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State Name: Virginia

State Plan Amendment (SPA)#: 18-0009

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 Pages

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

NOV 13 2018

Dr. Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond, VA 23219

RE: State Plan Amendment 18-0009

Dear Dr. Lee:

We have completed our review of State Plan Amendment (SPA) 18-0009. This SPA modifies Attachments 4.19-A and Attachment 4.19-D of Virginia's Title XIX State Plan. Specifically, the SPA continues supplemental payments to maintain residency slots at select facilities providing medical education, removes DSH eligibility for the out-of-state Children's National Medical Center and replaces the funding with an additional IME reimbursement, and continues supplemental payments to NSGO hospitals and state-owned Nursing Facilities with amended qualification criteria and payment methodology.

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 18-0009 effective July 1, 2018. 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

cc: Karen Cameron
Elisabeth Jones
William Lessard
Emily McClellan
Sarah Samick

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: 18-009

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, 2018

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 2018 $ 288,670.00
b. FFY 2019 $ 1,154,679.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Pages 9.1.1 - 9.1.1a,* 10, 10.1-10.2, 17.2.2,* & Attachment 4.19-D, Page 26.7.1.*

* next page

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ~~Same pages~~ Attachment 4-19-A, pages 9.1.1, 10, ~~10.1, 10.2~~ 10.1, and 10.2

10. SUBJECT OF AMENDMENT: 2018 Institutional Provider Reimbursement Changes

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2018
☐ 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: Jennifer S. Lee, M.D.

14. TITLE: Director

15. DATE SUBMITTED: 8/30/18

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: NOV 13 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2018

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

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 CME 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), Central Lynchburg General Hospital (I 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.

Effective July 1, 2018, the DMAS shall make supplemental payments to the following sponsoring institutions for the specified number of primary care residencies: Sentara Norfolk General (one residency), Maryview Hospital (one residency), and Carilion Medical Center (six residencies). The department shall make supplemental payments to Carilion Medical Center for two psychiatry residencies and to Sentara Norfolk General for one OB/GYN residency, two psychiatric residencies, and one urology residency.

The supplemental payment for each residency shall be $100,000 annually minus any Medicare residency payment for which the sponsoring institution is eligible.

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Supplemental payments shall be made for up to four years for each new qualifying resident. A sponsoring institution will be eligible for the supplemental payments as long as it 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 sponsoring institution must provide documentation annually by June 1st that it continues to meet the criteria for the supplemental payments and must report any changes during the year to the number of residents.

The department shall require all sponsoring institutions receiving medical education funding to report annually by September 15th on the number of residents in total and by specialty/subspecialty. Medical education funding includes payments for graduate medical education (GME) and indirect medical education (IME).

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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 of4, 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, IMB 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.

G. Effective July 1, 2018, an additional $362,360 IME payment shall be added to the IME payment calculated in Section B.2 for the Children's National Medical Center.

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12 VAC 30-70-300. Repealed

12 VAC 30-70-301. Payment to disproportionate share hospitals.

A. Definitions. The following words and terms shall have the following meanings unless the context clearly indicates otherwise:

"Uncompensated care costs" or "UCC" means unreimbursed costs incurred by hospitals from serving self-pay, charity, or Medicaid patients without regard to the disproportionate share adjustment payments.

B. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis and shall be final subject to provisions in subsections E, G, and H.

C. Effective July 1, 2014, in order to qualify for DSH payments, DSH eligible hospitals shall have a total Medicaid inpatient utilization rate equal to 14 percent or higher in the base year using Medicaid days eligible for Medicare DSH defined in 42 USC § 1396r-4(b)(2) or a low income utilization rate defined in 42 USC § 1396r-4(b)(3) in excess of 25 percent. Eligibility for out-of-state cost reporting hospitals shall be based on total Medicaid utilization or on total Medicaid neonatal intensive care unit (NICU) utilization equal to 14 percent or higher. Effective July 1, 2018, Children's National Medical Center (CNMC) shall not be eligible for DSH payments.

