Table of Contents

State/Territory Name: Virginia

State Plan Amendment (SPA) #: 21-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

September 24, 2021

Karen Kimsey, Director
The Commonwealth of Virginia
Department of Medical Assistance Services
600 Eat Broad Street, #1300
Richmond, VA 23219

Re: Virginia 21-0015

Dear Ms. Kimsey:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0015. Effective July 1, 2021, this amendment updates the methodology for establishing PRTF payment rates, establishes a supplemental payment for Lake Taylor, revises GME residency payments and the IME formula freestanding children's hospitals, and makes multiple revisions for nursing facility reimbursement.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 21-00215 is approved effective July 1, 2021. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Gary Knight at (304) 347-5723 or at gary.l.knight@hotmail.com.

Sincerely,

[redacted]

For
Rory Howe
Acting Director

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: 21-0015

2. STATE: Virginia

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 7/1/2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ 18,168,123
b. FFY 2022 $ 72,672,486

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, revised pages 9.1.1, 10, 17.1, 17.2, 17.2.2
Attachment 4.19-D, Supplement 1, revised pages 18.1, 21, 23, 26.1, 26.2, 26.3, 26.5, new page 26.5.1, revised pages 26.6, 26.7.1, 57

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

Same as box #8.

10. SUBJECT OF AMENDMENT

2021 Institutional Provider Reimbursement Changes

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Karen Kimsey

14. TITLE: Director

15. DATE SUBMITTED: 5/26/2021

16. RETURN TO

Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: May 26, 2021

18. DATE APPROVED: September 24, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted] For

21. TYPED NAME: Rory Howe

22. TITLE: Acting Director, Financial Management Group

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

A. The base amount shall be updated annually be the DRI-Virginia moving average values as compiled and published by DRIWEFA, Inc. (12 VACJ0-70-351). The updated per-resident amount will then be multiplied by the weighted number of full time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTEs reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

B. Type One hospitals shall be reimbursed l 00 percent of Medicaid allowable FFS and MCO GME costs for interns and residents.

1. Type One hospitals shall submit annually separate FFS and MCO GME cost schedules, approved by the agency, using GME per diems and GME RCCs (ratios of cost to charges) from the Medicare and Medicaid cost reports and FFS and MCO days and charges. Type One hospitals shall provide information on managed care days and charges in a format similar to FFS,

2. Interim lump sum GME payment for interns and residents shall be made quarterly based on the total cost from the most recently audited cost report divided by four and will be final settled in the audited cost report for the fiscal year end in which the payments are made.

C. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

D. DMAS will make supplemental payments to hospitals for qualified graduate medical residencies. Residency programs (along with their hospital partners) will submit applications for this funding each year. The applications will be scored and the top applicants will receive funding. The supplemental payment for each new qualifying residency slot will be $100,000 annually, minus any Medicare residency payment for which the sponsoring institution is eligible. For any residency program at a facility whose Medicaid payments are capped by the Centers for Medicare and Medicaid Services, the supplemental payments for each qualifying residency slot shall be $50,000 from the general fund annually minus any Medicare residency payments for which the residency program is eligible. The payments shall be made for up to four (4) years. Payments to hospitals will be made quarterly. Additional criteria include:

I. Sponsoring institutions or the primary clinical site must be:
   a. Physically located in Virginia;
   b. An enrolled hospital provider in Virginia Medicaid and continue as a Medicaid-enrolled provider for the duration of the funding;
   c. Not subject to a limit on Medicaid payments by the Centers for Medicare and Medicaid Services; and
   d. Accredited-through either the American Osteopathic Association (AOA) or the American Council for Graduate Medical Education (ACGME).

2. Applications must:
   a. Be complete and submitted by the posted deadline;
   b. Request funding for primary care (care (General Pediatrics, General Internal Medicine, or Family Practice) or high-need specialty residencies; and
   c. Provide substantiation of the need for the requested primary care or specialty residency.

3. Programs that are awarded funding in the full must attest (by June I) that the resident(s) have been hired for the start of the academic year and have continued employment with the program each year thereafter.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

3. For CHKD, effective July 1, 2021 the IME reimbursement for managed care discharges shall be calculated using a case mix adjustment factor of 2.718. This case mix index (CMI) factor shall take precedence over future calculations. Total payments for IME in combination with other payments for CHKD may not exceed the federal uncompensated care cost limit that disproportionate share hospital payments are subject to.

B. 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 utilizationin 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 percentageof Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

C. 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.

D. 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 maynot 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.

E. 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 30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.
A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12 VAC 30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio of total capital cost to total charges of the hospital, using data available from Medicare cost report.

