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State/Territory Name: VA

State Plan Amendment (SPA) #: 22-0017

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 S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

November 23, 2022

Cheryl Roberts
Acting Director
Department of Medical Assistance Services
600 East Broad St, #1300
Richmond, VA 23219

Reference: TN 22-0017

Dear Acting Director Roberts:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 22-0017. This amendment proposes to adjust the formula for indirect medical education (IME) reimbursement for discharges at freestanding children's hospitals.

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

This is to inform you that Medicaid State plan amendment VA-22-0017 is approved effective July 1, 2022. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Kristina Mack-Webb at 617-565-1225 or Kristina.Mack-Webb@cms.hhs.gov.

Sincerely,

[redacted]

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: 22-0017

2. STATE: VA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 3,080,166
b. FFY 2023 $ 12,375,439

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, revised pages 5, 10, and 17.2
Attachment 4.19-D, Supplement 1, revised pages 26.5 and 57

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same as box #7.

9. SUBJECT OF AMENDMENT

2022 Institutional Provider Reimbursement Changes

10. 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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Cheryl J. Roberts

13. TITLE
Acting Director

14. DATE SUBMITTED
08/01/22

15. RETURN TO
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Policy, Regulations, and Manuals Supervisor

FOR CMS USE ONLY

16. DATE RECEIVED
September 2, 2022

17. DATE APPROVED
November 23, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2022

ROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. Facilities acquired prior to July 1, 2022, by Type One hospitals shall continue to be designated as Type One hospitals for reimbursement purposes.

"Type Two" hospitals means all other hospitals. Effective July 1 2022, any hospitals acquired by or that become fully-owned by designated Type One hospitals shall be considered Type Two facilities for reimbursement purposes.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper. Effective October 1, 2014, "ungroupable cases" means cases assigned to DRG 955 (ungroupable) and DRG 956 (ungroupable) as determined by the APR-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Effective October 1, 2014, DMAS shall replace the AP-DRG grouper with the All Patient Refined Diagnosis Related Groups (APR-DRG) grouper for hospital inpatient reimbursement. The APR-DRG Grouper will produce a DRG as well as a severity level ranging from 1 to 4. DMAS shall phase in the APR- DRG weights by blending in 50 opercent of the full APR-DRG weights with 50 percent of FY 2014 AP- DRG weights for each APR-DRG group and severity level in the first year. In the second year, the blend will be 75 percent of full APR-DRG weights and 25 percent of the FY 2014 AP-DRG weights. Full APR-DRG weights shall be used in the third year and succeeding years for each APR-DRG group and severity. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identified key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology

Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

A. 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 oneand case mix adjusted by multiplying the operating rate per case in this subsection by the weightper case for FFS discharges that is determined during rebasing. This formula applied to CHKD effective July 1, 2017.

3. For CHKD, effective July 1, 2022, the IME reimbursement for managed care discharges shall be calculated using a case mix adjustment factor the greater of 3.2962 or the most recent rebasing. Total payments for IME in combination with other payments for CHKD may not exceed the hospital's Medicaid costs.

B. 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 utilizationin 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 percentageof Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

C. 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.

D. 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 maynot 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.

E. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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D. Effective July 1, 2014, services provided under arrangement, as defined in 12 VAC 30-50- 130(B)(6)(c), shall be reimbursed directly by DMAS according to the reimbursement methodology prescribed for these providers in 12 VAC 30-80, to a provider of services under arrangement if all of the following are met:
1.The services provided under arrangement are included in the active written treatment plan of care developed and signed as described in section 12 VAC 30-130-890 and
2.The services provided under arrangement are arranged and overseen by the residential treatment facility treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the residential treatment facility or under contract for services provided under arrangement.

E. Effective July 1, 2021, per diem rates paid to Virginia-based psychiatric residential treatment facilities will be revised using the provider's audited cost per day from the facility's cost report to provider fiscal years ending in state fiscal year 2018. New Virginia-based residential psychiatric facilities must submit proforma cost report data, which will be used to set the initial per diem rate for up to two years. After this period, the department shall establish a per diem rate based on an audited cost report for a 12-month period within the first two years of operation. Virginia-based residential psychiatric facilities that do not submit cost reports shall be paid at 75 percent of the established rate ceiling. If necessary to enroll out-of-state providers for network adequacy, the department shall negotiate rates with the provider and establish a single-case agreement. If there is sufficient utilization, the department may require out-of-state providers to submit a cost report to establish a per diem rate. In-state and out-of-state provider per diem rates shall be subject to a ceiling based on the statewide weighted average cost per day from fiscal year 2018 cost reports.

DMAS shall establish rebasing of PRTF rates every three years. The first rebasing of rates shall take effect July 1, 2023. All PRTF and Addiction and Rehabilitation Treatment Services (ARTS) providers who offer qualifying services under 12VAC30-70-418(C) shall be required to submit cost reports as a part of rebasing. Out of state providers with more than 1,500 paid days for Virginia Medicaid members in the most recently completed state fiscal year shall also be required to submit a cost report. A rate ceiling shall be established based on a statewide weighted average cost per day. Rate ceilings shall be established independently for PRTFs and participating ARTS residential services.

