COMMONWEALTH of VIRGINIA

Office of the Governor

Daniel Carey, MD
Secretary of Health and Human Resources

June 4, 2021

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Dear Mr. McMillion:

Attached for your review and approval is amendment 21-015, entitled "Institutional Provider Reimbursement Changes" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

Sincerely,

Daniel Carey, MD, MHCM

Attachment

cc: Karen Kimsey, Director, Department of Medical Assistance Services
CMS, Region III

Transmittal Summary

SPA 21-015

I. IDENTIFICATION INFORMATION

Title of Amendment: 2021 Institutional Provider Reimbursement Changes

II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

Additional authority was provided by the Virginia legislature as detailed below.

Purpose: The 2021 Appropriations Act requires DMAS to make the following changes:

a. Item 313.CC: The state plan is being revised to change per diem rates paid to Virginia-based psychiatric residential treatment facilities using the provider's audited cost per day from the facility's cost report for 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. 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.

b. Item 313.UU (9): The state plan is being revised to implement a supplemental inpatient payment for Lake Taylor Transitional Care Hospital based on the difference between Medicaid reimbursement and the inpatient Upper Payment Limit for non-state government owned hospitals. The department shall include in its contracts with managed care organizations a percentage increase for Lake Taylor Transitional Care Hospital consistent with the fee for service supplemental payment percentage increase. The department shall adjust capitation payments to Medicaid managed care organizations to fund this percentage increase. The originating funding for this program will come entirely from Lake Taylor for Lake Taylor.

c. Item 313.BBB: The state plan is being revised to clarify that supplemental payments for graduate medical education residency slots shall be in amounts of $100,000 minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose Medicaid payments are capped by the Centers for Medicare and Medicaid Services, the supplemental payments for each qualifying residency slot shall be

$50,000 from the general fund annually minus any Medicare residency payments for which the residency program is eligible.

d. Item 313.GGGG: The state plan is being revised to modify reimbursement for nursing facility services such that the direct peer group price percentage shall be increased to 109.3 percent and the indirect peer group price percentage shall be increased to 103.3 percent.

e. Item 313.IIIIII (1): The state plan is being revised to adjust the formula for indirect medical education (IME) reimbursement for managed care discharges for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 by increasing the case mix adjustment factor to 2.718. This increased case mix index (CMI) factor shall take precedence over future rebasing. Total payments for 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.

f. Item 313.JJJJ: The state plan is being revised to provide that any nursing facility which thereafter loses its Medicaid capital reimbursement status as a hospital-based nursing facility because a replacement hospital was built at a different location and Medicare rules no longer allow the nursing home's cost to be included on the hospital's Medicare cost report shall have its first fair rental value (FRV) capital payment rate set at the maximum FRV rental rate for a new free-standing nursing facility with the date of acquisition for its capital assets being the date the replacement hospital is licensed.

g. Item 313.KKKK: The state plan is being revised to increase the direct and indirect operating rates from 15 percent to 25.4 percent above a facility's calculated price-based rates where at least 80 percent of the resident population have 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 percent Medicaid utilization and a case mix index of 1.15 or higher in fiscal year 2014.

h. Item 313.LLLL (1): The state plan is being revised to increase nursing home and specialized care per diem rates by $15 per day effective July 1, 2021. Such adjustment shall be made through existing managed care capitation rates as a mandated specified rate increase. DMAS shall adjust capitation rates to account for the nursing facility rate increase. The specified rate increase in this paragraph applies across fee-for-service and Medicaid managed care.

i. Item 313.RRRRR: The state plan is being revised to implement a supplemental Medicaid payment for Department of Veterans Services (DVS) state government-owned nursing facilities. The total supplemental Medicaid payment for DVS state government owned nursing homes shall be based on the difference between the Upper Payment Limit of 42 CFR 447.272, as approved by the Centers for Medicare and Medicaid Services (CMS), and all other Medicaid payments subject to such limit made to such nursing homes.

j. Item 313.GGGGGG: The state plan is being revised to defer the next scheduled nursing facility rate rebasing for one year in order to utilize the calendar year 2021 cost reports as the

base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations.

Substance and Analysis: The sections of the State Plan for Medical Assistance that are affected by this action are "Methods & Standards for Establishing Payment Rates-Inpatient Care" and "Methods & Standards for Establishing Payment Rates-Long-Term Care."

Impact:
a. 313.CC. The expected increase in annual aggregate expenditures as a result of the changes in rates paid to psychiatric residential treatment facilities is $1,899,924 in state general funds and $1,899,924 in federal funds in federal fiscal year 2021.

b. 313.UU(9). The expected increase in annual aggregate expenditures as a result of payments to Lake Taylor Transitional Care Hospital is $1,359,319 in state general funds and $1,359,319 in federal funds in federal fiscal year 2021.

c. 313.BBB. There is no expected increase or decrease in annual aggregate expenditures as a result of changes to payments for graduate medical education.

d. 313.IIIIII(1). The expected increase in annual aggregate expenditures as a result of changes to indirect medical education payments for freestanding children's hospitals is $562,500 in state general funds and $562,500 in federal funds in federal fiscal year 2021.

e. 313.GGGG. The expected increase in annual aggregate expenditures as a result of changes to peer groups for nursing facilities is $1,746,197 in state general funds and $1,746,197 in federal funds in federal fiscal year 2021.

f. 313.JJJJ. The expected increase in annual aggregate expenditures as a result of changes to nursing facility capital reimbursement is $29,989 in state general funds and $29,989 and federal funds in federal fiscal year 2021.

g. 313.KKKK. The expected increase in annual aggregate expenditures as a result of changes to rates for facilities with special populations is $126,726 in state general funds and $126,726 in federal funds in federal fiscal year 2021.

h. 313.LLLL(1). The expected increase in annual aggregate expenditures as a result of changes in rates to the nursing facility per diem is $11,680,754 in state general funds and $11,680,754 in federal funds in federal fiscal year 2021.

i. 313.RRRRR. The expected increase in annual aggregate expenditures as a result of changes to nursing facilities owned by the Department of Veteran's services is $762,714 in federal funds, $576,048 in general funds, and $2,620 in special funds in federal fiscal year 2021.

j. 313.GGGGGG. There is no expected increase or decrease in annual aggregate expenditures as a result of changes to rebasing of nursing facility costs.

