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State Name: Virginia

State Plan Amendment (SPA)#: 19-0007

This file contains the following documents in the order listed:

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

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

September 19, 2019

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

RE: State Plan Amendment (SPA) 19-0007

Dear Dr. Lee:

We have completed our review of State Plan Amendment (SPA) 19-0007. This SPA modifies Attachment 4.19-A of Virginia's Title XIX State Plan. Specifically, the amendment increases reimbursement for critical access hospital's by reimbursing capital and operating rates at 100% of cost, and continues supplemental payments to support graduate medical education residencies.

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 Virginia State plan amendment 19-0007 with an effective date of July 1, 2019. 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

cc: Lisa Carroll
Gary Knight

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: 19-0007

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, 2019

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 447

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 146,873
b. FFY 2020 $ 587,491

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, pages 9.1.0, 9.1.1, ~~9.1.1a~~, 12.1

pen & ink 9/11/2019 EM

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same as box 8.

10. SUBJECT OF AMENDMENT: 2019 Institutional Provider Reimbursement Changes

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: 7/2/19

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 19 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2019

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

5. Effective October 1, 2010 through June 30, 2011, inpatient capital costs of Type One hospitals shall be settled at 100% of allowable cost. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 75% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 80% of allowable cost.

6. Effective July 1, 2011, inpatient capital costs of Type One hospitals shall be settled at 96% of allowable costs. Inpatient capital costs of Type Two hospitals, excluding hospitals with Virginia Medicaid utilization greater than 50%, shall be settled at 71% of allowable cost. Inpatient capital costs of Type Two hospitals with Virginia Medicaid utilization greater than 50% shall be settled at 76% of allowable cost.

7. Effective July 1, 2019, inpatient capital rates for critical access hospitals shall be increased to 100% of cost reimbursement.

C. The exception to the policy in subsection B of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12VAC30-70-321 B, shall be an all-inclusive payment for operating and capital costs. The capital rate per day determined in 12VAC30-70-321 will be multiplied by the same percentage of allowable cost specified in subsection B of this section.

12 VAC 30-70-280. Repealed.

12 VAC 30-70-281. Payment for direct medical education costs.

A. Direct medical education costs of nursing schools and paramedical programs shall be paid on an allowable cost basis.

1. Payments for these direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

2. Final payment for these direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

B. Effective with cost reporting periods beginning on or after July 1, 2002, direct Graduate Medical Education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis, subject to cost settlement as outlined below except that on or after April 1, 2012, payment for direct medical education for interns and residents for Type One hospitals shall be 100% of allowable costs as described in Subsection C.

1. The methodology provides for the determination of a hospital-specific base period per-resident amount to initially be calculated from cost reports with fiscal years 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Virginia

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT SERVICES

C. 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.

D. 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.

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

F. DMAS will make supplemental payments to hospitals for qualified graduate medical residencies. Residency programs (along with their hospital partners) will submit applications for this funding each year. The applications will be scored and the top applicants will receive funding. The supplemental payment for each new qualifying residency slot will be $100,000 annually and shall be made for up to four (4) years. Payments to hospitals will be made quarterly. Additional criteria include:

1. Sponsoring institutions or the primary clinical site must be:
    a. Physically located in Virginia;
    b. An enrolled hospital provider in Virginia Medicaid and continue as a Medicaid-enrolled provider for the duration of the funding;
    c. Not subject to a limit on Medicaid payments by the Centers for Medicare and Medicaid Services; and
    d. Accredited through either the American Osteopathic Association (AOA) or the American Council for Graduate Medical Education (ACGME).
2. Applications must:
    a. Be complete and submitted by the posted deadline;
    b. Request funding for primary care (care (General Pediatrics, General Internal Medicine, or Family Practice) or high-need specialty residencies; and
    c. Provide substantiation of the need for the requested primary care or specialty residency.
3. Programs that are awarded funding in the fall must attest (by June 1) that the resident(s) have been hired for the start of the academic year and have continued employment with the program each year thereafter.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Virginia

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT SERVICES

For Type Two hospitals the adjustment factor shall be:

a. 0.7800 effective July 1, 2006 through June 30, 2010.

b. 0.7500 effective July 1, 2010 through September 30, 2010.

c. 0.7800 effective October 1, 2010 through June 30, 2011.

C. For critical access hospitals, the operating rate shall be increased by using an adjustment factor of 1.0, effective July 1, 2019.

12VAC30-70-340. Repealed.

12 VAC 30-70-341. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12 VAC 30-70-371, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B or C of this section.

B. The adjustment factor for acute care rehabilitation cases shall be the one specified in subsection B of 12 VAC 30-70-331.

C. The adjustment factor for acute care psychiatric cases for:

1. Type One hospitals shall be the one specified in subdivision B 1 of 12VAC30-70-331 times the factor in subdivision C2 of 12 VAC 30-70-341 divided by the factor in subdivision B 2 of 12VAC30-70-331.

2. Type Two hospitals shall be:

a. 0.7800 effective July 1, 2006, through June 30, 2007.

b. 0.8400 effective July 1, 2007, through June 30, 2010.

c. 0.8100 effective July 1, 2010, through September 30, 2010.

d. 0.8400 effective October 1, 2010, through September 30, 2010.

3. Effective July 1, 2019, for critical access hospitals, the inpatient operating rate per day shall be increased using an adjustment factor or percent of cost reimbursement equal to 100%.

D. Effective July 1, 2009, for freestanding psychiatric facilities, the adjustment factor shall be 1.0000.