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State Name: Virginia

State Plan Amendment (SPA)#: 17-0006

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Eight (8) SPA Pages

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

DEC 13 2017

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

RE: State Plan Amendment 17-0006

Dear Ms. Jones:

We have completed our review of State Plan Amendment (SPA) 17-0006. This SPA modifies Attachments 4.19-A and Supplement 1 to Attachment 4.19-D of Virginia's Title XIX State Plan. Specifically, the SPA modifies the reimbursement for costs associated with interns & residents, and adds supplemental payments to maintain residency slots at facilities providing medical education.

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 17-0006 effective July 1, 2017. 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: 17-006

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, 2017

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 2017 $ 2,163,208
b. FFY 2018 $ 48,652,830

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-A, pages 9.1.1, 9.1.2, 10, 10.2, 13, 17, 17.1 & Sup. 1, Attach. 4.19-D, pages 26.4 and 26.5

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: 2017 Institutional Reimbursement Changes

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: 8/31/17

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: DEC 13 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMCO

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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ending in state fiscal year 1998 or as may be re-based in the future and provided to the public in an agency guidance document. The per-resident amount for new qualifying facilities shall be calculated from the most recently settled cost report. This per-resident amount shall be calculated by dividing a hospital's Medicaid allowable direct GME costs for the base period by its number of interns and residents in the base period yielding the base amount.

E. The base amount shall be updated annually be the DRI-Virginia moving average values as compiled and published by DRI·WEFA, Inc. (12 VAC30-70-351). The updated per-resident amount will then be multiplied by the weighted number of full time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTE's reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

F. Type One hospitals shall be reimbursed 100 percent of Medicaid allowable FFS and MCO GME costs for interns and residents.

1. Type One hospitals shall submit annually separate FFS and MCO GME cost schedules, approved by the agency, using GME per diems and GME RCCs (ratios of cost to charges) from the Medicare and Medicaid cost reports and FFS and MCO days and charges. Type One hospitals shall provide information on managed care days and charges in a format similar to FFS.

2. Interim lump sum GME payment for interns and residents shall be made quarterly based on the total cost from the most recently audited cost report divided by four and will be final settled in the audited cost report for the fiscal year end in which the payments are made.

G. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

H. Effective July 1, 2017, DMAS shall make supplemental payments to the following hospitals for the specified number of primary care residencies: Sentara Norfolk General (2 residencies), Carilion Medical Center (6 residencies), Centra Lynchburg General Hospital (1 residency), Riverside Regional Medical Center (2 residencies), Bon Secours St Francis Medical Center (2 residencies). The Department shall make supplemental payments to Carilion Medical Center for two psychiatric residencies. The supplemental payment for each residency shall be $100,000 annually minues any Medicare residency payment for which the hospital is eligible. Supplemental payments shall be made for up to four years for each new qualifying resident. A hospital will be eligible for the supplemental payments as long as the hospital maintains the number of residency slots in total and by category. Payments shall be made quarterly following the same schedule for other medical education payments Subsequent to the new award of a supplemental payment, the hospital must provide documentation annually by August 1, 2017 that it continues to meet the criteria for the supplemental payment(s) and must report any changes during the year to the number of residents

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12 VAC 30-70-290. Repealed.

12 VAC 30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education. Out-of-state cost reporting hospitals are eligible for this payment only if they have Virginia Medicaid utilization in the base year of at least 12 percent of total Medicaid days. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

1. Type One hospitals (this formula also applied to Children's Hospital of the King's Daughters (CHKD) effective July 1, 2013) shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

   IME Percentage for Type One Hospitals = [1.89 X ((1 + r)$^{0.405}$-1)] X (IME Factor)

   An IME factor shall be calculated for each Type One hospital and shall equal a factor that, when used in the calculation of the IME percentage, shall cause the resulting IME payments to equal what the IME payments would be with an IME factor of one, plus an amount equal to the difference between operating payments using the adjustment factor specified in subdivision B 1 of 12VAC30-70-331 and operating payments using an adjustment factor of one in place of the adjustment factor specified in subdivision B 1 of 12 VAC 30-70-331.

