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The state agency will pay the reasonable cost of in-patient hospital services provided under the Plan. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of medical assistance.

I. For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the state agency will apply the standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine service costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routine service charges or patient days as well as Title XVIII inpatient routine service cost.

II. For each hospital not participating in the Program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

III. For either participating or nonparticipating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services that the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary, HHS on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in paragraphs (a) and (b) above.

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural - 0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban - 0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Centers for Medicare and Medicaid Services in determining routine cost limitations.

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(2) Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982 were subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, based on available, allowable cost data for hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were re-adjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986 and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

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Effective on and after July 1, 1988 and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation shall be based on the percent of change in the Virginia moving average values as compiled and published by Global Insight (or its successor) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988 for all such hospitals shall be adjusted to reflect this change.

Effective on or after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation, shall be based on the percent of change in the Virginia values as compiled by Global Insight (or its successor) determined in the quarter in which the provider's new fiscal year begins. Such providers shall have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989 for all such hospitals shall be adjusted to reflect this change.

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described in this section, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points, (200 basis points) to the then current allowance for inflation. The escalation factor shall be applied in accordance with the inpatient hospital reimbursement methodology in effect on June 30, 1992. On July 1, 1992 the conversion to the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992 and their next fiscal year ending on or before May 31, 1993.

Effective July 1, 2009, the escalation factor shall be equal to the allowance for inflation.

Effective July 1, 2010 through June 30, 2012, the escalation factor shall be zero. In addition, ceilings shall remain at the same level as the ceilings for long stay hospitals with fiscal year ends of June 30, 2010.

Effective July 1, 2012, through June 30, 2013, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 2.6 percent.

Effective July 1, 2013, through June 30, 2014, the escalation factor for inpatient hospitals, including long stay hospitals, shall be 00 percent.

The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

(3) Subsequent to June 30, 1992, the group ceilings shall not be recalculated on allowable costs, but shall be updated by the escalator factor.

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(4) Prospective rates for each hospital shall be based upon the hospital's allowable costs plus the escalator factor, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment shall be made to prospective rates.

Capital and education costs approved pursuant to PRM-15 (§400), shall be considered as pass throughs and not part of the calculation. Capital cost is reimbursed the percentage of allowable cost specified in 12VAC30-70-271.

(5) An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 10.5% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report. Effective for dates of service July 1, 2010 through September 30, 2010, the incentive plan shall be eliminated.

(6) There shall be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.

(7) Disproportionate share hospitals defined.

Prior to July 1, 2014, the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share pay. Effective July 1, 2014, the payment methodology for DSH is defined in 12 VAC 30-70-301 beginning on page 10.1 of Attachent 4.19-A.

A. Criteria

1. A Medicaid inpatient utilization rate in excess of 10.5% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

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2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subsection A.2 does not apply to a hospital:

   a. at which the inpatients are predominantly individuals under 18 years of age; or

   b. which does not offer nonemergency obstetric services as of December 21, 1987.

B. Payment Adjustment.

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the type of hospital and on the individual hospital's Medicaid utilization. There shall be two types of hospitals: (i) Type One, consisting of state-owned teaching hospitals, and (ii) Type Two, consisting of all other hospitals. The Medicaid utilization shall be determined by dividing the number of utilization Medicaid inpatient days by the total number of inpatient days. Each hospital with a Medicaid utilization of over 8% shall receive a disproportionate share payment adjustment.

2. For Type One hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 10.5%, times eleven, times (ii) the lower of the prospective operating cost rate or ceiling. For Type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 10.5%, times (ii) the lower of the prospective operating cost rate or ceiling.

3. No payments made under subdivision 1 or 2 of this subsection shall exceed any applicable limitations upon such payments established by federal law or regulations.

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3. For hospitals which do not qualify under the 8% inpatient utilization rate, but do qualify under the low-income patient utilization rate exceeding 25% in A(1) above, the disproportionate share payment adjustment for Type One hospitals shall be equal to the product of (i) the hospital's low-income utilization in excess of 25%, times eleven, times (ii) the lower of the prospective operating cost rate or ceiling. For type Two hospitals, the disproportionate share payment adjustment shall be equal to the product of (i) the hospital's low-income utilization in excess of 25%, times (ii) the lower of the prospective operating cost rate or ceiling.

4. OBRA 1993 § 13621 Disproportionate Share Adjustments (DSA).
Definitions. The following words and terms shall have the following meaning unless the context clearly indicates otherwise.

"High disproportionate share hospital" is one whose Medicaid inpatient utilization rate is at least one standard deviation above the mean inpatient utilization rate in the state or which has the largest number of Medicaid days of any hospital in the Commonwealth for the previous State fiscal year.

"Medicaid losses" means Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year.

"Uninsured losses" means costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

"Private hospital" means a hospital which is not owned or operated by a state or an instrumentality or unit of government within a state.

"Public hospital" means a hospital which is owned or operated by a state or an instrumentality or unit of government within a state.

a. Limit on amount of payment. No payments made under items 1 or 2 above shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 § 13621. A payment adjustment during a fiscal year shall not exceed the sum of "Medicaid losses" and "uninsured losses".

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b. During state fiscal year 1995, the limit in this section shall apply only to public hospitals. During this year a high disproportionate share hospital shall be allowed a limit that is 200% of the limit described above which the Governor certifies to the Secretary of the U.S. Department of Health and Human Services that such amount (the amount by which the hospital's payment exceeds the limit described above) shall be used for health services during the year.

