 4, 7.3 and 8.1 of 15
~~Add: Attach. 4.19-B, p. 7.2.1, 7.2.2, 7.2.3, 7.2.4 of 15~~

10. SUBJECT OF AMENDMENT: Enhanced Ambulatory Patient Group Outpatient Hospital Reimbursement

11. 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: 2/19/14

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: February 19, 2014

18. DATE APPROVED: MAY 15 2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Francis McCullough

22. TITLE: Associate Regional Administrator /DMCHO

23. REMARKS

5/9/2014 - Pen and ink change made to Section #8 to add State Plan Page Attachment 4.19-B Page 4.1.1 of 15. (MK)

5/9/2014 - Pen and ink change made to Section #9 to remove Stak Plan Pages Attachment 4.19-B Pages 7.2.1, 7.2.2, 7.2.3 and 7.2.4 of 15. (MK)

FORM CMS-179 (07/92)

Instructions on Back

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

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. For dates of service prior to January 1, 2014, outpatient hospital services including rehabilitation hospital outpatient services and excluding laboratory

a. Definitions. The following words and terms, when used in this regulation, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency room and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§32.1-323-et seq.) of Title 32.1 of the Code of Virginia

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

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(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

§2.D.1. c. Limitation to allowable cost. Effective for services on and after July 1, 2003, reimbursement of hospitals for outpatient services shall be at various percentages of allowable cost, with cost to be determined as provided in §2.A, §2.B, and §2.C on pages 1 and 2 of 15. For hospitals with fiscal years that do not begin on July 1, outpatient costs, both operating and capital, for the fiscal year in progress on that date, shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date.

(1) Type One Hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating reimbursement shall be at 91.2% of allowable cost and capital reimbursement shall be at 87% of allowable cost.

(c) Effective October 2010, through June 30, 2011, hospital outpatient operating reimbursement shall be at 94.2% of allowable cost and capital reimbursement shall be at 90% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating reimbursement shall be at 90.2% of allowable cost and capital reimbursement shall be at 86% of allowable cost.

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2.D.1.c. (2) Type Two Hospitals.

(a) Effective July 1, 2003, through June 30, 2010, hospital outpatient operating and capital reimbursement shall be at 80% of allowable cost.

(b) Effective July 1, 2010, through September 30, 2010, hospital outpatient operating and capital reimbursement shall be at 77% of allowable cost.

(c) Effective October 2010, through June 30, 2011, hospital outpatient operating and capital reimbursement shall be at 80% of allowable cost.

(d) Effective July 1, 2011, hospital outpatient operating and capital reimbursement shall be at 76% of allowable cost.

§2.D.1.d Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) 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. See 12 VAC 30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

§2.D.2. Rehabilitation agencies operated by state agencies for physical therapy, occupational therapy, and speech-language therapy services. The reimbursement methodology for physical therapy, occupational therapy, and speech-language therapy applicable to other rehabilitation agencies, is based on Attachment 4.19-B, Supplement 5.

2.D.1.e. The last cost report with a fiscal year end on or after December 31, 2013, shall be used for reimbursement for dates of service through December 31, 2013, based on this section. Reimbursement shall be based on charges reported for dates of services prior to January 1, 2014, Settlement will be based on four months of runout from the end of the provider's fiscal year. Claims for services paid after the cost report runout period will not be settled.

a. Allowable cost shall be determined as provided in subsections §2.A and §2.B of page 1.1 of 15 and §2.C of page 2 of 15 of this section.

b. The following additional procedures shall be followed:

(1) The CMS-approved cost report determined reimbursable costs for physical therapy, occupational therapy, and speech-language pathology service cost centers. General service costs are stepped down to each service cost center (including any non-reimbursable service cost centers). The cost report shall calculate a ratio of cost to charges for each reimbursable service cost center. Cost finding shall be determined according to Medicare principles.

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§2.D.2. Rehabilitation agencies operated by state agencies for physical therapy, occupational therapy, and speech-language therapy services. The reimbursement methodology for physical therapy, occupational therapy, and speech-language therapy applicable to other rehabilitation agencies, is based on Attachment 4.19-B, Supplement 5.

a. Allowable cost shall be determined as provided in subsections §2.A and §2.B of page 1 of 15 and §2.C of page 2 of 15 of this section.

b. The following additional procedures shall be followed:

(1) The CMS-approved cost report determined reimbursable costs for physical therapy, occupational therapy, and speech-language pathology service cost centers. General service costs are stepped down to each service cost center (including any non-reimbursable service cost centers). The cost report shall calculate a ratio of cost to charges for each reimbursable service cost center. Cost finding shall be determined according to Medicare principles.

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Fee for Service Outpatient Hospitals (12VAC 30-80-36).

Enhanced Ambulatory Patient Group Methodology (EAPG).

A. Definitions: The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise:

"Enhanced Ambulatory Patient Group (EAPG)" means a defined group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Disease (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

"EAPG relative weight" means the expected average costs for each EAPG divided by the relative expected average costs for visits assigned to all EAPGs.