2. Type Two hospitals (excluding CHKD) shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

   IME Percentage for Type Two Hospitals = [1.89 X ((1 + r)0.405-1)] X 0.5695

   In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

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C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

1. For Type Two hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

2. For Type One hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section. Effective April 1, 2012, the operating rate per case used in the formula shall be revised to reflect an adjustment factor of one and case mix adjusted by multiplying the operating rate per case in this subsection by the weight per case for FFS discharges that is determined during rebasing. This formula applied to CHKD effective July 1, 2017.

D. An additional IME payment not to exceed $200,000 in total shall be apportioned among Type Two Hospitals excluding freestanding children's hospitals with Medicaid NICU utilization in excess of 50 percent as reported to the Department of Medical Assistance Services as of March 1, 2004. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

E. An additional IME not to exceed $500,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU days in excess of 4, 500 as reported to the Department of Medical Assistance Services as of March 1, 2005, that do not otherwise receive an additional IME payment under subsection D of this section. These payments shall be total of these days among eligible hospitals as reported by March 1, 2003.

F. Effective July 1, 2013, total payments of IME in combination with other payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 may not exceed the federal uncompensated care cost limit that disproportionate share hospital payments are subject to. Effective July 1, 2017, IME payments cannot exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject, excluding third party reimbursement for Medicaid eligible patients.

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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 (P.L. 111-148) 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 (P.L. 111-148), adjusted for the state fiscal year. Effective July 1, 2017, the annual DSH payment shall be calculated separately for each eligible hospital by multiplying each year's state inpatient psychiatric hospital DSH allocation described above by the ratio of each hospital's uncompensated care cost for the most recent DSH audited year completed prior to the DSH payment year to the uncompensated care cost of all state inpatient hospitals for the same audited 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 (P.L. 111-148) 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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2. Starting July 1, 1996, operating ceilings will be increased for inflation to the midpoint of the state fiscal year, not the hospital fiscal year. Inflation shall be based on the DRI-Virginia moving average value as compiled and published by DRI/McGraw-Hill under contract with DMAS, increased by two percentage points per year. The most current table available prior to the effective date of the new rates shall be used.

For services to be paid at SFY 1998 rates, per diem rates shall be adjusted consistent with the methodology for updating rates under the DRG methodology 12 VAC 30-70-351.

3. There will be no disproportionate share hospital (DSH) per diem.

4. To pay capital cost through claims, a hospital specific adjustment to the per diem rate will be made. At settlement of each hospital fiscal year, this per diem adjustment will be eliminated and capital shall be paid as a pass-through.

5. This methodology shall be used after the transition period to reimburse days of hospital stays with admission dates before July 1, 1996.

6. This methodology shall be used after the transition period to make interim payments until such time as the DRG payment methodology is operational.

12 VAC 30-70-410. State university teaching hospitals.

For hospitals that were state owned teaching hospitals on January 1, 1996, all the calculations which support the determination of hospital specific rate per case and rate per day amounts under the prospective payment methodology shall be carried out separately from other hospitals, using cost data taken only from state university teaching hospitals. Rates to be used shall be determined on the basis of cost report and other applicable data from the most recent year for which reliable data are available at the time of re-basing.

12 VAC 30-70-411. Supplemental payments for certain teaching hospitals.

Effective for dates of service on or after July 1, 2017, quarterly supplemental payments will be issued to qualifying private hospitals for inpatient services rendered during the quarter.

A. Qualifying Criteria. The primary teaching hospitals affiliated with an LCME accredited medical school located in Planning District 23 that is a political subdivision of the Commonwealth and an LCME accredited medical school located in Planning District 5 that has a partnership with a public university.

B. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter equal to the difference between the hospital's Medicaid payments and the hospital's disproportionate share limit (OBRA 93 DSH limit) for the most recent year for which the disproportionate share limit has been calculated divided by four. The supplemental payment amount will be determined prior to the beginning of the fiscal year.

C. Limit. Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit per state fiscal year.

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12 VAC 30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.

A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12 VAC 30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio of total capital cost to total charges of the hospital, using data available from Medicare cost report.