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(8) Outlier adjustments.

a. DMAS shall pay to all enrolled hospitals an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under one year of age.

b. DMAS shall pay to disproportionate share hospitals (as defined in V.(7) above) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1991, involving exceptionally high costs for individuals under six years of age.

c. The outlier adjustment calculation.

(1) Each eligible hospital which desires to be considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

(2) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals identified in (8) a or b above. Any hospital which qualifies for the extensive neonatal care provision (as governed by V.(6), above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals identified in (8) a or b above.

(3) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in (8) c (ii) above.

(4) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital. Pursuant to §1 of Supplement 1 to Attachment 3.1 A & B, there is no limit on length of time for medically necessary stays for individuals under

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six years of age. This section provides that consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under twenty-one (21) years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one (21) days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

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VI. In accordance with Title 42 §§447.250 through 447.272 of the Code of Federal Regulations which implements §1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);
2. The provider's trial balance showing adjusting journal entries;
3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of charges in financial position, and footnotes to the financial statements;
4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;
5. Home office cost report, if applicable; and
6. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

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VI. Cost Report Requirements (continued)

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare Program enacted October 1, 1983.

VII. Revaluation of Assets.

A. Effective July 1, 2008, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the seller's allowable depreciated historical cost (net book value) as determined for Medicaid reimbursement of the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the seller's allowable depreciated historical cost (net book value) as determined for Medicaid reimbursement of the first owner of record, or the acquisition cost to the new owner.

C. In establishing appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986), the base to be used for such computations shall be limited to subsection A or B of this section.

D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest, and (if applicable prior to July 1, 1986) return on equity based on cost of ownership as determined in accordance with subsections A and B of this section.

VIII. Refund of overpayments

A. Lump sum payment. When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS' determination of the overpayment.

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B. Offset. If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

C. Payment schedule. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

D. Extension request documentation. In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

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E. Interest charge on extended repayment. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

Interest charges on the unpaid balance of any overpayment shall accrue pursuant to §32.1-313 of the Code of Virginia from the date the director's determination becomes final.

The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding section I, II, III, IV, V, VI, VII, VIII and excluding V(6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost reporting forms (HCFA 2552 series) and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by the DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating cost or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

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X. Item 398D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

XI. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating cost shall be established for state-owned university teaching hospitals.

XII. Non-enrolled providers. Repealed.

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XIII. Payment Adjustment Fund.

A. A Payment Adjustment Fund shall be created in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The Payment Adjustment Fund shall consist of the Commonwealth's cumulative addition of five million dollars in General funds and its corresponding federal financial participation for reimbursement to non-state owned hospitals in each of the Commonwealth's fiscal years during this period. Each July 1, or as soon thereafter as is reasonably possible, the Commonwealth shall, through a single payment to each non-state owned hospital, equitably and fully disburse the Payment Adjustment Fund for that year.

B. In the absence of any amendment to the State Plan, Attachment 4.19A, for the Commonwealth's fiscal year after 1996, the Payment Adjustment Fund shall be continued at the level established in 1996 and shall be disbursed in accordance with the methodology described below.

C. The Payment Adjustment Fund shall be disbursed in accordance with the following methodology:

1. Identify each non-state owned hospital provider (acute, neonatal and rehabilitation) receiving payment based upon its peer group operating ceiling in May of each year.

2. For each such hospital identified in Paragraph 1, identify its Medicaid paid days for the 12 months ending each May 31.

3. Multiply each such hospital's days under Paragraph 2 by such hospital's May individual peer group ceiling (i.e., disregarding such hospital's actual fiscal year end ceiling) as adjusted by its then current disproportionate share factor.

4. Sum all hospital amounts determined in Paragraph 3.

5. For each such hospital, divide its amount determined in Paragraph 3 by the total of such amounts determined in Paragraph 4. This then becomes the hospital adjustment factor ("HAF") for each such hospital.

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6. Multiply each such hospital's HAF times the amount of the Payment Adjustment Fund ("PAF") to determine its potential PAF share.

7. Determine the unreimbursed Medicaid allowable operating cost per day for each such hospital in Paragraph 1 for the most recent fiscal year on file at DMAS as of May 31, inflate such costs by DRI-V+2 from the mid-point of such cost report to May 31 and multiply such inflated costs per day by the days identified for that hospital in Paragraph 2 above, creating the "unreimbursed amount."

8. Compare each such hospital's potential PAF share to its unreimbursed amount.

9. Allocate to all hospitals, where the potential PAF share exceeds the unreimbursed amount, such hospital's un-reimbursed amount as its actual PAF share.

10. If the PAF is not exhausted, for those hospitals with an un-reimbursed amount balance, recalculate a new HAF for each such hospital by dividing the hospital's HAF by the total of the HAFs for all hospitals with an un-reimbursed amount balance.

11. Re-compute each hospital's new potential share of the undisbursed PAF by multiplying such finds by each hospital's new HAF.

12. Compare each hospital's new potential PAF share to its un-reimbursed amount. If the un-reimbursed amounts exceed the PAF shares at all hospitals, each hospital's new PAF share becomes its actual PAF share. If some hospitals' un-reimbursed amounts are less than the new potential PAF shares, allocate to such hospitals their un-reimbursed amount as their actual PAF share. Then, for those hospitals with an un-reimbursed amount balance, repeat steps 10, 11, and 12 until each hospital's actual PAF share is determined and the PAF is exhausted.

13. The annual payment to be made to each non-state owned hospital from the PAF shall be equal to their actual PAF share as determined and allocated above. Each hospital's actual PAF share payment shall be made on July 1, or as soon thereafter as is reasonable feasible.