"Base year" means the state fiscal year for which data is used to establish the EAPG base rate. The base year will change when the EAPG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Cost" means the reported cost as defined in subsections §2.A and §2.B of page 1.1 of 15 and §2.C of page 2 of 15 of this section.

"Medicare wage index" is published annually in the Federal Register by the Centers for Medicare and Medicaid Services. The indices used in this section shall be those in effect in the base year.

"Cost-to-charge ratio" equals the hospital's total costs divided by the hospital's total charges. The 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.

B. Effective January 1, 2014, the prospective Enhanced Ambulatory Patient Group (EAPG) based payment system described as follows shall apply to reimbursement for outpatient hospital services with the exception of laboratory services referred to the hospital but not associated with an outpatient hospital visit, which will be reimbursed according to the laboratory fee schedule:

1. The payments for outpatient hospital visits shall be determined on the basis of a hospital-specific base rate per visit times the relative weights of the EAPGs (and the payment action) assigned for each of the services performed during a hospital visit.

2. The EAPG relative weights shall be the weights determined and published periodically by DMAS and shall be consistent with applicable Medicaid reimbursement limits and policies. The weights shall be updated at least every three years. Except as otherwise noted in the plan, the state-developed weights are the same for both governmental and private providers of outpatient hospital services. The agency's weights were set as of January 1, 2014 and are effective for services provided on or after that date. All rates are published at http://www.dmas.virginia.gov/Content pgs/pr-eapg.aspx.

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3. The statewide base rate shall be equal to the total costs described below divided by the wage-adjusted sum of the EAPG weights for each facility. The wage-adjusted sum of the EAPG weights shall equal the sum of the EAPG weights times the labor percentage times the hospital's Medicare wage index plus the sum of the EAPG weights times the nonlabor percentage. The base rate shall be determined for outpatient hospital services at least every three years so that total expenditures will equal the following:

a) When using base years prior to January 1, 2014, for all services, excluding all laboratory services and emergency services described in subdivision 3 c of this subsection, a percentage of costs defined in subsection A as reported in the available cost reports for the base period for each type of hospital as defined in Attachment 4.19-A, Methods and Standards for Establishing Payment Rates-Hospital Services, DRG-Payment Methodology (12VAC30-70-221).

i) Type One Hospitals: Effective January 1, 2014, hospital outpatient operating reimbursement shall be calculated at 90.2 percent of cost and capital reimbursement shall be at 86 percent of cost inflated to the rate year.

ii) Type Two Hospitals: Effective January 1, 2014, hospital outpatient operating and capital reimbursement shall be calculated at 76 percent of cost inflated to the rate year.

iii) When using base years after January 1, 2014, the percentages described in subdivision 3 of this subsection shall be adjusted according to subdivision 3 c.

b) Laboratory services (excluding laboratory services referred to the hospital but not associated with a hospital visit) calculated at the fee schedule in effect for the rate year.

c) Services rendered in emergency departments determined to be nonemergencies as prescribed in Attachment 4.19-B, section 2 D (12VAC30-80-20(D)(1)(b)) shall be calculated at the nonemergency reduced rate reported in the base year for base years prior to January 1, 2014. For base years after January 1, 2014, the cost percentages in subdivision 3(a) of this subsection shall be adjusted to reflect services paid at the non-emergency reduced rate in the last base year prior to January 1, 2014.

4. Inflation adjustment to base year costs. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with DMAS, shall be used to update the base year costs to the midpoint of the rate 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. 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. Inflation shall be applied to the costs identified in subdivision 3(a) of this subsection.

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5. Hospital-specific base rate. The hospital-specific base rate per case shall be adjusted for geographic variation. The hospital-specific base rate shall be equal to the labor portion of the statewide base rate times the hospital's Medicare wage index plus the nonlabor percentage of the statewide base rate. The labor percentage shall be determined at each rebasing based on the most recent reliable data. For rural hospitals, the hospital's Medicare wage index used to calculate the base rate shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher. A base rate differential of 5 percent shall be established for freestanding Type Two children's hospitals. The base rate for non cost-reporting hospitals shall be the average of the hospital-specific base rates of in-state Type Two hospitals.

6. The total payment shall represent the total allowable amount for a visit including ancillary services and capital.

7. The transition from cost-based reimbursement to EAPG reimbursement shall be transitioned over a three and half-year period. DMAS shall calculate a cost-based base rate at January 1, 2014, and at each rebasing during the transition.

a) Effective for dates of service on or after January 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 75 percent of the cost-based base rate and 25 percent of the EAPG base rate.

b) Effective for dates of service on or after July 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 50 percent of the cost-based base rate and 50 percent of the EAPG base rate.

c) Effective for dates of service on or after July 1, 2015, DMAS shall calculate the hospital-specific base rate as the sum of 25 percent of the cost-based base rate and 75 percent of the EAPG base rate.

d) Effective for dates of service on or after July 1, 2016, DMAS shall calculate the hospital-specific base rate as the EAPG base rate.

