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State/Territory Name: VA

State Plan Amendment (SPA) #: 24-0017

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

October 9, 2024

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

RE: TN 24-0017

Dear Agency Director:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed District of Columbia state plan amendment (SPA) to Attachment 4.19-A VA 24-0017, which was submitted to CMS on (September 9, 2024). This plan amendment revises the reimbursement methodologies for Psychiatric Residential Treatment Facilities (PRTF) and hospital supplement payments for freestanding children's hospitals with greater than fifty percent Medicaid utilization.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

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

Sincerely,

Rory Howe

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0017

2. STATE: VA

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

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

4. PROPOSED EFFECTIVE DATE
7/1/2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 2,039,600
b. FFY 2025 $ 8,158,400

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, revised pages 12.1, 17.2, and 17.3

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

9. SUBJECT OF AMENDMENT

2024 Institutional Provider Reimbursement Changes

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

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Secretary of Health and Human Resources

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Cheryl J. Roberts

13. TITLE
Director

14. DATE SUBMITTED
08/07/24

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

Attn: Policy, Regulations, and Manuals Supervisor

FOR CMS USE ONLY

16. DATE RECEIVED
September 9, 2024

17. DATE APPROVED
October 9, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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 1, 2010.

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. 0.7800 effective July l, 2006, through June30, 2007.

b. 0.8400 effective July l, 2007, through June30, 2010.

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

d. 0.8400 effective October l, 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.