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State/Territory Name: Virginia

State Plan Amendment (SPA) #: 20-0020

This file contains the following documents in the order listed:

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

December 22, 2021

Ms. Karen Kimsey, Director
Commonwealth of Virginia
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond, VA 23219

RE: State Plan Amendment (SPA) 20-0020

Attn: Regulatory Coordinator

Dear Ms. Kimsey:

We have reviewed the referenced amendment to Attachment 4.19-A of your Medicaid State Plan. This amendment establishes a readmission payment methodology for acute inpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This letter is to inform you that Medicaid State Plan Amendment is approved effective July 1, 2020. The CMS-179 and amended plan pages are enclosed.

If you have any questions, or require additional information, please call Gary Knight at (304) 347-5723.

Sincerely,

Rory Howe
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: 20-020

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: 07/01/2020

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 2020 $ ($776,623)
b. FFY 2021 $ ($3,122,025)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 4.19-A, pages 4 and 7

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same as box 8.

10. SUBJECT OF AMENDMENT: Hospital Readmissions

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: [redacted]

13. TYPED NAME: Karen Kimsey

14. TITLE: Director

15. DATE SUBMITTED: 9/25/2020

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 25, 2020

18. DATE APPROVED: December 22, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Rory Howe

22. TITLE: Director, Financial Management Group

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and include (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD-10-CD. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A&B (12 VAC 30-50-95 through 12 VAC 30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" occur when patients are readmitted to the same hospital for the same or a similar diagnosis Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

12 VAC 30-70-230. Repealed.

12 VAC 30-70-231. Operating payment for DRG cases.

A. The operating payment for DRG cases that are not transfer cases shall be equal to the hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the DRG relative weight, as determined in 12 VAC 30-70-381.

B. Exceptions.

1. Special provisions for calculating the operating payment for transfer cases are provided in 12 VAC 30-70-251.
2. Readmissions within five days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case.
3. Effective July 1, 2020, readmissions within six to thirty days of discharge shall be paid at fifty percent of the normal rate unless it is a planned readmission, an obstetrical readmission, an admission to critical access hospitals, or in any case where the patient was originally discharged against medical advice.

12 VAC 30-70-240. Repealed.

12 VAC 30-70-241. Operating payment for per diem cases.

A. The operating payment for acute care psychiatric cases and rehabilitation cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321, times the covered days for the case.

B. The payment for freestanding psychiatric cases shall be equal to the hospital specific rate per day for freestanding psychiatric cases, as determined in subsection B of 12 VAC 30-70-321, times the covered days for the case.

12 VAC 30-70-250. Repealed.

12 VAC 30-70-251. Operating payment for transfer cases.

A. The operating payment for transfer cases shall be determined as follows:

1. A transferring hospital shall receive the lesser of (i) a per diem payment equal to the hospital's DRG operating payment for the case, as determined in 12 VAC 30-70-231, divided by the arithmetic mean length of stay for the DRG into which the case falls times the length of stay for the case at the transferring hospital or (ii) the hospital's full DRG operating payment for the case, as determined in 12 VAC 30-70-231. The transferring hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.
2. The final discharging hospital shall receive the hospital's full DRG operating payment, as determined in 12 VAC 30-70-231. The final discharging hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

B. Exceptions.

1. Cases falling into DRG 456, 639, or 640 shall not be treated as transfer cases. Effective October 1, 2014, cases falling into DRG 580 and 581 shall not be treated as transfer cases. Both the transferring hospital and the final discharging hospital shall receive the full DRG operating payment.