Tribal Notice: Please see Attachments A-1 and A-2.

Prior Public Notice: Please see Attachment B-1.

Public Comments and Agency Analysis: Attachment B-2.

ATTACHMENT A-1

Commonwealth of Virginia

Mcclellan, Emily <emily.mcclellan@dmas.virginia.gov>

Tribal Notice re: Changes in reimbursement for long-term care and hospital servicesies

Mcclellan, Emily <emily.mcclellan@dmas.virginia.gov> Wed, May 26, 2021 at 4:27 PM
To: TribalOffice@monacannation.com, "chiefannerich@aol.com" <chiefannerich@aol.com>, Gerald Stewart <wasandson@cox.net>, Pam Thompson <Pamelathompson4@yahoo.com>, rappahannocktrib@aol.com, regstew007@gmail.com, robert.gray@pamunkey.org, Rufus Elliott <tribaladmin@monacannation.com>, Samuel Bass <samflyingeagle48@yahoo.com>, Stephen Adkins <chiefstephenadkins@gmail.com>, Frank <WFrankAdams@verizon.net>, "bradbybrown@gmail.com" <bradbybrown@gmail.com>, heather.hendrix@ihs.gov, "Garrett, Tabitha (IHS/NAS/RIC)" <tabitha.garrett@ihs.gov>, Kara.Kearns@ihs.gov

Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid Director Karen Kimsey indicating that the Dept. of Medical Assistance Services (DMAS) plans to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services. This SPA includes changes in reimbursement for "institutional" facilities, which include long-term care facilities, hospitals, and psychiatric residential treatment facilities.

If you would like a copy of the SPA documents or proposed text changes, or if you have any questions, please let us know.

Thank you! -- Emily McClellan

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Emily McClellan
Policy, Regulation, and Member Engagement Division Director
Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219
(804) 371-4300
www.dmas.virginia.gov

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Tribal Notice Letter (signed) 5-25-21.pdf

403K

ATTACHMENT A-2

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

May 26, 2021

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to 2021 Provider Reimbursement Changes for Inpatient and Long-Term Care Services

Dear Tribal Leader and Indian Health Programs:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to amend the Virginia State Plan for Medical Assistance with the Centers for Medicare and Medicaid Services (CMS). Specifically, DMAS is providing you notice about a State Plan Amendment (SPA) that the Agency will file with CMS in order to make changes to institutional (inpatient and long-term care) provider reimbursement as a result of items in the 2021 Appropriations Act. These items include:

Methods & Standards for Establishing Payment Rates-Inpatient Care (12 VAC 30-70)

1. In accordance with the 2021 Special Session, Items 313.CC, the state plan is being revised to change per diem rates paid to Virginia-based psychiatric residential treatment facilities using the provider's audited cost per day from the facility's cost report for provider fiscal years ending in state fiscal year 2018. New Virginia-based residential psychiatric facilities must submit pro forma 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. 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.

2. In accordance with the 2021 Special Session, Items 313.UU (9), the state plan is being revised to implement a supplemental inpatient payment for Lake Taylor Transitional Care Hospital based on the difference between Medicaid reimbursement and the inpatient Upper Payment Limit for non-state government owned hospitals. The department shall include in its contracts with managed care organizations a percentage increase for Lake Taylor Transitional Care Hospital consistent with the fee for service supplemental payment percentage increase. The department shall adjust capitation payments

to Medicaid managed care organizations to fund this percentage increase. The originating funding for this program will come entirely from Lake Taylor for Lake Taylor.

3. In accordance with the 2021 Special Session, Items 313.BBB, the state plan is being revised to clarify that supplemental payments for graduate medical education residency slots shall be in amounts of $100,000 minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose Medicaid payments are capped by the Centers for Medicare and Medicaid Services, the supplemental payments for each qualifying residency slot shall be $50,000 from the general fund annually minus any Medicare residency payments for which the residency program is eligible.

4. In accordance with the 2021 Special Session, Items 313.IIIIII (1), the state plan is being revised to adjust the formula for indirect medical education (IME) reimbursement for managed care discharges for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 by increasing the case mix adjustment factor to 2.718. This increased case mix index (CMI) factor shall take precedence over future rebasing. Total payments for 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.

Methods & Standards for Establishing Payment Rates-Long-Term Care (12 VAC 30-90)

1. In accordance with the 2021 Special Session, Items 313.GGGG, the state plan is being revised to modify reimbursement for nursing facility services such that the direct peer group price percentage shall be increased to 109.3 percent and the indirect peer group price percentage shall be increased to 103.3 percent.

2. In accordance with the 2021 Special Session, Item 313.JJJJ, the state plan is being revised to provide that any nursing facility which thereafter loses its Medicaid capital reimbursement status as a hospital-based nursing facility because a replacement hospital was built at a different location and Medicare rules no longer allow the nursing home's cost to be included on the hospital's Medicare cost report shall have its first fair rental value (FRV) capital payment rate set at the maximum FRV rental rate for a new free-standing nursing facility with the date of acquisition for its capital assets being the date the replacement hospital is licensed.

3. In accordance with the 2021 Special Session, Item 313.KKKK, the state plan is being revised to increase the direct and indirect operating rates from 15 percent to 25.4 percent above a facility's calculated price-based rates where at least 80 percent of the resident population have 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 percent Medicaid utilization and a case mix index of 1.15 or higher in fiscal year 2014.

4. In accordance with the 2021 Special Session, Item 313.LLLLL (1), the state plan is being revised to increase nursing home and specialized care per diem rates by $15 per day effective July 1, 2021. Such adjustment shall be made through existing managed care capitation rates as a mandated specified rate increase. DMAS shall adjust capitation rates to account for the nursing facility rate increase. The specified rate increase in this paragraph applies across fee-for-service and Medicaid managed care.

