COMMONWEALTH of VIRGINIA
Office of the Governor

Janet Vestal Kelly
Secretary of Health and Human Resources

August 26, 2024

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 24-0017, entitled "2024 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,

Janet V. Kelly

Attachment
cc: Cheryl J. Roberts, Director, Department of Medical Assistance Services
CMS, Region III

Transmittal Summary

SPA 24-017

I. IDENTIFICATION INFORMATION

Title of Amendment: 2024 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.

Purpose: The 2024 Appropriations Act requires DMAS to make the following two changes:

- Item 288.HH.5: The state plan is being amended to revise reimbursement methodologies for Psychiatric Residential Treatment Facilities (PRTFs) rates to implement inflation increases for each fiscal year to be effective July 1, 2024. Inflation rates shall be tied to the Nursing Facility Moving Average as established by IHS Markit (or its successor). The most recent four quarters will be averaged to create the PRTF inflation rate.
- Item 288.PP.2: The state plan is being revised to make hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs effective June 2, 2017 equal the greater of what would have been paid to the freestanding children's hospitals under the current uncompensated care formula or $16,000,000 annually, the average due by formula prior to Medicaid expansion without regard to the uncompensated care cost limit.

The state plan is also being revised to correct language to be consistent with current DMAS policies and regulations. Specifically, the state plan is being revised to remove two phrases that pertain to adjustment factors for Type Two hospitals that were not authorized by the Virginia General Assembly or approved by CMS for addition to the state plan. As stated below, there are no costs associated with these changes because the phrases were unauthorized errors.

Substance and Analysis: The section of the State Plan that is affected by this amendment is "Methods & Standards for Establishing Payment Rates-Inpatient Care"

Impact:

- Item 288.HH.5. There is no expected increase or decrease in annual fee-for-service aggregate expenditures in federal fiscal year 2024 or 2025.
- Item 288.PP.2. The expected increase in annual aggregate fee-for-service expenditures is $1,960,400 in state general funds and $2,039,600 in federal funds in federal fiscal year 2024

and $7,841,600 in state general funds and $8,158,400 in federal funds in federal fiscal year 2025.

- Type Two Hospital Adjustment Factor Correction. There is no expected increase or decrease in annual fee-for-service aggregate expenditures in federal fiscal year 2024 or 2025.

Tribal Notice: Please see attached.

Prior Public Notice: See Attached.

Public Comments and Agency Analysis: Please see attached.

Tribal Notice – Institutional Provider Reimbursement Changes

Lee, Meredith (DMAS) <Meredith.Lee@dmas.virginia.gov>

Wed 8/7/2024 3:28 PM

To:TribalOffice@MonacanNation.com <TribalOffice@MonacanNation.com>;Ann Richardson <chiefannerich@aol.com>; pamelathompson4@yahoo.com (pamelathompson4@yahoo.com) <pamelathompson4@yahoo.com>;rappahannocktrib@aol.com (rappahannocktrib@aol.com) <rappahannocktrib@aol.com>;regstew007@gmail.com (regstew007@gmail.com) <regstew007@gmail.com>;Gray, Robert <robert.gray@pamunkey.org>;Adrian Compton <tribaladmin@monacannation.com>; chiefstephenadkins@gmail.com (chiefstephenadkins@gmail.com) <chiefstephenadkins@gmail.com>;bradbybrown@gmail.com (bradbybrown@gmail.com) <bradbybrown@gmail.com>;tabitha.garrett@ihs.gov (tabitha.garrett@ihs.gov) <tabitha.garrett@ihs.gov>; kara.kearns@ihs.gov (kara.kearns@ihs.gov) <kara.kearns@ihs.gov>;ReBecca.Robinson@ihs.gov <ReBecca.Robinson@ihs.gov>; davehennaman@gmail.com <davehennaman@gmail.com>;administrator@nansemond.gov <administrator@nansemond.gov>; info@afwellness.com <info@afwellness.com>;info@fishingpointhc.com <info@fishingpointhc.com>;contact@Nansemond.gov <contact@Nansemond.gov>;brandon.custalow@mattaponination.com <brandon.custalow@mattaponination.com>; admin@umitribe.org <admin@umitribe.org>;Reels-Pearson, Lorraine (IHS/NAS/AO) <Lorraine.Reels-Pearson@ihs.gov>

1 attachments (179 KB)

Tribal Notice letter 08-07-24, signed by CR.pdf;

Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid Director, Cheryl Roberts, indicating that the Department of Medical Assistance Services (DMAS) plans to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services. This SPA will allow DMAS to make institutional provider reimbursement changes.

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! -- Meredith

Meredith Lee
Policy, Regulations, and Manuals Supervisor
Policy Division
Department of Medical Assistance Services
meredith.lee@dmas.virginia.gov, (804) 371-0552
Hours: 7:00 am - 3:30 pm (Monday-Friday)
www.dmas.virginia.gov

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL J. ROBERTS
DIRECTOR

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

August 7, 2024

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to 2024 Institutional Provider Reimbursement Changes.