E. Effective July 1, 2014, services provided under arrangement, as defined in 12 VAC 30-50-130(B)(6)(a) and (b), shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in Attachment 4.19-B (12 VAC 30-80), to a provider of services under arrangement if all of the following are met:

1. The services are included in the active treatment plan of care developed and signed as described in section 12 VAC 30-60-25(C)(4) and

2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.

12 VAC 30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.

A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all service provided under arrangement that are reimbursed in the manner described in subsection D of this section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the program shall take action in accordance with its policies to assure that an overpayment is not being made.

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The following definitions shall apply to indirect peer groups. The indirect peer group for Northern Virginia is the same as the direct peer group for Northern Virginia. Rest of State peer groups shall be defined as any localities other than localities in the Northern Virginia peer group for nursing facilities with greater than 60 beds or 60 beds or less. Rest of State greater than 60 beds shall be further subdivided into Other MSA, Northern Rural and Southern Rural peer groups using the locality definitions for direct peer groups.

Direct Peer Groups
- Northern Virginia
- Other MSAs
- Northern Rural
- Southern Rural

Indirect Peer Groups
- Northern Virginia MSA
- Rest of State – Greater than 60 Beds
  - -Other MSAs
  - -Northern Rural
  - -Southern Rural
- Rest of State – 60 Beds or Less

Any changes to peer group assignment based on changes in bed size or MSA will be implemented for reimbursement purposes for July 1 following the effective date of the change. For re-basings effective July 1, 2020 or later, the Department shall move nursing facilities located in the former Danville Metropolitan Statistical Area (MSA) to the Other MSA peer group.

f. The direct and indirect price for each peer group shall be based on the following adjustment factors:

1) Direct adjustment factor – 105.00 percent of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities. Effective July 1, 2017, the direct adjustment factor shall be 106.8 percent of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities.

2) Indirect adjustment factor – 100.735 percent of the peer group day-weighted median inflated cost per day for freestanding nursing facilities. Effective July 1, 2017, the indirect adjustment factor shall be 101.3 percent of the peer group day-weighted median inflated cost per day for freestanding nursing facilities.

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g. Facilities with costs projected to the rate year below 95 percent of the price shall have an adjusted price equal to the price minus the difference between the facility's cost and 95 percent of the unadjusted price. Adjusted prices will be established at each rebasing. New facilities after the base year shall not have an adjusted price until the next rebasing.

h. Special Circumstances

1) Effective July, 2017, DMAS shall increase the direct and indirect operating rates under the nursing facility price based reimbursement methodology by 15 percent for nursing facilities where at least 80 percent of the resident population has one or more of the following diagnoses: quadriplegia, traumatic brain injury, multiple sclerosis, paraplegia, or cerebral palsy. In addition, a qualifying facility must have at least 90 percent Medicaid utilization and a case mix index of 1.15 or higher in fiscal year 2014.
2) Effective July 1, 2017 through June 30, 2020, nursing facilities located in the former Danville MSA shall be paid the operating rates calculated for the Other MSA peer group.

i. Individual claim payment for direct costs shall be based on each resident's Resource Utilization Group (RUG) during the service period times the facility direct price.

j. Resource Utilization Group (RUG) is a resident classification system that groups nursing facility residents according to resource utilization and assigns weights related to the resource utilization for each classification The department shall use RUGs to determine facility case mix for cost neutralization as defined in the Nursing Horne Payment System, Supp. 1, Appendix IV, page 3 (12 VAC 30-90-306-) in determining the direct costs used in setting the price and for adjusting the claim payments for residents.

1) The department shall neutralize direct costs per day in the base year using the most current RUG group applicable to thebase year.
2) The department shall utilize RUG-III, version 34 groups and weights in fiscal years 2015-17 for claim payments.
3) Beginning in fiscal year 2018, the department shall implement RUG-IV, version 48 Medicaid groups and weights for claim payments.
4) RUG-IV, version 48 weights used for claim payments will be normalized to RUG-III, version 34 weights as long as base year costs are neutralized by the RUG-III 34 group. In that the weights are not he same under RUG-IV as under RUG-III, normalization will insure that total direct operating payments using the RUGS IV 48 weights will be the same as total direct operating payments using the RUGs-III 34 grouper.