5. In accordance with the 2021 Special Session, Item 313.RRRRR, the state plan is being revised to implement a supplemental Medicaid payment for Department of Veterans Services (DVS) state government-owned nursing facilities. The total supplemental Medicaid payment for DVS state government owned nursing homes shall be based on the difference between the Upper Payment Limit of 42 CFR 447.272, as approved by the Centers for Medicare and Medicaid Services (CMS), and all other Medicaid payments subject to such limit made to such nursing homes.

6. In accordance with the 2021 Special Session, Item 313.GGGGGG, the state plan is being revised to defer the next scheduled nursing facility rate rebasing for one year in order to utilize the calendar year 2021 cost reports as the base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations.

The tribal comment period for this SPA is open through June 25, 2021. You may submit your comments directly to Emily McClellan, DMAS Policy Division, by phone (804) 371-4300, or via email: Emily.McClellan@dmas.virginia.gov Finally, if you prefer regular mail you may send your comments or questions to:

Virginia Department of Medical Assistance Services
Attn: Emily McClellan
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,

Karen Kimsey

Karen Kimsey

ATTACHMENT B-1

Virginia.gov Agencies | Governor

Agency Department of Medical Assistance Services

Board Board of Medical Assistance Services

Edit Notice

General Notice

Public Notice - Intent to Amend State Plan - 2021 Institutional Provider Reimbursement Changes

Date Posted: 5/26/2021

Expiration Date: 10/26/2021

Submitted to Registrar for publication: YES

30 Day Comment Forum is underway. Began on 5/26/2021 and will end on 6/25/2021

LEGAL NOTICE

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF INTENT TO AMEND

(Pursuant to §1902(a)(13) of the *Act (U.S.C. 1396a(a)(13)*)

THE VIRGINIA STATE PLAN FOR MEDICAL ASSISTANCE

This Notice was posted on May 26, 2021

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to provide for changes to the *Methods and Standards for Establishing Payment Rates — Inpatient Care (12 VAC 30-70) and Methods and Standards for Establishing Payment Rates – Long-Term Care (12 VAC 30-90)*.

This notice is intended to satisfy the requirements of 42 C.F.R. § 447.205 and of § 1902(a)(13) of the *Social Security Act*, 42 U.S.C. § 1396a(a)(13). A copy of this notice is available for public review from Emily McClellan, DMAS, 600 Broad Street, Suite 1300, Richmond, VA 23219, or via e-mail at: Emily.McClellan@dmas.virginia.gov

DMAS is specifically soliciting input from stakeholders, providers and beneficiaries, on the potential impact of the proposed changes discussed in this notice. Comments or inquiries may be submitted, in writing, within 30 days of this notice publication to Emily McClellan and such comments are available for review at the same address. Comments may also be submitted, in writing, on the Town Hall public comment forum attached to this notice.

This notice is available for public review on the Regulatory Town Hall (www.townhall.com), on the General Notices page, found at: https://townhall.virginia.gov/L/generalnotice.cfm

Methods & Standards for Establishing Payment Rates-Inpatient Care (12 VAC 30-70)

1. In accordance with the 2021 Special Session, Items 313.CC, the state plan is being revised to change per diem rates paid to Virginia-based psychiatric residential treatment facilities using the provider's audited cost per day from the facility's cost report for 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. 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.

The expected increase in annual aggregate expenditures is $1,899,924 in state general funds and $1,899,924 in federal funds in federal fiscal year 2021.

2. In accordance with the 2021 Special Session, Items 313.UU (9), the state plan is being revised to implement a supplemental inpatient payment for Lake Taylor Transitional Care Hospital based on the difference between Medicaid reimbursement and the inpatient Upper Payment Limit for non-state government owned hospitals. The department shall include in its contracts with managed care organizations a percentage increase for Lake Taylor Transitional Care Hospital consistent with the fee for service supplemental payment percentage increase. The department shall adjust capitation payments to Medicaid managed care organizations to fund this percentage increase. The originating funding for this program will come entirely from Lake Taylor for Lake Taylor.

The expected increase in annual aggregate expenditures is $1,359,319 in state general funds and $1,359,319 in federal funds in federal fiscal year 2021.

3. In accordance with the 2021 Special Session, Items 313.BBB, the state plan is being revised to clarify that supplemental payments for graduate medical education residency slots shall be in amounts of $100,000 minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose Medicaid payments are capped by the Centers for Medicare and Medicaid Services, the supplemental payments for each qualifying residency slot shall be $50,000 from the general fund annually minus any Medicare residency payments for which the residency program is eligible.

There is no expected increase or decrease in annual aggregate expenditures as a result of this clarification.

4. In accordance with the 2021 Special Session, Items 313.IIIIII (1), the state plan is being revised to adjust the formula for indirect medical education (IME) reimbursement for managed care discharges for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 by increasing the case mix adjustment factor to 2.718. This increased case mix index (CMI) factor shall take precedence over future rebasing. Total payments for 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.

The expected increase in annual aggregate expenditures is $562,500 in state general funds and $562,500 in federal funds in federal fiscal year 2021.

Methods & Standards for Establishing Payment Rates-Long-Term Care (12 VAC 30-90)

1. In accordance with the 2021 Special Session, Items 313.GGGG, the state plan is being revised to modify reimbursement for nursing facility services such that the direct peer group price percentage shall be increased to 109.3 percent and the indirect peer group price percentage shall be increased to 103.3 percent.

The expected increase in annual aggregate expenditures is $1,746,197 in state general funds and $1,746,197 in federal funds in federal fiscal year 2021.

2. In accordance with the 2021 Special Session, Item 313.JJJJ, the state plan is being revised to provide that any nursing facility which thereafter loses its Medicaid capital reimbursement status as a hospital-based nursing facility because a replacement hospital was built at a different location and Medicare rules no longer allow the nursing home's cost to be included on the hospital's Medicare cost report shall have its first fair rental value (FRV) capital payment rate set at the maximum FRV rental rate for a new free-standing nursing facility with the date of acquisition for its capital assets being the date the replacement hospital is

licensed.

The expected increase in annual aggregate expenditures is $29,989 in state general funds and $29,989 in federal funds in federal fiscal year 2021.

