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State Name: Virginia

State Plan Amendment (SPA) #: 16-008

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

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

SWIFT #093020164024

May 9, 2017

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) 16-008, 2016 Non-Institutional Provider Reimbursement. This SPA proposes that in addition to payments for physician services specified elsewhere in the State Plan, the Department of Medical Assistance Services will make supplemental payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 with more than 50 percent Medicaid inpatient utilization in fiscal year 2014. This applies to physician practices affiliated with Children's National Health System. The supplemental payment amount for qualifying physician services shall be the difference between the Medicaid payments otherwise made and 178% of Medicare rates but no more than $551,000 for all qualifying physicians. The inflation adjustment for the state fiscal year 2017 shall be 50% of the full inflation adjustment with the exception of 100% of inflation to the Children's Hospital of the King's Daughters.

This SPA is acceptable. Therefore, we are approving SPA 16-008 with an effective date of July 1, 2016. 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: 16-008

2. STATE: Virginia

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

C. 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 $ 266,634
b. FFY 2017 $ 1,066,536

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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, pages 4.8, 6.2, 7.1, 7.2.3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: 2016 Non-Institutional Provider Reimbursement

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2016
☐ 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/ [redacted]

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 9/19/16

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: September 30, 2016

18. DATE APPROVED: May 9, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Francis McCullough

22. TITLE: Associate Regional Administrator

23. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

1. Supplemental Payments for FQHCs/RHCs selecting the PPS methodology. FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the FQHC/RHC receives from MCEs and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of each FQHCs/RHCs fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHCs/RHCs contract with MCE would have yielded under the PPS. If the PPS amount exceeds the total amount of supplemental and MCE payments, the FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC/RHC. If the PPS amount is less than the total amount of supplemental and MCE payments, the FQHC/RHC will refund to DMAS the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC.

D. These providers shall be subject to the same cost reporting submission requirements as specified in Attachment 4.19-B, page 1.1 (12VAC30-80-20) for cost-based reimbursed providers.

§6. Fee-for-service providers. (12 VAC 30-80-30).

A. Payment for the following services, except for physician services, shall be the lower of the State agency fee schedule (Supplement 4 has information about the State agency fee schedule except as specified below) or actual charge (charge to the general public). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private individual practitioners. Fee schedules and any annual/periodic adjustments to the fee schedule are published on the DMAS website at the following web address: http://www.dmas.virginia.gov

1. Physicians' services. Payment for physician services shall be the lower of the State agency fee schedule or actual charge (charge to the general public).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

§6 A Fee for service providers. Durable Medical Equipment (continued)

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, and suction machines. Ventilators, non-continuous ventilators, and suction machines may be purchase based on the individual patient's medical necessity and length of need.

3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

§7 Local health services, including services paid to local school districts
§8 Laboratory services (other than inpatient hospital) The agency's rates for clinical laboratory services were set as of July 1, 2014, and are effective for services on or after that date).
§9 Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)
§10 X-ray services.
§11 Optometry services
§12 Reserved.
§13 Home health services: Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate visit by discipline shall be established as set forth by Supplement 3. (12 VAC 30-80-180)
§14 Physical therapy, occupational therapy, and speech, hearing, language disorders services when rendered to non-institutionalized recipients. Physical therapy, occupational therapy, and speech-language therapy services furnished by state rehabilitation agencies are paid on a cost basis (see sec. 2D, page 4.1). All other services under this section furnished by rehabilitation agencies are paid rates established by Supplement 5.
§15 Clinic services, as defined under 42 CFR 440.90, except for services in ambulatory surgery clinics reimbursed under Attachment 4.19-B, page 7.2 (12 VAC 30-80-35).
§16 Supplemental payments to state government-owned or operated clinics. (*Repealed effective July 1, 2005*).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

18.1 Supplemental payments for services provided by physicians at freestanding children's hospitals serving children in planning district 8.

a. In addition to payments for physician services specified elsewhere in the State Plan, DMAS shall make supplemental payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 with more than 50 percent Medicaid inpatient utilization in fiscal year 2014 This applies to physician practices affiliated with Children's National Health System.

b. The supplemental payment amount for qualifying physician services shall be the difference between the Medicaid payments otherwise made and 178% of Medicare rates but no more than $551,000 for all qualifying physicians. The methodology for determining allowable percent of Medicare rates is based on the Medicare equivalent of the average commercial rate described in Supplement 6.

c. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter. Any quarterly payment that would have been due prior to the approval date shall be made no later than 90 days after the approval date.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

a. The inflation adjustment for state fiscal year 2017 shall be 50% of the full inflation adjustment calculated according to this section with the exception of 100% of inflation to the Children's Hospital of King's Daughters.

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 instate 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.