12 VAC 30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.

A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all service provided under arrangement that are reimbursed in the manner described in subsection D ofthis section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the program shall take action in accordance with its policies to assure that an overpayment is not being made'

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. 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.

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 bythe 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

12 VAC 30-70-425. Supplemental Payments for Non-State Government-Owned Hospitals for Inpatient Services.

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 hospitals as certified by the provider through cost reports.

B. A non-state government-owned hospital is owned or operated by a unit of government other than astate.

C. Effective July 1, 2018, additional supplemental payments will be issued to each non-state government owned acute care hospital for inpatient services provided to Medicaid patients.

D. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital clam payments times the Upper Payment Limit (UPL) gap percentage.

a. The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each non-state government owned acute care hospital between a reasonable estimate of the amount that would be paid under Medicare payment principles for inpatient hospital services provided to Medicaid patients (calculated in accordance with 42 CFR § 447.272) and what Medicaid paid for such services and the denominator is Medicaid claim payments to each hospital for inpatient hospital services provided to Medicaid patients in the same years used in the numerator.

b. The UPL gap percentage will be calculated annually for each hospital using data for the most recent year for which comprehensive annual data are available and inflated to the state fiscal year for which payments are to be made.

c. Maximum aggregate payments to all qualifying hospitals shall not exceed the available upper payment limit. If inpatient payments for non-state government owned hospitals would exceed the upper payment limit, the numerator in the calculation of the UPL gap percentage shall be reduced proportionately.

E. Quarterly Payments. After the close of each quarter, beginning with the July l, 2018, to September 30, 2018 quarter, each qualifying hospital shall receive supplemental payments for the inpatient services paid during the prior quarter. The supplemental payments for each qualifying hospital for each quarter shall be calculated by multiplying the Medicaid inpatient hospital payments paid in that quarter by the annual UPLgap percentage for each hospital.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

1. Mid-year FRV rate change. Facilities requiring a mid-year FRV rate change must follow the procedures as specified in 4.19-D, Supp 1, pages 1-3.

2. The capital per diem rate for hospital-based nursing facilities shall be the last settled capital per diem.

3. Effective for dates of service on or after July 1, 2021, any nursing facility which thereafter loses its Medicaid capital reimbursement status as a hospital-based nursing facility because a replacement hospital was built at a different location and Medicare rules no longer allow the nursing home's cost to be included on the hospital's Medicare cost report shall have its first FRV capital payment rate set at the maximum FRV rental rate for a new free-standing nursing facility with the date of acquisition for its capital assets being the date the replacement hospital is licensed.

12 VAC 30-90-37. Calculation of FRV Per Diem Rate for Capital. Calculation of FRV Rental Amount. Change of Ownership.

A. Calculation of FRV Per Diem Rate for Capital. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of actual patient days or the required occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see 4.19-D, Supp 1, p 26 (12 VAC 30-90-264) section 10, for special procedures for computing the number of patient days required to meet the required occupancy percentage requirement.

Facilities shall be required to submit a calendar year FRV report covering both NF and specialized care beds to be used to set a prospective FRV rate effective the following July 1 for both the NF and the specialized care facility. The calendar year FRV report shall be submitted by the end of February following the end of the calendar year. FRV reports shall be settled within 90 days of filing the FRV report. For late FRV reports, the prospective rate may be effective 90 days after the date of filing even if after July 1. No capital rate shall be paid between July 1 and the effective date of the prospective FRV rate for a late report.

New nursing facilities or major renovations that qualify for mid-year FRV rate adjustments must follow pro forma submission procedures as specified in 4.19-D, Supp 1, pages 1-3.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

Article 4
Operating Cost Component

12VAC30-90-40. Operating cost.

A. Effective July 1, 2001, operating cost shall be the total allowable inpatient cost less plant cost or capital, as appropriate, and NATCEPs costs. See Subpart VII (12 VAC 30-90-170) for rate determination procedures for NATCEPs costs. Operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I (12 VAC 30-90-271). Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs or the actual charges by the Central Criminal Records Exchange for criminal records checks for nursing facility employees (see Appendix I (12 VAC 30-90-272)). For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or the occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period times the Medicaid utilization percentage. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90 percent, for dates of service on or after July 1, 2013 shall be 88 percent. For facilities that also provide specialized care services, see 12 VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the occupancy percentage requirement.

12VAC30-90-41. Nursing facility reimbursement formula.

A. Effective on and after July I, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group (RUG) System as defined in Appendix IV (12 VAC 30-90-305 through 307)." The RUG model is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12 VAC 30-90-305 through 307 for details on the Resource Utilization Groups.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the *Social Security Act* as they relate to provision of services, residents' rights and administration and other matters.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

c. See 12VAC 30-90-307 for the applicability of case-mix indices.