3. In accordance with the 2021 Special Session, Item 313.KKKK, the state plan is being revised to increase the direct and indirect operating rates from 15 percent to 25.4 percent above a facility's calculated price-based rates where at least 80 percent of the resident population have 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 percent Medicaid utilization and a case mix index of 1.15 or higher in fiscal year 2014.

The expected increase in annual aggregate expenditures is $126,726 in state general funds and $126,726 in federal funds in federal fiscal year 2021.

4. In accordance with the 2021 Special Session, Item 313.LLLLL (1), the state plan is being revised to increase nursing home and specialized care per diem rates by $15 per day effective July 1, 2021. Such adjustment shall be made through existing managed care capitation rates as a mandated specified rate increase. DMAS shall adjust capitation rates to account for the nursing facility rate increase. The specified rate increase in this paragraph applies across fee-for-service and Medicaid managed care.

The expected increase in annual aggregate expenditures is $11,680,754 in state general funds and $11,680,754 in federal funds in federal fiscal year 2021.

5. In accordance with the 2021 Special Session, Item 313.RRRRR, the state plan is being revised to implement a supplemental Medicaid payment for Department of Veterans Services (DVS) state government-owned nursing facilities. The total supplemental Medicaid payment for DVS state government owned nursing homes shall be based on the difference between the Upper Payment Limit of 42 CFR 447.272, as approved by the Centers for Medicare and Medicaid Services (CMS), and all other Medicaid payments subject to such limit made to such nursing homes.

The expected increase in annual aggregate expenditures is $762,714 in federal funds, $576,048 in general funds, and $2,620 in special funds in federal fiscal year 2021.

6. In accordance with the 2021 Special Session, Item 313.GGGGGG, the state plan is being revised to defer the next scheduled nursing facility rate rebasing for one year in order to utilize the calendar year 2021 cost reports as the base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations.

There is no expected increase or decrease in annual aggregate expenditures as a result of this change.

Contact Information

Name / Title:	Emily McClellan / *Regulatory Manager*
Address:	Division of Policy and Research 600 E. Broad St., Suite 1300 Richmond, 23219
Email Address:	**Emily.McClellan@dmas.virginia.gov**
Telephone:	(804)371-4300 FAX: (804)786-1680 TDD: (800)343-0634

This general notice was created by Emily McClellan on 05/26/2021 at 1:02pm

ATTACHMENT B-2

Comments	Practitioner Provider Manual	Closed: 6/23/21 0 comments
View Comments	Draft Psychiatric Provider Manual	General Notice Draft Psychiatric Provider Manual Closed: 6/23/21 0 comments
View Comments	Draft ARTS Provider Manual	General Notice Draft ARTS Provider Manual Closed: 6/23/21 1 comments Last comment: 6/22/21 1:12 pm
View Comments	Draft Provider Manual Chapter 1	General Notice Draft Provider Manual Chapter 1 Closed: 6/23/21 0 comments
View Comments	Draft Pharmacy Provider Manual	General Notice Draft Pharmacy Provider Manual Closed: 6/23/21 0 comments
View Comments	Public Notice - Intent to Amend State Plan - 2021 Institutional Provider Reimbursement Changes	General Notice Public Notice - Intent to Amend State Plan - 2021 Institutional Provider Reimbursement Changes Closed: 6/25/21 0 comments
View Comments	Draft Home Health Provider Manual	General Notice Draft Home Health Provider Manual Closed: 6/25/21 2 comments Last comment: 6/25/21 9:23 am
View Comments	Draft Local Education Agency Provider Manual	General Notice Draft Local Education Agency Provider Manual Closed: 6/25/21 0 comments
View Comments	Chapter: [12 VAC 30 - 70] Methods and Standards for Establishing Payment Rates; in-Patient Hospital Care	Action: Fee For Service Supplemental Payments and Hospital Assessment Stage: Proposed Closed: 6/11/21 0 comments

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

A. The base amount shall be updated annually be the DRI-Virginia moving average values as compiled and published by DRIWEFA, Inc. (12 VACJ0-70-351).The updated per-resident amount will then be multiplied bythe 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 FTEs 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.

B. Type One hospitals shall be reimbursed l 00 percent of Medicaid allowable FFS and MCO GME costs forinterns 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 caredays 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 costfrom the most recently audited cost report divided by four and will be final settled in the audited cost report forthe fiscal year end in which the payments are made.

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

D. 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 foreach new qualifying residency slot will be $100,000 annually, minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose Medicaid payments are capped by the Centers for Medicare and Medicaid Services, the supplemental payments for each qualifying residency slot shall be $50,000 from the general fund annually minus any Medicare residency payments for which the residency program is eligible. ~~and~~ The payments shall be made for up to four (4) years.Payments to hospitals will be made quarterly. Additional criteria include:

I. 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 Councilfor 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 full must attest (by June I) 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

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, 2021 the IME reimbursement for managed care discharges shall be calculated using a case mix adjustment factor of 2.718. This case mix index (CMI) factor shall take precedence over future calculations. Total payments for IME in combination with other payments for CHKD may not exceed the federal uncompensated care cost limit that disproportionate share hospital payments are subject to.

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.

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12 VAC 30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.
A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12 VAC 30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio of total capital cost to total charges of the hospital, using data available from Medicare cost report.

~~E. Effective July 1,2014, services provided under arrangement, as defined in 12 VAC 30-50-130(BX6Xa) and (b), shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in Attachment 4.19-B (12 VAC 30-80), to a provider of services under arrangement if all of the following are met:~~

~~1. The services are included in the active treatment plan of care developed and signed as described in section 12 V AC 30-60-25(C)(4) and~~

~~2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team ' through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.~~

12 VAC 30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.

A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.
B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all service provided under arrangement that are reimbursed in the manner described in subsection D ofthis section.
C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the program shall take action in accordance with its policies to assure that an overpayment is not being made'

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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. 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.

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 bythe Medicaid program in the facility's home state or the rate defined in the subsection A of this section.

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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 astate.

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.

D.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 hospital 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~~ hospitals would exceed the upper payment limit, the numerator in the calculation of the UPL gap percentage shall be reduced proportionately.