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 to make the following institutional (inpatient) changes arising out of the 2024 Appropriations Act:

- In accordance with Item 288.HH.5, the state plan is being amended to revise reimbursement methodologies for Psychiatric Residential Treatment Facilities (PRTFs) rates to implement inflation increases for each fiscal year to be effective July 1, 2024. Inflation rates shall be tied to the Nursing Facility Moving Average as established by IHS Markit (or its successor). The most recent four quarters will be averaged to create the PRTF inflation rate.

- In accordance with Item 288.PP.2, the state plan is being revised to make hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs effective June 2, 2017 equal the greater of what would have been paid to the freestanding children's hospitals under the current uncompensated care formula or $16,000,000 annually, the average due by formula prior to Medicaid expansion without regard to the uncompensated care cost limit.

This SPA will also correct language to be consistent with current DMAS policies and regulations. Specifically, the state plan is being revised to remove two phrases that pertain to adjustment factors for Type Two hospitals that were not authorized by the Virginia General Assembly or approved by CMS for addition to the state plan.

We realize that the changes in this SPA may impact Medicaid members and providers, including tribal members and providers. Therefore, we encourage you to let us know if you have any comments or questions. The tribal comment period for this SPA is open through September 6, 2024. You may submit your comments directly to Meredith Lee, DMAS Policy Division, by phone (804) 371-0552, or via email: Meredith.Lee@dmas.virginia.gov. Finally, if you prefer regular mail you may send your comments or questions to:

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

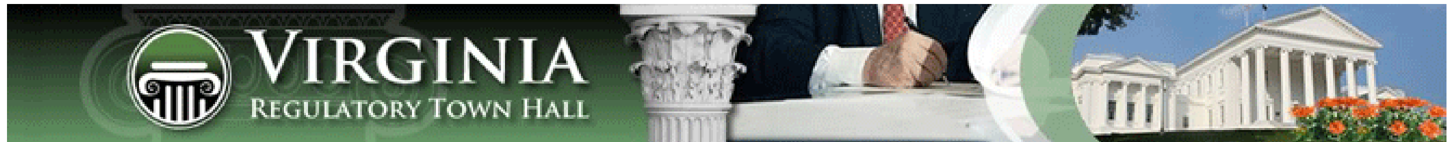
Please forward this information to any interested party.

Sincerely,

Cheryl J. Roberts, JD
Director

Department of Planning and Budget
An official website Here's how you know

Find a Commonwealth Resource



Agency Department of Medical Assistance Services

Board Board of Medical Assistance Services

Edit Notice

General Notice

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

Date Posted: 5/24/2024

Expiration Date: 11/24/2024

Submitted to Registrar for publication: YES

30 Day Comment Forum closed. Began on 5/24/2024 and ended 6/23/2024

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 24, 2024

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)*.

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 Meredith Lee, DMAS, 600 Broad Street, Suite 1300, Richmond, VA 23219, or via e-mail at: Meredith.Lee@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 Meredith Lee 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 (**https://townhall.virginia.gov**) 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 Item 288.HH.5 of the 2024 Appropriations Act, the state plan is being amended to revise reimbursement methodologies for Psychiatric Residential Treatment Facilities (PRTFs) rates to implement inflation increases for each fiscal year to be effective July 1, 2024. Inflation rates shall be tied

to the Nursing Facility Moving Average as established by IHS Markit (or its successor). The most recent four quarters will be averaged to create the PRTF inflation rate.

There is no expected increase or decrease in annual fee-for-service aggregate expenditures in federal fiscal year 2024 or 2025.

2. To correct language to be consistent with current DMAS policies and regulations, the state plan is being revised to remove two phrases that pertain to adjustment factors for Type Two hospitals that were not authorized by the Virginia General Assembly or approved by CMS for addition to the state plan. As stated below, there are no costs associated with these changes because the phrases were unauthorized errors.

There is no expected increase or decrease in annual fee-for-service aggregate expenditures in federal fiscal year 2024 or 2025.

3. In accordance with Item 288.PP.2 of the 2024 Appropriations Act, the state plan is being revised to make hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs effective June 2, 2017 equal the greater of what would have been paid to the freestanding children's hospitals under the current uncompensated care formula or $16,000,000 annually, the average due by formula prior to Medicaid expansion without regard to the uncompensated care cost limit.

The expected increase in annual aggregate fee-for-service expenditures is $1,960,400 in state general funds and $2,039,600 in federal funds in federal fiscal year 2024 and $7,841,600 in state general funds and $8,158,400 in federal funds in federal fiscal year 2025.

Contact Information

Name / Title:	Meredith Lee / *Policy, Regulations, and Manuals Supervisor*
Address:	Division of Policy and Research 600 East Broad Street, Suite 1300 Richmond, 23219
Email Address:	Meredith.Lee@dmas.virginia.gov
Telephone:	(804)371-0552 FAX: (804)786-1680 TDD: (800)343-0634

This general notice was created by Meredith Lee on 05/24/2024 at 7:50am

Public comment forums

Make your voice heard! Public comment forums allow all Virginia's citizens to participate in making and changing our state regulations.

See our public comment policy

Currently showing **14** comment forums closed within the last 45 days for the Board of Medical Assistance Services.