D. Effective July 1, 2014, the DSH reimbursement methodology for all hospitals except Type One hospitals shall be the following:

1. Each hospital's DSH payment shall be equal to the DSH per diem multiplied by each hospital's eligible DSH days in a base year. Days reported in provider fiscal years in state FY 2011 (available from the Medicaid cost report through the Hospital Cost Report Information System (HCRIS) as of July 30, 2013) will be the base year for FY 2015 prospective DSH payments. DSH shall be recalculated annually with an updated base year. Future base year data shall be extracted from Medicare cost report summary statistics available through HCRIS as of October 1 prior to next year's effective date.
2. Eligible DSH days are the sum of all Medicaid inpatient acute, psychiatric and rehabilitation days above 14 percent for each DSH hospital subject to special rules for out-of-state cost reporting hospitals. Eligible DSH days for out-of-state cost reporting hospitals shall be the higher of the number of eligible days based on the calculation in the first sentence times Virginia Medicaid utilization (Virginia Medicaid days as a percent of total Medicaid days) or the Medicaid NICU days above 14 percent times Virginia NICU Medicaid utilization (Virginia NICU Medicaid days as a percent of total NICU Medicaid days). Eligible DSH days for out-of-state cost reporting hospitals who qualify for DSH but that have less than 12 percent Virginia Medicaid utilization shall be 50 percent of the days that would have otherwise been eligible DSH days.

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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. Effective July 1, 2018, the Type Two hospital DSH allocation shall be reduced by the amount of DSH allocated to the Children's National Medical Center in state FY 2018.
   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 DSII 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. 11 1-148) 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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12 VAC 30-70-425. Supplemental Payments for Non-State Government-Owned Hospitals for Inpatient Services.

A. In addition to payments made elsewhere, effective July 1, 2005, DMAS shall draw down federal funds to cover unreimbursed Medicaid costs for inpatient services provided by non-state government-owned hospitals as certified by the provider through cost reports.

B. A non-state government-owned hospital is owned or operated by a unit of government other than a state.

C. Effective July 1, 2018, additional supplemental payments will be issued to each non-state government owned acute care hospital for inpatient services provided to Medicaid patients.

1. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital clam payments times the Upper Payment Limit (UPL) gap percentage.

a. The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each non-state government owned acute care hospitals between a reasonable estimate of the amount that would be paid under Medicare payment principles for inpatient hospital services provided to Medicaid patients (calculated in accordance with 42 CFR § 447.272) and what Medicaid paid for such services and the denominator is Medicaid claim payments to each hospital for inpatient hospital services provided to Medicaid patients in the same years used in the numerator.

b. The UPL gap percentage will be calculated annually for each hospital using data for the most recent year for which comprehensive annual data are available and inflated to the state fiscal year for which payments are to be made.

c. Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit. If inpatient payments for non-state government owned state nursing facilities would exceed the upper payment limit, the numerator in the calculation of the UPL gap percentage shall be reduced proportionately.

2. Quarterly Payments. After the close of each quarter, beginning with the July 1, 2018, to September 30, 2018 quarter, each qualifying hospital shall receive supplemental payments for the inpatient services paid during the prior quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated by multiplying the Medicaid inpatient hospital payments paid in that quarter by the annual UPL gap percentage for each hospital.

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12 VAC 30-90-45. Supplemental payments for state-owned nursing facilities.

A. Effective July 1, 2018, DMAS shall make supplemental payments to state-owned nursing facilities owned or operated by a Type One hospital. Quarterly supplemental payments for each facility shall be calculated in the following manner:

B. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital claim payments times the Upper Payment Limit (UPL) gap percentage.

1. The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each nursing facility between a reasonable estimate of the amount that would be paid under Medicare payment principles for nursing facility services provided to Medicaid patients calculated in accordance with 42 CFR 447.272 and what Medicaid paid for such services and the denominator is Medicaid payments to each nursing facility for nursing facility services provided to Medicaid patients in the same year used in the numerator.

2. The UPL gap percentage will be calculated annually for each nursing facility using data for the most recent year for which comprehensive annual data are available and inflated to the state fiscal year for which payments are to be made.

3. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available UPL. If nursing facility payments for state nursing facilities would exceed the UPL, the numerator in the calculation of the UPL gap percentage shall be reduced proportionately.

C. Quarterly Payments. After the close of each quarter, beginning with the July 1, 2018 to September 30, 2018 quarter, each qualifying nursing facility shall receive supplemental payments for the nursing facility services paid during the prior quarter. The supplemental payments for each qualifying nursing facility shall be calculated by multiplying Medicaid nursing facility payments paid in that quarter by the annual UPL gap percentage.