E. Quarterly Payments. After the close of each quarter, beginning with the July l, 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 UPLgap percentage for each hospital.

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1. Mid-year FRV rate change. Facilities requiring a mid-year FRV rate change must follow the procedures as specified in 4.19-D, Supp 1, pages 1-3.

2. The capital per diem rate for hospital-based nursing facilities shall be the last settled capital per diem.

3. Effective for dates of service on or after July 1, 2021, any nursing facility which thereafter loses its Medicaid capital reimbursement status as a hospital-based nursing facility because a replacement hospital was built at a different location and Medicare rules no longer allow the nursing home's cost to be included on the hospital's Medicare cost report shall have its first FRV capital payment rate set at the maximum FRV rental rate for a new free-standing nursing facility with the date of acquisition for its capital assets being the date the replacement hospital is licensed.

12 VAC 30-90-37. Calculation of FRV Per Diem Rate for Capital. Calculation of FRV Rental Amount. Change of Ownership.

A. Calculation of FRV Per Diem Rate for Capital. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of actual patient days or the required occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see 4.19-D, Supp 1, p 26 (12 VAC 30-90-264) section 10, for special procedures for computing the number of patient days required to meet the required occupancy percentage requirement.

Facilities shall be required to submit a calendar year FRV report covering both NF and specialized care beds to be used to set a prospective FRV rate effective the following July 1 for both the NF and the specialized care facility. The calendar year FRV report shall be submitted by the end of February following the end of the calendar year. FRV reports shall be settled within 90 days of filing the FRV report. For late FRV reports, the prospective rate may be effective 90 days after the date of filing even if after July 1. No capital rate shall be paid between July 1 and the effective date of the prospective FRV rate for a late report.

New nursing facilities or major renovations that qualify for mid-year FRV rate adjustments must follow pro forma submission procedures as specified in 4.19-D, Supp 1, pages 1-3.

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Article 4
Operating Cost Component

12VAC30-90-40. Operating cost.

A. Effective July 1, 2001, operating cost shall be the total allowable inpatient cost less plant cost or capital, as appropriate, and NATCEPs costs. See Subpart VII (12 VAC 30-90-170) for rate determination procedures for NATCEPs costs. Operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I (12 VAC 30-90-271). Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs or the actual charges by the Central Criminal Records Exchange for criminal records checks for nursing facility employees (see Appendix I (12 VAC 30-90-272)). For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or the occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period times the Medicaid utilization percentage. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90 percent, for dates of service on or after July 1, 2013 shall be 88 percent. For facilities that also provide specialized care services, see 12 VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the occupancy percentage requirement.

12VAC30-90-41. Nursing facility reimbursement formula.

A. Effective on and after July I, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group ~~III~~ (RUG ~~III~~) System as defined in Appendix IV (12 VAC 30-90-305 through 307)." The RUG ~~III~~ model is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMis) are assigned to RUG ~~III~~ groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12 VAC 30-90-305 through 307 for details on the Resource Utilization Groups.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the *Social Security Act* as they relate to provision of services, residents' rights and administration and other matters.

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c. See 12VAC 30-90-307 for the applicability of case-mix indices.

5. Direct and indirect payment methods.

a. Effective for services on or after July 1, 2006, the direct patient care operating ceiling shall be set at 117% of the respective peer group day-weighted median of the facilities' case-mix neutralized direct care operating costs per day. The calculation of the medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group direct patient care operating ceilings shall be revised and case-mix neutralized every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

b. The indirect patient care operating ceiling shall be set at 107% of the respective peer group day-weighted median of the facility's specific indirect operating cost per day. The calculation of the peer group medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

6. Reimbursement for use of specialized treatment beds. Effective for services on and after January 1, 2005, nursing facilities shall be reimbursed an additional $10 per day for those recipients who require a specialized treatment bed due to their having at least one stage IV pressure ulcer. Recipients must meet criteria as outlined in 12 VAC30-60-350, and the additional reimbursement must be preauthorized as provided in 12 VAC30-60-40. Nursing facilities shall not be eligible to receive this reimbursement for individuals whose services are reimbursed under the Specialized Care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12 VAC30-90-41B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.

B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI. ~~For state fiscal year 2003, peer group ceilings and rates for indirect costs will not be adjusted for inflation.~~

1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

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I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

~~J. Effective July 1, 2005, the total per diem payment to each nursing home shall be increased by $3 per day. This increase in the total per diem payment shall cease, effective July 1, 2006. Effective July 1, 2006, when cost data that include time period before July 1, 2005, are used to set facility specific rates,a portion of the $3.00 per day amount identified above, based on the percentage of patient days in the provider's cost reporting period that fall before July 1, 2005, adjusted for appropriate inflation and multiplied times the providers' Medicaid utilization rate, shall be allocated to the facility specific direct and indirect cost per day prior to comparison to the peer group ceilings. For purposes of this subsection, $1.68 of the $3.00 shall be considered direct costs and $1.32 of the $3.00 shall beconsidered indirect costs.~~

~~K. Effective July 1, 2008, and ending after June 30, 2010, the operating rate for nursing facilities shall be reduced by 1.329 percent.~~

~~L. Effective July 1, 2009, through June 30, 2010, there will be no inflation adjustment for nursing facility operating rates and ceilings and specialized care operating rates and ceilings. Exempt from this are government-owned nursing facilities with Medicaid utilization of 85% or greater in provider fiscal year 2007.~~

~~M. Effective July 1, 2010, through June 30, 2012, there shall be no inflation adjustment for nursing facility and specialized care operating rates. Nursing facility and specialized care ceilings shall be frozen at the same level as the ceilings for nursing facilities with provider fiscal year ends of June 30, 2010.~~

~~N. Effective July 1, 2010, through September 30, 2010, the operating nursing facilities shall be reduced 3.0% below the rates otherwise calculated.~~

~~O. Effective July 1, 2012, through June 30, 2014, the inflation adjustment for nursing facility andspecialized care operating rates shall be 2.2 percent. Nursing facility and specialized care ceilings in effect for SFY 2012 shall be increased 3.2 percent in SFY 2013 and 2.2 percent in SFY 2014.~~

