COMMONWEALTH of VIRGINIA
Office of the Governor

Janet Vestal Kelly
Secretary of Health and Human Resources

August 18, 2025

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 25-011, entitled "2025 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

Janet V. Kelly

Attachment

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

Transmittal Summary

SPA 25-011

I. IDENTIFICATION INFORMATION

Title of Amendment: 2025 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 2025 Appropriations Act requires DMAS to make the following changes:

- Item 288.MMMMM: The state plan is being revised to include a provision for payment of medical assistance for FDA approved long-acting injectable or extended-release medications administered for a serious mental illness or substance use disorder in any hospital inpatient setting. This payment shall be unbundled from the hospital rate.

- Item 288.RRRRR: The state plan is being revised to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, not to exceed $30,000,000 total computable for teaching hospitals affiliated with Virginia Tech Carilion School of Medicine. The public entity shall transfer the non-federal share of the authorized supplemental payments. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. Such funds may not be paid from any private agreements with Virginia Tech Carilion School of Medicine that are in excess of fair market value or that alleviate pre-existing financial burdens of the school. The Virginia Tech Carilion School of Medicine is authorized to use general fund dollars to accomplish this transfer. The Virginia Tech Carilion School of Medicine would enter into an Interagency Agreement with the department for this purpose and must attest to compliance with applicable CMS criteria.

- Item 3-5.15: The state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for inpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

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

Impact:

- Item 288.MMMMM: There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025 or federal fiscal year 2026.

- Item 288.RRRRR: There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025. The expected increase in annual fee-for-service aggregate expenditures is $8,297,630 in state general funds and $21,702,370 in federal funds in federal fiscal year 2026.

- Item 3-5.15: There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025. The expected increase in annual fee-for-service aggregate expenditures is $308,224 in state general funds and $621,882 in federal funds in federal fiscal year 2026.

Tribal Notice: Please see attached.

Prior Public Notice: See Attached.

Public Comments and Agency Analysis: One tribal comment was submitted that indicated no meeting was necessary and there were no substantive comments.

Outlook

Tribal Notice –2025 Institutional Provider Reimbursement Changes

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

Date Tue 8/12/2025 3:30 PM

To TribalOffice@MonacanNation.com <tribaloffice@monacannation.com>; Ann Richardson <chiefannerich@aol.com>; pamelathompson4@yahoo.com <pamelathompson4@yahoo.com>; rappahannocktrib@aol.com <rappahannocktrib@aol.com>; regstew007@gmail.com <regstew007@gmail.com>; Richard.matens@pamunkey.org <richard.matens@pamunkey.org>; Chief Diane Shields <chief@monacannation.gov>; chiefstephenadkins@gmail.com <chiefstephenadkins@gmail.com>; bradbybrown@gmail.com <bradbybrown@gmail.com>; tabitha.garrett@ihs.gov <tabitha.garrett@ihs.gov>; kara.kearns@ihs.gov <kara.kearns@ihs.gov>; administrator@nansemond.gov <administrator@nansemond.gov>; Information <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>; Holmes, Remedios (IHS/NAS/RIC) <remedios.holmes@ihs.gov>; Lindsey.Taylor@ihs.gov <lindsey.taylor@ihs.gov>

1 attachment (178 KB)

Tribal Notice Letter 08-12-25, signed.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 changes to institutional provider reimbursement.

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 Lee

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

CHERYL J. ROBERTS
DIRECTOR

Department of Medical Assistance Services

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

August 12, 2025

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to 2025 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 changes to the state plan to comply with the 2025 Appropriations Act:

- Item 288.MMMMM: The state plan is being revised to include a provision for payment of medical assistance for FDA approved long-acting injectable or extended-release medications administered for a serious mental illness or substance use disorder in any hospital inpatient setting. This payment shall be unbundled from the hospital rate.

- Item 288.RRRRR: The state plan is being revised to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, not to exceed $30,000,000 total computable for teaching hospitals affiliated with Virginia Tech Carilion School of Medicine. The public entity shall transfer the non-federal share of the authorized supplemental payments. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. Such funds may not be paid from any private agreements with Virginia Tech Carilion School of Medicine that are in excess of fair market value or that alleviate pre-existing financial burdens of the school. The Virginia Tech Carilion School of Medicine is authorized to use general fund dollars to accomplish this transfer. The Virginia Tech Carilion School of Medicine would enter into an Interagency Agreement with the department for this purpose and must attest to compliance with applicable CMS criteria.

