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State Name: Virginia

State Plan Amendment (SPA)#: 16-0007

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Seven (7) SPA Page

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

APR 25 2017

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

RE: State Plan Amendment 16-0007

Dear Ms. Jones:

We have completed our review of State Plan Amendment (SPA) 16-0007. This SPA modifies Attachments 4.19-A and 4.19D of Virginia's Title XIX State Plan. Specifically, the SPA reduces the inflation factor for inpatient hospital services from 2% to 1% for FY 2017 and makes specialized nursing care reimbursement fully prospective.

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 16-0007 effective July 1, 2016. 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/

Kristin Fan
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: 16 — 007

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

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

4. PROPOSED EFFECTIVE DATE: July 1, 2016

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 2016 $ (1,342,036)
b. FFY 2017 $ (5,368,143)
Pen & ink 1/26/17 EM

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Pen & ink 1/26/17 EM
Attachment 4.19-A, pages 3.1, 13, 15
Supplement 1 to Attachment 4.19-D, pages 54.1, 55, 56, ~~56.1~~, ~~56.2~~, 57

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: 2016 Institutional Provider 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

2016

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 9/16/16

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: APR 25 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Kristin Fan

22. TITLE: 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 costs shall be calculated by multiplying the per diems and ancillary cost-to-charge ratios from each hospital's cost report ending in the state fiscal year used as the base year to the corresponding days and ancillary charges by revenue code for each hospital's groupable cases.

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12 VAC 30-70-351. Updating rates for inflation.

A. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department shall be used to update the base year standardized operating costs per case, as determined in 4.19-A, page 13 (12VAC30-70-361), and the base year standardized operating costs per day, as determined in 4.19-A, page 14 (12VAC30-70-371), to the midpoint of the upcoming state fiscal 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. Thus, 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.

B. The inflation adjustment for hospital operating rates, disproportionate share hospitals (DSH) payments, and graduate medical education payments shall be eliminated for fiscal year (FY) 2010, with the exception of long stay hospitals.

C. In FY 2011, hospital operating rates shall be rebased; however the 2008 base year costs shall only be increased 2.58% for inflation. For FY 2011 there shall be no inflation adjustment for graduate medical education (GME) or freestanding psychiatric facility rates. The inflation adjustment shall be eliminated for hospital operating rates, GME payments, and freestanding psychiatric facility rates for FY 2012. The inflation adjustment shall be 2.6 percent for inpatient hospitals, including hospital operation rates, GME payments, DSH payments, and freestanding psychiatric facility rates for FY 2013 and 0.0 percent for the same facilities for FY 2014 and FY 2015. For FY 2017, the inflation adjustment shall be 50% of the adjustment calculated in Subsection A above with the exception of 100% inflation for the Children's Hospital of King's Daughters.

12 VAC 30-70-360. Repealed.

12 VAC 30-70-361. Base year standardized operating costs per case.
A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

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C. For general acute care hospitals with psychiatric DPUs, the psychiatric operating cost-to-charge ratio shall be used in the above calculations.

12 VAC 30-70-380. Repealed.

12 VAC 30-70-381. DRG relative weights and hospital case-mix indices.

A. For the purposes of calculating DRG relative weights and hospital case-mix indices, base year claims data for all groupable cases shall be used. Base year claims data for ungroupable cases and per diem cases shall not be used. In calculating the DRG relative weights, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in Subsection E of 4.19-A, page 5 (12 VAC 30-70-221), the following methodology shall be used to calculate the DRG relative weights:

1. The operating costs for each groupable case shall be calculated by multiplying the per diems and ancillary cost-to-charge ratios from each hospital's cost report ending in the state fiscal year used as the base year to the corresponding days and ancillary charges by revenue code for each hospital's groupable cases.

2. The standardized operating costs for each groupable case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of all operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding the standardized operating costs.

3. The average standardized cost per DRG shall be calculated by dividing the standardized operating costs for all groupable cases in the DRG by the number of groupable cases classified in the DRG.