5. Direct and indirect payment methods.
a. Effective for services on or after July 1, 2006, the direct patient care operating ceiling shall be set at 117% of the respective peer group day-weighted median of the facilities' case-mix neutralized direct care operating costs per day. The calculation of the medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group direct patient care operating ceilings shall be revised and case-mix neutralized every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

b. The indirect patient care operating ceiling shall be set at 107% of the respective peer group day-weighted median of the facility's specific indirect operating cost per day. The calculation of the peer group medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using the most recent reliable calendar year cost settled cost reports for freestanding nursing facilities that have been completed as of September 1.

6. Reimbursement for use of specialized treatment beds. Effective for services on and after January 1, 2005, nursing facilities shall be reimbursed an additional $10 per day for those recipients who require a specialized treatment bed due to their having at least one stage IV pressure ulcer. Recipients must meet criteria as outlined in 12 VAC30-60-350, and the additional reimbursement must be preauthorized as provided in 12 VAC30-60-40. Nursing facilities shall not be eligible to receive this reimbursement for individuals whose services are reimbursed under the Specialized Care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12 VAC30-90-41B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.

B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI.

1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

J. The reimbursement methodology described in this section shall be utilized for dates of service through June 30, 2014. Effective July 1, 2014, nursing facilities shall be reimbursed the price-based methodology described in 12 VAC 30-90-44 except, effective July 1, 2021, for nursing facilities operated by the Department of Veteran Affairs.

12VAC 30-90-41.1 Modifications to Nursing Facility Reimbursement Formula. Repealed. 12VAC30-90-42. Repealed. 12VAC30-90-43. Repealed.

12 VAC 30-90-44. Nursing Facility Price Based Payment Methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates in 12 VAC 30-90-41 to a price-based methodology except for nursing facilities operated by the Department of Veteran Affairs. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

a. The department shall calculate the cost per day in the base year for direct and indirect operating costs for each nursing facility. The department shall use existing definitions of direct and indirect costs.

b. The initial base year for calculating the cost per day shall be cost reports ending in calendaryear 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent, reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1. Effective July 1, 2021 DMAS shall defer the next scheduled nursing facility rate rebasing for one year in order to utilize cost reports ending in 2021as the base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations. No adjustments will be made to the base year data for purposes of rate setting after September 1.

c. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost perday by the raw Medicaid facility case-mix that corresponds to the base year by facility.

d. Costs per day shall be inflated to the midpoint of the fiscal year rate period using the moving average Virginia Nursing Home inflation index for the fourth quarter of each year (the midpoint of the fiscal year). Costs in the 2011 base year shall be inflated from the midpoint of the cost report year to the midpoint of fiscal year 2012 by prorating fiscal year 2012 inflation and annual inflation after that. Annual inflation adjustments shall be based on the last available report prior to the beginning of the fiscal year and corrected for any revisions to prior year inflation.

e. Prices will be established for the following peer groups using a combination of Medicare wage regions and Medicaid rural and bed size modifications based on similar costs.

The following definitions shall apply to direct peer groups. The Northern Virginia peer group shall be defined as localities in the Washington DC-MD-VA MSA as published by the Centers for Medicare and Medicaid Services (CMS) for skilled nursing facility rates. The Other MSA peer group includes localities in any MSA defined by CMS other than the Northern Virginia MSA and non-MSA designations. The Rural peer groups are non-MSA areas of the state divided into Northern and Southern Rural peer groups based on drawing a line between the following points on the Commonwealth of Virginia map with the coordinates: 37.4203914 Latitude, 82.0201219 Longitude and 37.1223664 Latitude, 76.3457773 Longitude.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

THIS PAGE IS INTENTIONALLY LEFT BLANK.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

THIS PAGE IS INTENTIONALLY LEFT BLANK.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

h. The direct and indirect price for each peer group shall be based on the followingadjustment factors:

a. Direct adjustment factor- 105.000% of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities.

- Effective July 1, 2021, the direct adjustment factor shall be 109.3% of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities.

b. Indirect adjustment factor - 100.735% of the peer group day-weighted median inflated cost per day for freestanding nursing facilities.

- Effective July 1, 2021, the indirect adjustment factor shall be 103.3% of the peer group day-weighted median inflated cost per day for freestanding nursing facilities.

i. Facilities with costs projected to the rate year below 95% of the price shall have an adjusted price equal to the price minus the difference between the facility's cost and 95% of the unadjusted price. Adjusted prices will be established at each rebasing. New facilities after the base year shall not have an adjusted price until the next rebasing.

j. Special circumstances.