- Item 3-5.15: The state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for inpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

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 11, 2025. 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

Agency **Department of Medical Assistance Services**

Board **Board of Medical Assistance Services**

Edit Notice

General Notice

Public Notice - Intent to Amend State Plan - 2025 Institutional Provider Reimbursement Changes

Date Posted: 5/30/2025

Expiration Date: 11/30/2025

Submitted to Registrar for publication: YES

30 Day Comment Forum closed. Began on 5/30/2025 and ended 6/29/2025

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 30, 2025

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 — In-Patient Hospital 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**

In accordance with the 2025 Appropriations Act, DMAS will be making the following changes:

Methods & Standards for Establishing Payment Rates-In-Patient Hospital Care (12 VAC 30-70)

1. In accordance with Item 288.MMMMM, the state plan is being revised to include a provision for payment of medical assistance for FDA approved long-acting injectable or extended-release medications administered for a serious mental illness or substance use disorder in any hospital inpatient setting. This payment shall be unbundled from the hospital rate.

There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025 or federal fiscal year 2026.

2. In accordance with Item 288.RRRRR, the state plan is being revised to make supplemental payments through an adjustment to the formula for indirect medical education (IME) reimbursement, using managed care discharge days, not to exceed $30,000,000 total computable for teaching hospitals affiliated with Virginia Tech Carilion School of Medicine. The public entity shall transfer the non-federal share of the authorized supplemental payments. The funds to be transferred must comply with 42 CFR 433.51 and 433.54. Such funds may not be paid from any private agreements with Virginia Tech Carilion School of Medicine that are in excess of fair market value or that alleviate pre-existing financial burdens of the school. The Virginia Tech Carilion School of Medicine is authorized to use general fund dollars to accomplish this transfer. The Virginia Tech Carilion School of Medicine would enter into an Interagency Agreement with the department for this purpose and must attest to compliance with applicable CMS criteria.

There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025. The expected increase in annual fee-for-service aggregate expenditures is $8,297,630 in state general funds and $21,702,370 in federal funds in federal fiscal year 2026.

3. In accordance with Item 3-5.15, the state plan is being revised to broaden the types of hospitals that qualify for supplemental payments for inpatient services to Medicaid patients. Specifically, all private hospitals will include critical access hospitals. (The provider rate assessment is used to fund the state general fund of the hospital supplemental payments and the change in how private hospitals is defined will increase the number of hospitals participating in the assessment.)

There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2025. The expected increase in annual fee-for-service aggregate expenditures is $308,224 in state general funds and $621,882 in federal funds in federal fiscal year 2026.

Contact Information

Name / Title:	Meredith Lee / *Policy, Regulations, and Manuals Supervisor*
Address:	600 E Broad Street Richmond, 23219
Email Address:	**meredith.lee@dmas.virginia.gov**
Telephone:	(804)371-0552 FAX: (804)768-1680 TDD: (800)343-0634

This general notice was created by Meredith Lee on 05/30/2025 at 7:36am
This general notice was last modified by Meredith Lee on 05/30/2025 at 7:40am

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 **34** comment forums closed within the last 21 days

Recently closed
Recently opened
Active Forums
More filter options

Regulatory Activity Forums (30) | Guidance Document Forums (4)

Actions (12) | Periodic Reviews (13) | Petitions for Rulemaking (1) | General Notices (4)

Board of Medical Assistance Services

View Comments	Public Notice - Intent to Amend State Plan - 2025 Institutional Provider Reimbursement Changes	General Notice Public Notice - Intent to Amend State Plan - 2025 Institutional Provider Reimbursement Changes Closed: 6/29/25 0 comments

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post- hospitalization for the transplant procedure or pre-transplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

E. Effective July 1, 2025, a provision for payment shall be made for FDA approved long-acting injectable or extended-release medications administered for serious mental illness or substance use disorder in any hospital inpatient setting. This payment shall be unbundled from the hospital daily rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

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

4. Effective November 1, 2024, an additional IME payment for managed care discharges shall be made annually to an acute care hospital with a level one trauma center in the Tidewater Metropolitan Statistical Area (MSA) in 2020. The payment shall be based on the formula for Type One hospitals in paragraph 2 (using an IME percentage as determined in subsection B of this section) minus the IME payment for managed care discharges based on the formula for Type Two hospitals in paragraph 1. This additional IME payment shall not exceed $43 million in FY25. In future years, the payment shall be determined at the beginning of the fiscal year using the most current information available and shall be final.