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~~P.~~ J. The reimbursement methodology described in this section shall be utilized for dates of service through June 30, 2014. Effective July 1, 2014, nursing facilities shall be reimbursed the price-based methodology described in 12 VAC 30-90-44 except, effective July 1, 2021, for nursing facilities operated by the Department of Veteran Affairs. ~~The last cost report with a fiscal year end before June 30, 2014, shall be used to establish the operating per diem rates for payment for the remainder of state fiscal year 2014. The last cost report with a fiscal year end on or after June 30, 2014, shall be used to settle reimbursement for plan costs, NATCEPS, and criminal records check costs for periods in state fiscal year 2014. Reimbursement for these componensts shall be prorated based on the number of cost report months prior to July 1, 2014, as a percentage of total months in the cost report. Settlement for these components will be based on two months of run-out from the end of the provider's fiscal year. Claims for services paid after the cost report run-out period will not be settled.~~

12VAC 30-90-41.1 Modifications to Nursing Facility Reimbursement Formula. Repealed.

12VAC30-90-42. Repealed.

12VAC30-90-43. Repealed.

12 VAC 30-90-44. Nursing Facility Price Based Payment Methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates in 12 VAC 30-90-41 to a price-based methodology except for nursing facilities operated by the Department of Veteran Affairs. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

~~1.~~ a. The department shall calculate the cost per day in the base year for direct and indirect operating costs for each nursing facility. The department shall use existing definitions of direct and indirect costs.

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b. The initial base year for calculating the cost per day shall be cost reports ending in calendar year 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent, reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1. Effective July 1, 2021 DMAS shall defer the next scheduled nursing facility rate rebasing for one year in order to utilize cost reports ending in 2021as the base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations. No adjustments will be made to the base year data for purposes of rate setting after ~~that date~~ September 1.

c. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost perday by the raw Medicaid facility case-mix that corresponds to the base year by facility.

d. Costs per day shall be inflated to the midpoint of the fiscal year rate period using the moving average Virginia Nursing Home inflation index for the fourth quarter of each year (the midpoint of the fiscal year). Costs in the 2011 base year shall be inflated from the midpoint of the cost report year to the midpoint of fiscal year 2012 by prorating fiscal year

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2012 inflation and annual inflation after that. Annual inflation adjustments shall be based on the last available report prior to the beginning of the fiscal year and corrected for any revisions to prior year inflation. ~~Effective July 1, 2015, therough June 30, 2016, the inflation adjustment for nursing facility operating rates shall be zero (0) percent.~~

e. Prices will be established for the following peer groups using a combination of Medicare wage regions and Medicaid rural and bed size modifications based on similar costs.

The following definitions shall apply to direct peer groups. The Northern Virginia peer group shall be defined as localities in the Washington DC-MD-VA MSA as published by the Centers for Medicare and Medicaid Services (CMS) for skilled nursing facility rates. The Other MSA peer group includes localities in any MSA defined by CMS other than the Northern Virginia MSA and non-MSA designations. The Rural peer groups are non-MSA areas of the state divided into Northern and Southern Rural peer groups based on drawing a line between the following points on the Commonwealth of Virginia map with the coordinates: 37.4203914 Latitude, 82.0201219 Longitude and 37.1223664 Latitude, 76.3457773 Longitude.

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h. The direct and indirect price for each peer group shall be based on the followingadjustment 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, 2021, DMAS shall increase the direct and indirect operating rates under the nursing facility price based reimbursement methodology from 15% to 25.4% above a facility's calculated price-based rates for nursing facilities where 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.

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.

~~j.~~ 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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~~k.~~ l. Resource Utilization Group (RUG) is a resident classification system that groups nursing facility residents according to resource utilization and assigns weights related to the resource utilization for each classification. The department shall use RUGs to determine facility case-mix for cost neutralization as defined in 12 VAC 30-90-306 in determining the direct costs in setting the price and for adjusting the claim payments for residents.

a. The department shall neutralize direct costs per day in the base year using the most current RUG grouper applicable to the base year.

b. The department shall utilize RUG-III, version 34 groups and weights in fiscal years 2015 through 2017 for claim payments.

c. Beginning in fiscal year 2018, the department shall implement RUG-IV, version 48 Medicaid groups and weights for claim payments.

d. RUG-IV, version 48 weights used for claim payments will be normalized to RUG-III, version 34 weights as long as base year costs are neutralized by the RUG-III 34 group. In that the weights are not the same under RUG-IV as under RUG-III, normalization will ensure that total direct operating payments using the RUG-IV 48 weights will be the same as total direct operating payments using the RUG-III 34 grouper.

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

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B. Transition from nursing facility cost based rates to nursing facility price-based rates. The department shall transition to the price-based methodology over a period of four years, blending the adjusted price-based rate with the facility-specific case-mix neutral cost-based rate calculated according to 12 VAC 30-90-41 as if ceilings had been rebased for fiscal year 2015. The cost-based rates are calculated using the 2011 base year data, inflated to 2015 using the inflation methodology in 12 VAC 30-90-41 and adjusted to state fiscal year 2015. In subsequent years of the transition, the cost-based rates shall be increased by inflationdescribed in this section.

~~1. Based on a four-year transition, the rate will be based on the following blend:~~

~~a. Fiscal year 2015 – 25% of the adjusted price-based rate and 75% of the cost-based rate.~~
~~b. Fiscal year 2016 – 50% of the adjusted price-based rate and 50% of the cost-based rate.~~
~~c. Fiscal year 2017 – 75% of the adjusted price-based rate and 25% of the cost-based rate.~~
~~d. Fiscal year 2018 – 100% of the adjusted price-based rate (fully implemented).~~

~~2. During the first transition year for the period July 1, 2014, through October 31, 2014, DMAS shall case-mix adjust each facility's direct cost component of the rates using the average facility case-mix from the two most recent finalized quarters (September and December 2013) instead of adjusting this component claim by claim.~~

~~3.~~ 1. Cost-based rates to be used in the transition for facilities without cost data in the base year but placed in service prior to July 1, 2013, shall be determined based on the most recently settled cost data. If there is no settled cost report at the beginning of a fiscal year, then 100% of the price-based rate shall be used for that fiscal year. Facilities placed in service after June 30, 2013, shall be paid 100% of the price-based rate.

