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State Name: Virginia

State Plan Amendment (SPA) #: 14-0021

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 MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

MAR 25 2015

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

RE: State Plan Amendment 14-0021

Dear Ms. Jones:

We have completed our review of State Plan Amendment (SPA) 14-0021. This SPA modifies Attachment 4.19-A of Virginia's Title XIX State Plan. Specifically, the SPA replaces the existing DRG classification system for inpatient hospital services with a more refined grouper that recognizes the differences in severity of illness – the 3M APR-DRG.

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 14-0021 effective October 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,

/S/

Timothy Hill
Director

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 — 0 2 81

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: October 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 2015 $ 0
b. FFY 2016 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-A, Pages 5, 7 ~~xxxxx~~ of 23

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*): Same pages

10. SUBJECT OF AMENDMENT: Inpatient Hospital APR-DRG

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2015
☐ 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: 12/11/2014

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: 12/29/2014

18. DATE APPROVED: MAR 25 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FMG

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

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. Effective October 1, 2014, "ungroupable cases" means cases assigned to DRG 955 (ungroupable) and DRG 956 (ungroupable) as determined by the APR-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Effective October 1, 2014, DMAS shall replace the AP-DRG grouper with the All Patient Refined Diagnosis Related Groups (APR-DRG) grouper for hospital inpatient reimbursement. The APR-DRG Grouper will produce a DRG as well as a severity level ranging from 1 to 4. DMAS shall phase in the APR-DRG weights by blending in 50 percent of the full APR-DRG weights with 50 percent of FY 2014 AP-DRG weights for each APR-DRG group and severity level in the first year. In the second year, the blend will be 75 percent of full APR-DRG weights and 25 percent of the FY 2014 AP-DRG weights. Full APR-DRG weights shall be used in the third year and succeeding years for each APR-DRG group and severity. DMAS shall notify hospitals when updating the system to later grouper versions.

E. 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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

12 VAC 30-70-230. Repealed.

12 VAC 30-70-231. Operating payment for DRG cases.

A. The operating payment for DRG cases that are not transfer cases shall be equal to the hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the DRG relative weight, as determined in 12 VAC 30-70-381.

B. Exceptions.

1. Special provisions for calculating the operating payment for transfer cases are provided in 12 VAC 30-70-251.

2. Readmissions shall be considered a continuation of the same stay and shall not be treated as a new case.

12 VAC 30-70-240. Repealed.

12 VAC 30-70-241. Operating payment for per diem cases.

A. The operating payment for acute care psychiatric cases and rehabilitation cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321, times the covered days for the case.

B. The payment for freestanding psychiatric cases shall be equal to the hospital specific rate per day for freestanding psychiatric cases, as determined in subsection B of 12 VAC 30-70-321, times the covered days for the case.

12 VAC 30-70-250. Repealed.

12 VAC 30-70-251. Operating payment for transfer cases.

A. The operating payment for transfer cases shall be determined as follows:

1. A transferring hospital shall receive the lesser of (i) a per diem payment equal to the hospital's DRG operating payment for the case, as determined in 12 VAC 30-70-231, divided by the arithmetic mean length of stay for the DRG into which the case falls times the length of stay for the case at the transferring hospital or (ii) the hospital's full DRG operating payment for the case, as determined in 12 VAC 30-70-231. The transferring hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

2. The final discharging hospital shall receive the hospital's full DRG operating payment, as determined in 12 VAC 30-70-231. The final discharging hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

B. Exceptions.

1. Cases falling into DRG 456, 639, or 640 shall not be treated as transfer cases. Effective October 1, 2014, cases falling into DRG 580 and 581 shall not be treated as transfer cases. Both the transferring hospital and the final discharging hospital shall receive the full DRG operating payment.