4. The average standardized cost per case shall be calculated by dividing the standardized operating costs for all groupable cases by the total number of groupable cases.

5. The average standardized cost per DRG shall be divided by the average standardized cost per case to determine the DRG relative weight.

C. Statistical outliers shall be eliminated from the calculation of the DRG relative weights. Within each DRG, cases shall be eliminated if (i) their standardized costs per case are outside of the 3.0 standard deviations of the mean of the log distribution of the standardized costs per case and (ii) their standardized costs per day are outside of the 3.0 standard deviations of the mean of the log distribution of the standardized costs per day. To eliminate a case, both conditions must be satisfied.

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12 VAC 30-90-258. Reserved.
12 VAC 30-90-259. Reserved.

Subpart XVI
Revaluation of Assets

12 VAC 30-90-260. Repealed.
12 VAC 30-90-261 through 12 VAC 30-90-263. Reserved.

12VAC30-90-264. Specialized care services.

Specialized care services provided in conformance with Attachment 3.1-C, page 6 (12VAC30-60-40 E and H), Attachment 3.1-C, Supplement 1, page 16 (12VAC30-60-320) and Attachment 3.1-C, Supplement 1, page 17 (12VAC30-60-340) shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the category of Ventilator Dependent Care will be placed in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in Appendix 1 of the NHPS, page 2, section 2.1 (12VAC30-90-271) and Appendix 1 of the NHPS, page 4, section 3.1 (12VAC30-90-272). To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days. Effective July 1, 2016, the base year for routine operating cost shall be the most recently settled cost reports with a fiscal year ending in a calendar year for all specialized care facilities as of the end of the calendar year prior to the prospective rate year.

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article 5 of Part II of this chapter (Attachment 4.19-D, Supplement 1, page 26.8, 12VAC30-90-50 et seq.) and of Appendix III of Part II of this chapter (Nursing Home Payment System, Appendix III, page 2, 12VAC30-90-290) shall apply to specialized care cost and reimbursement.

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine

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operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 4.19-D, Supp 1, page 21 (12 VAC 30-90-41).

4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:

a. Statewide ceiling. The statewide routine operating ceiling shall be $415 as of July 1, 2002. This routine operating ceiling amount shall be adjusted for inflation based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). Effective July 1, 2016, the routine operating ceiling shall be $573.05 as of SFY 15 and shall be adjusted for inflation based on 4.19-D, Supp 1, page 26.2 (12 VAC 30-90-44) to the upcoming state fiscal year, the prospective rate year.

b. The portion of the statewide routing operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after January 1 for which the normalization is calculated. Effective July 1, 2016, the normalized wage index for the FFY following the base year shall be applied to the SFY ceiling.

5. Facility-specific prospective routing operating base cost per day: The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted for inflation based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). Effective July 1, 2016, the routine operating base cost per day in subdivision 1 shall be adjusted for inflation based on 4.19-D, Supp 1, page 26.2 (12 VAC 30-90-44) to the upcoming state fiscal year, the prospective rate year.

6. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report available at the time the interim rates must be set, except that failure to submit a cost report timely may result in adjustment to interim rates as provided elsewhere. Effective July 1, 2016, this section is no longer applicable.

7. Ancillary costs. Specialized ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:

a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. Effective for specialized care days on or after January 15, 2007, reimbursement for reasonable costs shall be subject to a ceiling. The ceiling shall be $238.81 per day for calendar year 2004 (150% of average costs) and shall be inflated to the appropriate provider fiscal year. For cost reports beginning in each calendar year, ancillary ceilings will be inflated based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). See NHPS, Appendix III, Page 2 (12 VAC 30-90-290) for the cost reimbursement limitations. Effective July 1, 2016, the ancillary ceiling of $300.88 in SFY15, inclusive of kinetic therapy devices, shall be adjusted for inflation to the prospective rate year based on 4.19-D, Supp 1, page 26.2 (12 VAC 30-90-44).

