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State Name: Virginia

State Plan Amendment (SPA)#: 18-0014

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Four (4) 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

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

September 20, 2018

RE: State Plan Amendment 18-0014

Dear Ms. Jones:

We have completed our review of State Plan Amendment (SPA) 18-0014. This SPA modifies Attachment 4.19-A of Virginia's Title XIX State Plan. Specifically, the SPA authorizes supplemental payments to private inpatient hospitals and sunsets other supplemental payments.

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 18-0014 effective October 1, 2018. We are enclosing the CMS-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: Brian McCormick
William Lessard
Emily McClellan
Sarah Samick

bcc: Francis McCullough, ARA, RO3
Teia Miller, Manager, FMB RO3
Sabrina Tillman-Boyd, Manager, POB RO3
Peggi Kosherzenko, VA State Lead
Lisa Carroll, CO NIRT
Official NIRT File

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: 18-014

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: October 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 2019 $ 182,532,907
b. FFY 2020 $ 333,346,647

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 4.19-A: revised page 17 and 17.4; new pages 17.5 and 17.6

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: FFS Supplemental Payments - Inpatient Services

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2019
☐ 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: 7/23/18

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: SEP 20 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 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

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT SERVICES

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.

12VAC 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 rebasing.

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. These supplemental payments will cease effective for dates of service on or after October 1, 2018

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. In SFY19, the upper payment limit shall be prorated for the time period these supplemental payments are in effect.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

12 VAC 30-70-428. Supplemental Payments for Private Hospital Partners of Type One Hospitals.

Quarterly supplemental payments will be issued to qualifying private hospitals for inpatient services rendered during the quarter. These supplemental payments will cease effective for dates of service on or after October 1, 2018.

A. Qualifying criteria. In order to qualify for the supplemental payment, the hospital must be currently enrolled as a Virginia Medicaid provider, and must be owned or operated by a private entity where a Type One hospital has a non-majority interest. Qualifying hospitals and their effective dates are listed below:

1. Culpeper Hospital, effective October 25, 2011
2. Prince William Hospital, effective February 11, 2017
3. Haymarket Hospital, effective February 11, 2017

B. Reimbursement methodology. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than 2 years after the year in which the qualifying hospitals' entitlement arises. The annual supplemental payments in any fiscal year will be the lesser of:

1. The difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the fiscal year; or

2. $14,620 per Medicaid discharge at Culpeper Hospital for state plan rate year 2012, $9,741 per Medicaid discharge for state plan rate year 2015 for Prince William Hospital and $8,596 per Medicaid discharge for state plan rate year 2015 for Haymarket Hospital. For future state plan rate years, this number shall be adjusted by inflation based on the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department).

3. For hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the limit calculated under the Social Security Act § 1923(g) and the hospital's DSH payments for the applicable payment period.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

12 VAC 30-70-429. Supplemental Payments for Private Acute Care Hospitals.

A. Effective October 1, 2018, supplemental payments will be issued to qualifying hospitals for inpatient services provided to Medicaid patients.

B. Definitions. As used in this section:
"Acute care hospital" means any hospital that provides emergency medical services on a 24-hour basis.

"Children's hospital" means a hospital (i) whose inpatients are predominantly under 18 years of age and (ii) which is excluded from the Medicare prospective payment system pursuant to the Social Security Act.

"Critical access hospital" means a facility that meets the requirements of the State Medicare Rural Hospital Flexibility Program (Flex), 42 U.S.C. 1395i-4, for such designation.

"Freestanding psychiatric and rehabilitation hospital" means a freestanding psychiatric hospital, which means a hospital that provides services consistent with 42 CFR 482.60, or a freestanding rehabilitation hospital, which means a hospital that provides services consistent with 42 CFR 482.56.

"Hospital" means a medical care facility licensed as an inpatient hospital or outpatient surgical center by the Department of Health or as a psychiatric hospital by the Department of Behavioral Health and Developmental Services.

"Long stay hospital" means specialty facilities that serve individuals receiving medical assistance who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide.

"Long-term acute care hospital" or "LTACH" means an inpatient hospital that provides care for patients who require a length of stay greater than 25 days and is, or proposes to be, certified by CMS as a long-term care inpatient hospital pursuant to 42 CFR Part 412. A LTACH may be either a freestanding facility or located within an existing or host hospital.

"Public hospital" means a hospital that is solely owned by a government or governmental entity.

"Supplemental payment" means an increased payment to a qualifying hospital up to the upper payment limit gap from the Health Care Provider Rate Assessment Fund as authorized in the 2018 Appropriation Act.

"Upper payment limit" means the limit on payment for inpatient services for recipients of medical assistance established in accordance with 42 CFR 447.272 and on payment for outpatient services for recipients of medical assistance pursuant to 42 CFR 447.321 for private hospitals.

"Upper payment limit gap" means the difference between the amount of the private acute care hospital upper payment limits estimated for the rate year using the last available cost report data and the amount estimated would otherwise be paid for the same rate year pursuant to the reimbursement methodology for inpatient and outpatient services. The upper payment limit payment gap shall be updated annually for each rate year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. Qualifying Criteria. Qualifying hospitals are all in-state private acute care hospitals excluding public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, long-term acute care hospitals and critical access hospitals.

D. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital claim payments times the "UPL gap percentage".

1. The annual UPL gap percentage is the percentage calculated when the numerator is the upper payment limit gap for inpatient services for private hospitals and the denominator is Medicaid claim payments to all qualifying hospitals for inpatient hospital services provided to Medicaid patients in the same year used in the numerator.
2. The UPL gap percentage will be calculated annually.

E. Quarterly Payments. After the close of each quarter, beginning with the quarter including the CMS effective date of all necessary state plan amendments authorizing increased payments to qualifying hospitals, each qualifying hospital shall receive supplemental payments for the inpatient services paid during that quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated based on the Medicaid inpatient hospital payments paid in that quarter multiplied by the annual UPL gap percentage.