8. To maintain budget neutrality during the first six years, DMAS shall compare the total reimbursement of hospitals claims based on the parameters in subdivision 3 of this subsection to EAPG reimbursement every six months based on the six months of claims ending three months prior to the potential adjustment. If the percentage difference between the reimbursement target in subdivision 3 of this subsection and EAPG reimbursement is greater than 1 percent, plus or minus, DMAS shall adjust the statewide base rate by the percentage difference the following July 1 or January 1. The first possible adjustment would be January 1, 2015, using reimbursement between January 1, 2014, and October 31, 2014.

C. The Enhanced Ambulatory Patient Group (EAPG) grouper version used for outpatient hospital services shall be determined by DMAS. Providers or provider representatives shall be given notice prior to implementing a new grouper. Except as otherwise noted in the plan, the state-approved EAPG grouper version is the same for both governmental and private providers of outpatient hospital services. The EAPG grouper version was set as of January 1, 2014 and is effective for services provided on or after that date. The grouper version is published at http://www.dmas.virginia.gov/Content pgs/pr-eapg.aspx.

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D. The primary data sources used in the development of the EAPG payment methodology are the DMAS' hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals. The following table identifies key data elements that are used to develop the EAPG payment methodology. DMAS may supplement this data with similar data for Medicaid services furnished by managed care organizations if DMAS determines that it is reliable.

Data Elements for EAPG Payment Methodology	
Data Elements	Source
Total charges for each outpatient hospital visit	Claims history file
Number of groupable claims lines in each EAPG	Claims history file
Total number of groupable claim lines	Claims history file
Total charges for each outpatient hospital revenue line	Claims history file
Total number of EAPG assignments	Claims history file
Cost-to-charge ratio for each hospital	Cost report file
Medicare wage index for each hospital	Federal Register

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§7. Fee-for-service providers: pharmacy. (12VAC30-80-40)

Payment for pharmacy services (excluding outpatient hospital) shall be the lowest of subdivisions 1 through 6 of this section (except that subdivisions 1 and 2 of this section will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in the longstanding provisions formerly at 42 CFR 447.331(c) if the brand cost is greater than the Centers for Medicare and Medicaid Services (CMS) upper limit or VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 7 and 8 of this section:

1. The upper limit established by the CMS for multiple source drugs pursuant to the longstanding provisions formerly at 42 CFR 447.331 and 447.332, as determined by the CMS Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the CMS Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

2. The methodology used to reimburse for generic drug products shall be the higher of either (i) the lowest Wholesale Acquisition Cost (WAC) plus 10% or (ii) the second lowest WAC plus 6.0%. This methodology shall reimburse for products' costs based on a Maximum Allowable Cost (VMAC) list to be established by the single state agency.

A. In developing the maximum allowable reimbursement rate for generic pharmaceuticals, the department or its designated contractor shall:

(i) Identify three different suppliers, including manufacturers that are able to supply pharmaceutical products in sufficient quantities. The drugs considered must be listed as therapeutically and pharmaceutically equivalent in the Food and Drug Administration's most recent version of the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). Pharmaceutical products that are not available from three different suppliers, including manufacturers, shall not be subject to the VMAC list.

(ii) Identify that the use of a VMAC rate is lower than the Federal Upper Limit (FUL) for the drug. The FUL is a known, widely published price provided by CMS; and

(iii) Distribute the list of state VMAC rates to pharmacy providers in a timely manner prior to the implementation of VMAC rates and subsequent modifications. DMAS shall publish on its website, each month, the information used to set the Commonwealth's prospective VMAC rates, including, but not necessarily limited to:

(a) The identity of applicable reference products used to set the VMAC rates;

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10. Supplemental rebate agreement. The Commonwealth complies with the requirements in § 1927 of the *Social Security Act* and 42 CFR 447.500 et seq. with regard to supplemental drug rebates. In addition, the following requirements are met:

a. The model supplemental rebate agreement between the Commonwealth and pharmaceutical manufacturers for legend drugs provided to Medicaid recipients, entitled Virginia Supplemental Drug Rebate Agreement Contract and Addendum A, have been authorized by CMS on to be effective April 1, 2012. All amendments to the Supplemental Drug Rebate Agreement Contract shall also be authorized by CMS.

b. Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

c. Prior authorization requirements found in § 1927(d)(5) of the *Social Security Act* have been met.

d. Non-preferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Non-preferred drugs will be made available to Medicaid beneficiaries through prior authorization.

e. Payment of supplemental rebates may result in a product's inclusion on the PDL.

11. Each drug administered in an outpatient hospital setting and reimbursed based on the Enhanced Ambulatory Patient Group methodology as described in Attachment 4.19-B, section 2.5 Enhanced Ambulatory Patient Group (12 VAC 30-80-36) shall be reimbursed separately at a rate greater than zero to be eligible for drug rebate claiming.

End of Pharmacy Reimbursement Methodology