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b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See NHPS, Appendix III, Page 2 (12 VAC 30-90-290) for the cost reimbursement limitations.

c. Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet the following wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that cannot be closed, or second to third degree burns covering more than 10% of the body.

8. Covered ancillary services are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services, psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care nursing facility cost reporting period.

9. Capital costs. Effective July 1, 2016, capital cost reimbursement rates shall be based on subsection C of 12 VAC 30-90-44 in accordance with 4.19-D. Supp 1, p 14-19 (12 VAC 30-90-35 through 12 VAC 30-90-37) inclusive, except that the required occupancy percentage shall not be separately applied to specialized care. To determine the capital cost related to specialized care patients, the following calculation shall be applied:

a. Licensed beds, including specialized care beds, multiplied by days in the cost reporting period, shall equal available days.

b. The required occupancy days shall equal the required occupancy percentage multiplied by available days.

c. The required occupancy days minus actual resident days, including specialized care days, shall equal the shortfall of days. If the shortfall of days is negative, the shortfall of days shall be zero.

d. Actual resident days, not including specialized care days, plus the shortfall of days shall equal the minimum number of days to be used to calculate the capital cost per day.

10. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs. NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS. Effective July 1, 2016, NATCEP costs shall be paid on a prospective basis in accordance with 4.19-D, Supp 1, page 45 (12 VAC 30-90-170).

11. Pediatric routine operating cost rate. For pediatric specialized care in a distinct part pediatric specialized care unit, one routine operating cost ceiling will be developed. The routine operating cost ceiling will be $418 as of July 1, 2002. Effective July 1, 2016, the pediatric routine operating cost ceiling shall be $577.24 as of SFY 15.

a. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivision 4 of this section.

b. The final routine operating cost reimbursement rate shall be computed as described for other than pediatric units in subdivision 3 of this section.

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12. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with subdivision 9 of this section, except that the occupancy requirement shall be 70% rather than the required occupancy percentage.

13. The cost reporting requirements of 4.19-D, Supp 1, page 35 (12 VAC 30-90-70) and 4.19-D, Supp 1, page 37 (12 VAC 30-90-80) shall apply to specialized care providers.

12 VAC 30-90-265. Reserved.
12 VAC 30-90-266. Traumatic Brain Injury (TBI) payment.

DMAS shall provide a fixed per day payment for nursing facility residents with TBI served in the program in accordance with resident and provider criteria, in addition to the reimbursement otherwise payable under the provisions of the Nursing Home Payment System. Effective for dates of service on and after August 19, 1988, a per day rate add-on shall be paid for recipients who meet the eligibility criteria for these TBI payments and who are residents in a designated nursing facility TBI unit of 20 beds or more that meets the provider eligibility criteria. The rate add-on for any qualifying provider's fiscal year shall be reviewed annually to determine the appropriateness of the amount, not to exceed $50 per patient day, and any changes will be published and distributed to the providers. (Refer to NHPS, Appendix VII, page 1 (12 VAC 30-90-330), Traumatic brain injury diagnoses, for related resident and provider requirements.)

12 VAC 30-90-267. Private room differential.

A. Payment shall be made for a private room or other accomodations more expensive than semi-private (two or more bed accomodations) only when such accomodations are medically necessary. Private rooms will be considered necessary when the resident's condition requires him/her to be isolated for his/her own health or that of others.

B. Physician certification justifying the private room must be on file prior to the resident's discharge from the semi-private room. The term "isolation" applies when treating a number of physical and mental conditions. These include communicable diseases which require isolation for the resident for certain periods. Private room accomodations may also be necessary for residents whose symptoms or treatments are likely to alarm or disturb others in the same room.

C. Reimbursement for private rooms will only be made when authorized by the Virginia Department of Medical Assistance Services (DMAS).

D. The Medicaid private room differential shall be calculated by applying the percent difference between the facility's private and semi-private room charges to the total case mix neutral Medicaid rate for this facility.

12 VAC 30-90-268 through 12 VAC 30-60-269. Reserved.