~~4.~~ 2. Effective July 1, 2015, nursing facilities whose licensed bed capacity decreased by at least 30 beds after 2011 and whose occupancy increased from less than 70 percent in 2011 to more than 80 percent in 2013 shall be reimbursed the price-based operating rate rather than the transition operating rate.

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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 nursingfacilities ~~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 inaccordance 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 fiscalyear 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, thenumerator 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.

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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, 2022, specialized care operating rates shall be increasedannually by inflation 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.

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.

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: 21-0015

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: 7/1/2021

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 2021 $ 18,168,123
b. FFY 2022 $ 72,672,486

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, revised pages 9.1.1, 10, 17.1, 17.2, 17.2.2
Attachment 4.19-D, Supplement 1, revised pages 18.1, 21, 23, 26.1, 263, 26.5, new page 26.5.1, revised pages 26.6, 26.7.1, 57

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

Same as box #8.

10. SUBJECT OF AMENDMENT: 2021 Institutional Provider Reimbursement Changes

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: Karen Kimsey

13. TYPED NAME: Karen Kimsey

14. TITLE: Director

15. DATE SUBMITTED: 5/26/2021

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

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

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

A. The base amount shall be updated annually be the DRI-Virginia moving average values as compiled and published by DRIWEFA, Inc. (12 VACJ0-70-351). 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 FTEs 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.

B. Type One hospitals shall be reimbursed l 00 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.

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

D. 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, minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose Medicaid payments are capped by the Centers for Medicare and Medicaid Services, the supplemental payments for each qualifying residency slot shall be $50,000 from the general fund annually minus any Medicare residency payments for which the residency program is eligible. The payments shall be made for up to four (4) years. Payments to hospitals will be made quarterly. Additional criteria include:

I. 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 full must attest (by June I) that the resident(s) have been hired for the start of the academic year and have continued employment with the program each year thereafter.

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State of VIRGINIA
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, 2021 the IME reimbursement for managed care discharges shall be calculated using a case mix adjustment factor of 2.718. This case mix index (CMI) factor shall take precedence over future calculations. Total payments for IME in combination with other payments for CHKD may not exceed the federal uncompensated care cost limit that disproportionate share hospital payments are subject to.

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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

12 VAC 30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.
A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12 VAC 30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio of total capital cost to total charges of the hospital, using data available from Medicare cost report.

12 VAC 30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.

A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all service provided under arrangement that are reimbursed in the manner described in subsection D ofthis section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the program shall take action in accordance with its policies to assure that an overpayment is not being made'

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

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. 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.

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 bythe Medicaid program in the facility's home state or the rate defined in the subsection A of this section.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

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 astate.

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.

D. 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 hospital 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 hospitals would exceed the upper payment limit, the numerator in the calculation of the UPL gap percentage shall be reduced proportionately.

E. Quarterly Payments. After the close of each quarter, beginning with the July l, 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 UPLgap percentage for each hospital.

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

1. Mid-year FRV rate change. Facilities requiring a mid-year FRV rate change must follow the procedures as specified in 4.19-D, Supp 1, pages 1-3.

2. The capital per diem rate for hospital-based nursing facilities shall be the last settled capital per diem.

3. Effective for dates of service on or after July 1, 2021, any nursing facility which thereafter loses its Medicaid capital reimbursement status as a hospital-based nursing facility because a replacement hospital was built at a different location and Medicare rules no longer allow the nursing home's cost to be included on the hospital's Medicare cost report shall have its first FRV capital payment rate set at the maximum FRV rental rate for a new free-standing nursing facility with the date of acquisition for its capital assets being the date the replacement hospital is licensed.

12 VAC 30-90-37. Calculation of FRV Per Diem Rate for Capital. Calculation of FRV Rental Amount. Change of Ownership.

A. Calculation of FRV Per Diem Rate for Capital. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of actual patient days or the required occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see 4.19-D, Supp 1, p 26 (12 VAC 30-90-264) section 10, for special procedures for computing the number of patient days required to meet the required occupancy percentage requirement.

Facilities shall be required to submit a calendar year FRV report covering both NF and specialized care beds to be used to set a prospective FRV rate effective the following July 1 for both the NF and the specialized care facility. The calendar year FRV report shall be submitted by the end of February following the end of the calendar year. FRV reports shall be settled within 90 days of filing the FRV report. For late FRV reports, the prospective rate may be effective 90 days after the date of filing even if after July 1. No capital rate shall be paid between July 1 and the effective date of the prospective FRV rate for a late report.

New nursing facilities or major renovations that qualify for mid-year FRV rate adjustments must follow pro forma submission procedures as specified in 4.19-D, Supp 1, pages 1-3.

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

Article 4
Operating Cost Component

12VAC30-90-40. Operating cost.

A. Effective July 1, 2001, operating cost shall be the total allowable inpatient cost less plant cost or capital, as appropriate, and NATCEPs costs. See Subpart VII (12 VAC 30-90-170) for rate determination procedures for NATCEPs costs. Operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I (12 VAC 30-90-271). Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs or the actual charges by the Central Criminal Records Exchange for criminal records checks for nursing facility employees (see Appendix I (12 VAC 30-90-272)). For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or the occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period times the Medicaid utilization percentage. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90 percent, for dates of service on or after July 1, 2013 shall be 88 percent. For facilities that also provide specialized care services, see 12 VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the occupancy percentage requirement.

12VAC30-90-41. Nursing facility reimbursement formula.

A. Effective on and after July I, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group (RUG) System as defined in Appendix IV (12 VAC 30-90-305 through 307)." The RUG model is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12 VAC 30-90-305 through 307 for details on the Resource Utilization Groups.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the *Social Security Act* as they relate to provision of services, residents' rights and administration and other matters.

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

c. See 12VAC 30-90-307 for the applicability of case-mix indices.