5. Effective July 1, 2025, an additional IME payment for managed care discharges shall be made annually to teaching hospitals affiliated with Virginia Tech Carilion School of Medicine. The payment shall be based on the formula for Type One hospitals in paragraph 2 (using an IME percentage as determined in subsection B of this section) minus the IME payment for managed care discharges based on the formula for Type Two hospitals in paragraph 1. This additional IME payment shall not exceed $30 million.

D. 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 utilization in 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 percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

E. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICE

[Text moved down from Page 10]

F. 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 may not 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.

G. Effective July 1, 2018, an additional $362,360 IME payment shall be added to the IME payment calculated in Section B.2 for the Children's National Medical Center.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

12 VAC 30-70-429. Supplemental Payments for Private ~~Acute Care~~ Hospitals.

A. Effective October 1, 2018, supplemental payments will be issued to qualifying hospitals for inpatient services provided to Medicaid patients.

B. Definitions. As used in this section:

"Acute care hospital" means any hospital that provides emergency medical services on a 24-hour basis.

"Children's hospital" means a hospital (i) whose inpatients are predominantly under 18 years of age and (ii) which is excluded from the Medicare prospective payment system pursuant to the Social Security Act.

"Critical access hospital" means a facility that meets the requirements of the State Medicare Rural Hospital Flexibility Program (Flex), 42 U.S.C. 1395i-4, for such designation.

"Freestanding psychiatric and rehabilitation hospital" means a freestanding psychiatric hospital, which means a hospital that provides services consistent with 42 CFR 482.60, or a freestanding rehabilitation hospital, which means a hospital that provides services consistent with 42 CFR 482.56.

"Hospital" means a medical care facility licensed as an inpatient hospital or outpatient surgical center by the Department of Health or as a psychiatric hospital by the Department of Behavioral Health and Developmental Services.

"Long stay hospital" means specialty facilities that serve individuals receiving medical assistance who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide.

"Long-term acute care hospital" or "LTACH" means an inpatient hospital that provides care for patients who require a length of stay greater than 25 days and is, or proposes to be, certified by CMS as a long-term care inpatient hospital pursuant to 42 CFR Part 412. A LTACH may be either a freestanding facility or located within an existing or host hospital.

"Public hospital" means a hospital that is solely owned by a government or governmental entity.

"Supplemental payment" means an increased payment to a qualifying hospital up to the upper payment limit gap from the Health Care Provider Rate Assessment Fund as authorized in the 2018 Appropriation Act.

"Upper payment limit" means the limit on payment for inpatient services for recipients of medical assistance established in accordance with 42 CFR 447.272 and on payment for outpatient services for recipients of medical assistance pursuant to 42 CFR 447.321 for private hospitals.

"Upper payment limit gap" means the difference between the amount of the private acute care hospital upper payment limits estimated for the rate year using the last available cost report data and the amount estimated would otherwise be paid for the same rate year pursuant to the reimbursement methodology for inpatient and outpatient services. The upper payment limit payment gap shall be updated annually for each rate year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. Qualifying Criteria. Qualifying hospitals are all in-state private ~~acute care~~ hospitals, including acute care hospitals and critical access hospitals, and excluding public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, and long-term acute care hospitals ~~and critical access hospitals~~.

D. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital claim payments times the "UPL gap percentage".

1. The annual UPL gap percentage is the percentage calculated when the numerator is the upper payment limit gap for inpatient services for private hospitals and the denominator is Medicaid claim payments to all qualifying hospitals for inpatient hospital services provided to Medicaid patients in the same year used in the numerator.

2. The UPL gap percentage will be calculated annually.

E. Quarterly Payments. After the close of each quarter, beginning with the quarter including the CMS effective date of all necessary state plan amendments authorizing increased payments to qualifying hospitals, each qualifying hospital shall receive supplemental payments for the inpatient services paid during that quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated based on the Medicaid inpatient hospital payments paid in that quarter multiplied by the annual UPL gap percentage.

