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The policy and the method to be used in establishing payment rates for nursing facilities listed in §1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs.

a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan to the extent these are available to the general population.

b. Participation in the Program will be limited to providers of services who accept, as payment in full, the amounts so paid.

c. Payment for care of service will not exceed the amounts indicated to be reimbursed in accord with the policy and the methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.253(b)(2).

d. Payments for services to non-state owned nursing facilities shall be based on methodologies set out in 12 VAC 30-90-44 of the Nursing Home Payment System (Part II (12 VAC 30-90-19 et seq.) of this chapter for nursing facilities and in Subpart XVII (12 VAC 30-90-264 et seq.) of the Nursing Home Payment System for specialized care facilities.

e. Facilities operated by the Department of Behavioral Health and Developmental Services and facilities operated by the Department of Veterans Services shall be reimbursed retrosptectively based on cost.

f. Reimbursement to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) shall be retrospecitve on the basis of easonable costs in accordance with Medicare principles of reimbursement. Nonstate faciltiies shall be limited to a ceilign based on the highest as filed rate paid to an ICF/IID institution in state fiscal year 2012 and annually adjusted thereafter with the application of the NF inflation factor, as set out in 4.19-D, supp. 1, p. 26.2-26.7 (12 VAC 30-90-41 B).

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g. Except as specifically modified in this section, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate methodologies. Allowable costs shall be claissified in accordance with the DMAS uniform chart of accounts (see 12 VAC 30-90-270 through 12 VAC 30-90-276) and shall be identifiable and verfiable by contemporaneous documentation. All matters of reimbursement that are part of DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement sytstem conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence.

h. All nursing facilities and intermediate care facilities shall submit cost reports on the basis of reasonable cost in accordance with the standards and principles set forth in 42 CFR 447.252 as follows:

(1) A uniform annual cost report which itemizes allowable cost will be required to be filed within 150 days of each provider's fiscal year end.

(2) The determination of allowable costs will be in accordance with Medicare principles as established in the Provider Reimbursement Manual (PRM-15) except where otherwise noted in this Plan.

(3) Field audits will be conducted on the cost data submitted by the provider to verify the accuracy and reasonableness of such data. Audits will be conducted for each facility on a periodic basis as determined from internal desk audits and more often as required. Audit procedures are in conformance with SSA standards set forth in PRM-13-2. Internal desk audits are conducted annually within six months of receipt of a completed cost report from the provider.

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(4) Reports of field audits are retained by the state agency for at least three years following submission of the report.

(5) Modifications to the Plan for reimbursement will be submitted as Plan amendments.

(6) Covered cost will include such items as:

(a) Cost of meeting certification standards.

(b) Routine services which include items expense providers normally incur in the provision of services.

(c) The cost of such services provided by related organizations except as modified in the payment system supplement 4.19-D.

(7) Bad debts, charity and courtesy allowances shall be excluded from allowable cost.

(8) Payments will be made to facilities no less than monthly based on claims submitted by the facility.

(9) Payments shall be adequate to reimburse in full such actual allowable costs that an economically and efficiently operated facility must incur.

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(10) In accordance with 42 CFR 447.205, an opportunity for public comment was permitted before final implementation of rate setting processes.

(11) Return on equity capital to proprietary providers shall not be an allowable expense.

e. Reimbursement of non-enrolled long-term care facilities.

(1) Non-enrolled providers of institutional long-term care services shall be reimbursed based upon the average per diem cost, updated annually, reimbursed to enrolled nursing facility providers.

(2) Prior approval must be received from the DMAS for recipients to receive institutional services from non-enrolled long-term care facilities. Prior approval can only be granted:

(a) when the non-enrolled long-term care facility with an available bed is closer to the recipient's Virginia residence than the closest facility located in Virginia with an available bed,

(b) when long term care special services, such as intensive rehabilitation services, are not available in Virginia, or

(c) if there are no available beds in Virginia facilities.

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12 VAC 30-90-266. Traumatic Brain Injury (TBI) Payment.

h. DMAS shall provide a fixed per day payment for nursing facility residents with TBI served in the program in accordance with resident and provider criteria, in addition to the reimbursement otherwise payable under the provisions of the Nursing Home Payment System (NHPS). Effective for dates of service on and after August 19, 1998, a per day rate add-on shall be paid for recipients who meet the eligibility criteria for these TBI payments and who are residents in a designated nursing facility TBI unit of 20 beds or more that meets the provider eligibility criteria. The value of the rate add-on shall be $22.00 on August 19, 1998. The rate add-on for any qualifying provider's fiscal year shall be reviewed annually to determine the appropriateness of the amount and any changes will be published and distributed to the providers. (Refer to 12 VAC 30-90-330 (Appendix VII) for related provider and recipient requirements.

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12 VAC 30-90-18. Supplemental Payments for Private Nursing Facility Partners of Type One Hospitals.

Effective for dates of service on or after October 25, 2011, quarterly supplemental payments will be issued to qualifying private nursing facilities for services rendered during the quarter.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the nursing facility must be currently enrolled as a Virginia Medicaid provider, and must be owned or operated by a private entity where a Type One hospital has a non-0marotiy interest. There are no qualifying nursing facilities as of October 25, 2011.

2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Each quarterly payment distribution shall occur not more than 2 years after the year in which the qualifying nursing facility's entitlement arises. The annual supplement payments in any fiscal year will be the difference between each qualifying nursing facility's Medicaid billed charges and Medicaid payments the nursing facility receives for payments processed for fee-for-service Medicaid recipients during the fiscal year.

3. Limit. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available upper payment limit per state fiscal year.

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12 VAC 30-90-19. Supplemental payments for non-state government-owned nursing facilities.

A. In addition to payments made elsewhere, effective July 1, 2005, DMAS shall draw down federal funds to cover unreimbursed Medicaid costs for inpatient services provided by non-state government-owned nursing homes as certified by the provider through cost reports. A local government nursing facility is defined as a provider owned or operated by a county, city, or other local government agency, instrumentality, authority, or commission.

B. Effective July 1, 2014, DMAS shall make additional supplemental payments to non-state government-owned nursing facilities that meet the requirements in subsection A. Quarterly supplemental payment for each facility shall be calculated in the following manner:

1. Annually calculate for each nursing facility what Medicare would have paid for Medicaid services in the base year, which is the most recently available state fiscal year, using the Medicare skilled nusing facility prospective payment system updated for market basket adjustments and other rate changes to the rate year, which is the upcoming state fiscal year.
2. Annually calculate for each facility what Medicaid paid in the base year including any supplemental payments in resulting from subsection A updated for inflation and other rate changes to the rate year.
3. Calculate a per diem supplemental payment for each facility by subtracting Medicaid expenditures calculated in B(2) from what Medicare would have paid calculated in B(1) and dividing rhe result by the number of paid days for each facility in the base year.
4. At the end of each quarter of the rate year, calculate the number of paid days in the quarter for each facility and multiply it by the per diem supplemental payment for each facility.

C. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available upper payment in the current state fiscal year.

(Former methodology repealed July 1, 2005)