DMAS shall also establish inflation increases for each non-rebasing fiscal year for both PRTF and qualifying ARTS providers. Inflation rates shall be tied to the Nursing Facility Moving Average as established by IHS Markit (or its successor). The most recent four quarters will be averaged to create the PRTF inflation rate.

Effective July 1, 2022, the department shall adjust PRTF rates by 8.89% to account for inflation since the last audited cost report of fiscal year 2018. The rate ceiling shall increase to $460.89 per day.

12 VAC 30-70-420. Reimbursement of non-cost-reporting general acute care hospital providers.

A. Effective July 1, 2000, non-cost-reporting (general acute care hospitals that are not required to file cost reports) shall be paid based on DRG rates unadjusted for geographic variation increased by the average capital percentage among hospitals filing cost reports in a recent year. General acute care hospitals shall not file cost reports if they have less than 1,000 days per year (in the most recent provider fiscal year) ofinpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.

B. Effective July 1, 2011, out-of-state hospitals shall be reimbursed the lesser of the amount reimbursed by the Medicaid program in the facility's home state or the rate defined in the subsection A of this section.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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

a. Direct adjustment factor- 105.000% of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities.

- Effective July 1, 2021, the direct adjustment factor shall be 109.3% of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities.

b. Indirect adjustment factor - 100.735% of the peer group day-weighted median inflated cost per day for freestanding nursing facilities.

- Effective July 1, 2021, the indirect adjustment factor shall be 103.3% of the peer group day-weighted median inflated cost per day for freestanding nursing facilities.

i. Facilities with costs projected to the rate year below 95% of the price shall have an adjusted price equal to the price minus the difference between the facility's cost and 95% 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.

j. Special circumstances.

1. Effective July 1, 2022, DMAS shall establish a new direct and indirect peer group for nursing facilities operating with at least 80% 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% Medicaid utilization and a nursing facility case-mix index of 1.15 or higher in fiscal year 2014.

- The department shall utilize the data from the most recent rebasing to make this change effective for fiscal year 2023 and subsequent rate years until this change is incorporated into the next scheduled rebasing.

2. For rebasings effective on or after July 1, 2020, DMAS shall move nursing facilities located in the former Danville Metropolitan Statistical Area to the Other MSAs peer group.

k. 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.

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12. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with subdivision 9 of this section, except that the occupancy requirement shall be 70% rather than the required occupancy percentage.

13. The cost reporting requirements of 4.19-D, Supp 1, page 35 (12 VAC 30-90-70) and 4.19-D, Supp 1, page 37 (12 VAC 30-90-80) shall apply to specialized care providers.

14. Effective July 1, 2020 through June 30, 2023, specialized care operating rates shall be increased by inflating the 2020 rates based on the section of the state plan called the Nursing Facility Price Based Payment Methodology, which starts on page 26.2 of 4.19D, Supplement 1. After state fiscal year 2023, the rates shall revert to the existing prospective methodology.

15. DMAS shall increase nursing facility per diem rates by $15 per day effective July 1, 2021.

12 VAC 30-90-265. Reserved.

12VAC30-90-266. Traumatic Brain Injury (TBI) payment.

DMAS shall provide a fixed per day payment for nursing facility residents with TBI served in the program in accordance with resident and provider criteria, in addition to the reimbursement otherwise payable under the provisions of the Nursing Home Payment System. Effective for dates of service on and after August 19, 1998, a per day rate add-on shall be paid for recipients who meet the eligibility criteria for these TBI payments and who are residents in a designated nursing facility TBI unit of 20 beds or more that meets the provider eligibility criteria. The rate add-on for any qualifying provider's fiscal year shall be reviewed annually to determine the appropriateness of the amount, not to exceed $50 per patient day, and any changes will be published and distributed to the providers. (Refer to NHPS, Appendix VII, page 1 (12VAC30-90-330), Traumatic brain injury diagnoses, for related resident and provider requirements.)

12 VAC 30-90-267. Private room differential.

A. Payment shall be made for a private room or other accommodations more expensive than semi-private (two or more bed accomodations) only when such accommodations are medically necessary. Private rooms will be considered necessary when the resident's condition requires him/her to be isolated for his/her own health or that of others.

B. Physician certification justifying the private room must be on file prior to the resident's discharge from the semi-private room. The term 'isolation' applies when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the resident for certain periods. Private room accommodations may also be necessary for residents whose symptoms or treatments are likely to alarm or disturb others in the same room.

C. Reimbursement for private rooms will only be made when authorized by the Virginia Department of Medical Assistance Services (DMAS).

D. The Medicaid private room differential shall be calculated by applying the percent difference between the facility's private and semi-private room charges to the total case mix neutral Medicaid rate for the facility.

12 VAC 30-90-268 through 12 VAC 30-90-269. Reserved.