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: 25-0011

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
7/1/2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 22,324,252

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, revised pages 1.1, 10, 10-A, 17.5 and 17.6

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

9. SUBJECT OF AMENDMENT

2025 Institutional Provider Reimbursment 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
Agency Director

14. DATE SUBMITTED
August 12, 2025

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

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

D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post- hospitalization for the transplant procedure or pre-transplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

E. Effective July 1, 2025, a provision for payment shall be made for FDA approved long-acting injectable or extended-release medications administered for serious mental illness or substance use disorder in any hospital inpatient setting. This payment shall be unbundled from the hospital daily rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

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

4. Effective November 1, 2024, an additional IME payment for managed care discharges shall be made annually to an acute care hospital with a level one trauma center in the Tidewater Metropolitan Statistical Area (MSA) in 2020. The payment shall be based on the formula for Type One hospitals in paragraph 2 (using an IME percentage as determined in subsection B of this section) minus the IME payment for managed care discharges based on the formula for Type Two hospitals in paragraph 1. This additional IME payment shall not exceed $43 million in FY25. In future years, the payment shall be determined at the beginning of the fiscal year using the most current information available and shall be final.

5. Effective July 1, 2025, an additional IME payment for managed care discharges shall be made annually to teaching hospitals affiliated with Virginia Tech Carilion School of Medicine. The payment shall be based on the formula for Type One hospitals in paragraph 2 (using an IME percentage as determined in subsection B of this section) minus the IME payment for managed care discharges based on the formula for Type Two hospitals in paragraph 1. This additional IME payment shall not exceed $30 million.

D. 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 utilization in 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 percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

E. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICE

[Text moved down from Page 10]

F. 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 may not 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.

G. Effective July 1, 2018, an additional $362,360 IME payment shall be added to the IME payment calculated in Section B.2 for the Children's National Medical Center.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

12 VAC 30-70-429. Supplemental Payments for Private Hospitals.

A. Effective October 1, 2018, supplemental payments will be issued to qualifying hospitals for inpatient services provided to Medicaid patients.

B. Definitions. As used in this section:

"Acute care hospital" means any hospital that provides emergency medical services on a 24-hour basis.

"Children's hospital" means a hospital (i) whose inpatients are predominantly under 18 years of age and (ii) which is excluded from the Medicare prospective payment system pursuant to the Social Security Act.

"Critical access hospital" means a facility that meets the requirements of the State Medicare Rural Hospital Flexibility Program (Flex), 42 U.S.C. 1395i-4, for such designation.

"Freestanding psychiatric and rehabilitation hospital" means a freestanding psychiatric hospital, which means a hospital that provides services consistent with 42 CFR 482.60, or a freestanding rehabilitation hospital, which means a hospital that provides services consistent with 42 CFR 482.56.

"Hospital" means a medical care facility licensed as an inpatient hospital or outpatient surgical center by the Department of Health or as a psychiatric hospital by the Department of Behavioral Health and Developmental Services.

"Long stay hospital" means specialty facilities that serve individuals receiving medical assistance who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide.

"Long-term acute care hospital" or "LTACH" means an inpatient hospital that provides care for patients who require a length of stay greater than 25 days and is, or proposes to be, certified by CMS as a long-term care inpatient hospital pursuant to 42 CFR Part 412. A LTACH may be either a freestanding facility or located within an existing or host hospital.

"Public hospital" means a hospital that is solely owned by a government or governmental entity.

"Supplemental payment" means an increased payment to a qualifying hospital up to the upper payment limit gap from the Health Care Provider Rate Assessment Fund as authorized in the 2018 Appropriation Act.

"Upper payment limit" means the limit on payment for inpatient services for recipients of medical assistance established in accordance with 42 CFR 447.272 and on payment for outpatient services for recipients of medical assistance pursuant to 42 CFR 447.321 for private hospitals.

"Upper payment limit gap" means the difference between the amount of the private acute care hospital upper payment limits estimated for the rate year using the last available cost report data and the amount estimated would otherwise be paid for the same rate year pursuant to the reimbursement methodology for inpatient and outpatient services. The upper payment limit payment gap shall be updated annually for each rate year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. Qualifying Criteria. Qualifying hospitals are all in-state private hospitals, including acute care hospitals and critical access hospitals, and excluding public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, and long stay hospitals, and long- term acute care hospitals.

D. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital claim payments times the "UPL gap percentage".

1. The annual UPL gap percentage is the percentage calculated when the numerator is the upper payment limit gap for inpatient services for private hospitals and the denominator is Medicaid claim payments to all qualifying hospitals for inpatient hospital services provided to Medicaid patients in the same year used in the numerator.

2. The UPL gap percentage will be calculated annually.

E. Quarterly Payments. After the close of each quarter, beginning with the quarter including the CMS effective date of all necessary state plan amendments authorizing increased payments to qualifying hospitals, each qualifying hospital shall receive supplemental payments for the inpatient services paid during that quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated based on the Medicaid inpatient hospital payments paid in that quarter multiplied by the annual UPL gap percentage.