Recently closed
Recently opened
Active Forums
More filter options

Regulatory Activity Forums (12) | Guidance Document Forums (2)

Actions (3) | Periodic Reviews () | Petitions for Rulemaking () | General Notices (9)

Board of Medical Assistance Services

View Comments	Public Notice - Intent to Amend State Plan - Institutional Provider Reimbursement Changes	**General Notice** Public Notice - Intent to Amend State Plan - Institutional Provider Reimbursement Changes Closed: 6/23/24 0 comments

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

For Type Two hospitals the adjustment factor shall be:

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

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

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

C. For critical access hospitals, the operating rates hall be increased by using an adjustment factor of 1.0, effective July I, 2019.

12VAC30-70-340. Repealed.

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

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

B. The adjustment factor for acute care rehabilitation cases shall be the one specified in subsection B of 12 VAC30-70-331.

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

I. Type One hospitals shall be the one specified in subdivision BI of 12VAC30-70-33 l times the factor in subdivision C2of 12VAC30-70-341 divided by the factor in subdivision B 2of 12VAC30-70-331.

2. Type Two hospitals shall be:

a. 0.7800effectiveJuly l, 2006,throughJune30, 2007.

b. 0.8400effectiveJuly l, 2007,throughJune30, 2010.

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

d. 0.8400 effective October l, 2010~~, through September 30,2010~~.

3. Effective July I, 2019, for critical access hospitals, the inpatient operating rate per day shall be increased using an adjustment factor or percent of cost reimbursement equal to I00%.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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 with the provider and establish a single-case agreement. If there is sufficient utilization, the department may require out-of-state providers to submit a cost report to establish a per diem rate. In-state and out-of-state provider per diem rates shall be subject to a ceiling based on the statewide weighted average cost per day from fiscal year 2018 cost reports.

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

DMAS shall also establish inflation increases for each non-rebasing fiscal year for both PRTF and qualifying ARTS providers. Effective July 1, 2024, the department shall implement inflation increases for each fiscal year (rebasing and non-rebasing fiscal years) for PRTF providers. Inflation rates shall be tied to the Nursing Facility Moving Average as established by IHS Markit (or its successor). The most recent four quarters will be averaged to create the PRTF inflation rate.

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

Supplemental Payments for Freestanding Children's Hospitals (12VAC 30-70-427)

Effective May 15, 2021, freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 will receive additional hospital supplemental payments equal to what would have been paid under the disproportionate share hospital (DSH) formula in effect prior to June 2, 2017, without regard to the uncompensated care cost limit.

Effective July 1, 2024, these payments shall equal the greater of what would have been paid to the freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 under the current disproportionate share hospital (DSH) formula or $16,000,000 annually, the average DSH that the freestanding children's hospital was due by formula prior to Medicaid expansion without regard to the uncompensated care cost limit.

These additional hospital supplemental payments shall take precedence over supplemental payments for private acute care hospitals. If the federal regulation is voided, DMAS shall continue DSH payments to the impacted hospitals and adjust the additional hospital supplemental payments authorized in this paragraph accordingly. ~~The department shall have the authority to implement these changes effective May 15, 2021, and prior to completion of any regulatory action to effect such changes.~~

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER

2. STATE

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

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

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY_____ $ _____
b. FFY_____ $ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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

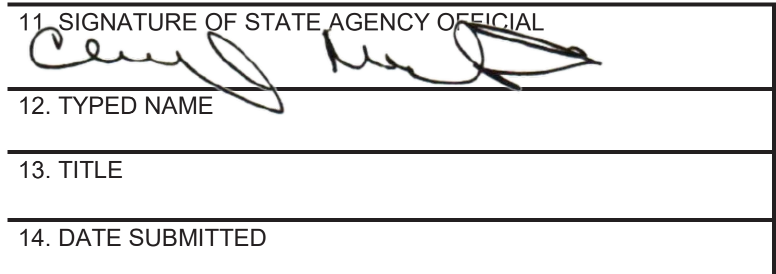
9. SUBJECT OF AMENDMENT

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

GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
Secretary of Health and Human Resources

11. SIGNATURE OF STATE AGENCY OFFICIAL



12. TYPED NAME

13. TITLE

14. DATE SUBMITTED

15. RETURN TO

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

For Type Two hospitals the adjustment factor shall be:

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3. Effective July I, 2019, for critical access hospitals, the inpatient operating rate per day shall be increased using an adjustment factor or percent of cost reimbursement equal to I00%.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

Supplemental Payments for Freestanding Children's Hospitals (12VAC 30-70-427)

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Effective July 1, 2024, these payments shall equal the greater of what would have been paid to the freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 under the current disproportionate share hospital (DSH) formula or $16,000,000 annually, the average DSH that the freestanding children's hospital was due by formula prior to Medicaid expansion without regard to the uncompensated care cost limit.

These additional hospital supplemental payments shall take precedence over supplemental payments for private acute care hospitals. If the federal regulation is voided, DMAS shall continue DSH payments to the impacted hospitals and adjust the additional hospital supplemental payments authorized in this paragraph accordingly.