5. Direct and indirect payment methods.

a. Effective for services on or after July 1, 2006, the direct patient care operating ceiling shall be set at 117% of the respective peer group day-weighted median of the facilities' case-mix neutralized direct care operating costs per day. The calculation of the medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group direct patient care operating ceilings shall be revised and case-mix neutralized every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

b. The indirect patient care operating ceiling shall be set at 107% of the respective peer group day-weighted median of the facility's specific indirect operating cost per day. The calculation of the peer group medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

6. Reimbursement for use of specialized treatment beds. Effective for services on and after January 1, 2005, nursing facilities shall be reimbursed an additional $10 per day for those recipients who require a specialized treatment bed due to their having at least one stage IV pressure ulcer. Recipients must meet criteria as outlined in 12 VAC30-60-350, and the additional reimbursement must be preauthorized as provided in 12 VAC30-60-40. Nursing facilities shall not be eligible to receive this reimbursement for individuals whose services are reimbursed under the Specialized Care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12 VAC30-90-41B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.

B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI.

1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

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

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

J. The reimbursement methodology described in this section shall be utilized for dates of service through June 30, 2014. Effective July 1, 2014, nursing facilities shall be reimbursed the price-based methodology described in 12 VAC 30-90-44 except, effective July 1, 2021, for nursing facilities operated by the Department of Veteran Affairs.

12VAC 30-90-41.1 Modifications to Nursing Facility Reimbursement Formula. Repealed. 12VAC30-90-42. Repealed. 12VAC30-90-43. Repealed.

12 VAC 30-90-44. Nursing Facility Price Based Payment Methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates in 12 VAC 30-90-41 to a price-based methodology except for nursing facilities operated by the Department of Veteran Affairs. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

a. The department shall calculate the cost per day in the base year for direct and indirect operating costs for each nursing facility. The department shall use existing definitions of direct and indirect costs.

b. The initial base year for calculating the cost per day shall be cost reports ending in calendaryear 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent, reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1. Effective July 1, 2021 DMAS shall defer the next scheduled nursing facility rate rebasing for one year in order to utilize cost reports ending in 2021as the base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations. No adjustments will be made to the base year data for purposes of rate setting after September 1.

c. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost perday by the raw Medicaid facility case-mix that corresponds to the base year by facility.

d. Costs per day shall be inflated to the midpoint of the fiscal year rate period using the moving average Virginia Nursing Home inflation index for the fourth quarter of each year (the midpoint of the fiscal year). Costs in the 2011 base year shall be inflated from the midpoint of the cost report year to the midpoint of fiscal year 2012 by prorating fiscal year 2012 inflation and annual inflation after that. Annual inflation adjustments shall be based on the last available report prior to the beginning of the fiscal year and corrected for any revisions to prior year inflation.

e. Prices will be established for the following peer groups using a combination of Medicare wage regions and Medicaid rural and bed size modifications based on similar costs.

The following definitions shall apply to direct peer groups. The Northern Virginia peer group shall be defined as localities in the Washington DC-MD-VA MSA as published by the Centers for Medicare and Medicaid Services (CMS) for skilled nursing facility rates. The Other MSA peer group includes localities in any MSA defined by CMS other than the Northern Virginia MSA and non-MSA designations. The Rural peer groups are non-MSA areas of the state divided into Northern and Southern Rural peer groups based on drawing a line between the following points on the Commonwealth of Virginia map with the coordinates: 37.4203914 Latitude, 82.0201219 Longitude and 37.1223664 Latitude, 76.3457773 Longitude.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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h. The direct and indirect price for each peer group shall be based on the followingadjustment 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, 2021, DMAS shall increase the direct and indirect operating rates under the nursing facility price based reimbursement methodology from 15% to 25.4% above a facility's calculated price-based rates for nursing facilities where 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.

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

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l. Resource Utilization Group (RUG) is a resident classification system that groups nursing facility residents according to resource utilization and assigns weights related to the resource utilization for each classification. The department shall use RUGs to determine facility case-mix for cost neutralization as defined in 12 VAC 30-90-306 in determining the direct costs in setting the price and for adjusting the claim payments for residents.

a. The department shall neutralize direct costs per day in the base year using the most current RUG grouper applicable to the base year.

b. The department shall utilize RUG-III, version 34 groups and weights in fiscal years 2015 through 2017 for claim payments.

c. Beginning in fiscal year 2018, the department shall implement RUG-IV, version 48 Medicaid groups and weights for claim payments.

d. RUG-IV, version 48 weights used for claim payments will be normalized to RUG-III, version 34 weights as long as base year costs are neutralized by the RUG-III 34 group. In that the weights are not the same under RUG-IV as under RUG-III, normalization will ensure that total direct operating payments using the RUG-IV 48 weights will be the same as total direct operating payments using the RUG-III 34 grouper.

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

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B. Transition from nursing facility cost based rates to nursing facility price-based rates. The department shall transition to the price-based methodology over a period of four years, blending the adjusted price-based rate with the facility-specific case-mix neutral cost-based rate calculated according to 12 VAC 30-90-41 as if ceilings had been rebased for fiscal year 2015. The cost-based rates are calculated using the 2011 base year data, inflated to 2015 using the inflation methodology in 12 VAC 30-90-41 and adjusted to state fiscal year 2015. In subsequent years of the transition, the cost-based rates shall be increased by inflationdescribed in this section.

1. Cost-based rates to be used in the transition for facilities without cost data in the base year but placed in service prior to July 1, 2013, shall be determined based on the most recently settled costdata. If there is no settled cost report at the beginning of a fiscal year, then 100% of the price-based rate shall be used for that fiscal year. Facilities placed in service after June 30, 2013, shall be paid 100% of the price-based rate.

2. Effective July 1, 2015, nursing facilities whose licensed bed capacity decreased by at least 30 beds after 2011 and whose occupancy increased from less than 70 percent in 2011 to more than 80 percent in 2013 shall be reimbursed the price-based operating rate rather than the transition operating rate.

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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. 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 inaccordance 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 fiscalyear 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, thenumerator 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.

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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, 2022, specialized care operating rates shall be increasedannually by inflation 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.

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.