1. Effective July 1, 2021, DMAS shall increase the direct and indirect operating rates under the nursing facility price based reimbursement methodology from 15% to 25.4% above a facility's calculated price-based rates for nursing facilities where at least 80% of the resident population has one or more of the following diagnoses: quadriplegia, traumatic brain injury, multiple sclerosis, paraplegia, or cerebral palsy. In addition, a qualifying facility must have at least 90% Medicaid utilization and a nursing facility case-mix index of 1.15 or higher in fiscal year 2014.

2. For rebasings effective on or after July 1, 2020, DMAS shall move nursing facilities located in the former Danville Metropolitan Statistical Area to the Other MSAs peer group.

k. Individual claim payment for direct costs shall be based on each resident's Resource Utilization Group (RUG) during the service period times the facility direct price.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

---

l. Resource Utilization Group (RUG) is a resident classification system that groups nursing facility residents according to resource utilization and assigns weights related to the resource utilization for each classification. The department shall use RUGs to determine facility case-mix for cost neutralization as defined in 12 VAC 30-90-306 in determining the direct costs in setting the price and for adjusting the claim payments for residents.

a. The department shall neutralize direct costs per day in the base year using the most current RUG grouper applicable to the base year.

b. The department shall utilize RUG-III, version 34 groups and weights in fiscal years 2015 through 2017 for claim payments.

c. Beginning in fiscal year 2018, the department shall implement RUG-IV, version 48 Medicaid groups and weights for claim payments.

d. RUG-IV, version 48 weights used for claim payments will be normalized to RUG-III, version 34 weights as long as base year costs are neutralized by the RUG-III 34 group. In that the weights are not the same under RUG-IV as under RUG-III, normalization will ensure that total direct operating payments using the RUG-IV 48 weights will be the same as total direct operating payments using the RUG-III 34 grouper.

m. DMAS shall increase nursing facility per diem rates by $15 per day effective July 1, 2021.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

B. Transition from nursing facility cost based rates to nursing facility price-based rates. The department shall transition to the price-based methodology over a period of four years, blending the adjusted price-based rate with the facility-specific case-mix neutral cost-based rate calculated according to 12 VAC 30-90-41 as if ceilings had been rebased for fiscal year 2015. The cost-based rates are calculated using the 2011 base year data, inflated to 2015 using the inflation methodology in 12 VAC 30-90-41 and adjusted to state fiscal year 2015. In subsequent years of the transition, the cost-based rates shall be increased by inflationdescribed in this section.

1. Cost-based rates to be used in the transition for facilities without cost data in the base year but placed in service prior to July 1, 2013, shall be determined based on the most recently settled costdata. If there is no settled cost report at the beginning of a fiscal year, then 100% of the price-based rate shall be used for that fiscal year. Facilities placed in service after June 30, 2013, shall be paid 100% of the price-based rate.

2. Effective July 1, 2015, nursing facilities whose licensed bed capacity decreased by at least 30 beds after 2011 and whose occupancy increased from less than 70 percent in 2011 to more than 80 percent in 2013 shall be reimbursed the price-based operating rate rather than the transition operating rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

---

12 VAC 30-90-45. Supplemental payments for state-owned nursing facilities.

A. Effective July 1, 2018, DMAS shall make supplemental payments to state-owned nursing facilities. Quarterly supplemental payments for each facility shall be calculated in the following manner:

B. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital claim payments times the Upper Payment Limit (UPL) gap percentage.

1. The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each nursing facility between a reasonable estimate of the amount that would be paid under Medicare payment principles for nursing facility services provided to Medicaid patients calculated inaccordance with 42 CFR 447.272 and what Medicaid paid for such services and the denominator is Medicaid payments to each nursing facility for nursing facility services provided to Medicaid patients in the same year used in the numerator,

2. The UPL gap percentage will be calculated annually for each nursing facility using data for the most recent year for which comprehensive annual data are available and inflated to the state fiscalyear for which payments are to be made.

3. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available UPL. If nursing facility payments for state nursing facilities would exceed the UPL, thenumerator in the calculation of the UPL gap percentage shall be reduced proportionately,

C. Quarterly Payments. After the close of each quarter, beginning with the July 1, 2018 to September 30, 2018 quarter, each qualifying nursing facility shall receive supplemental payments for the nursing facility services paid during the prior quarter. The supplemental payments for each qualifying nursing facility shall be calculated by multiplying Medicaid nursing facility payments paid in that quarter by the annual UPL gap percentage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

12. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with subdivision 9 of this section, except that the occupancy requirement shall be 70% rather than the required occupancy percentage.

13. The cost reporting requirements of 4.19-D, Supp 1, page 35 (12 VAC 30-90-70) and 4.19-D, Supp 1, page 37 (12 VAC 30-90-80) shall apply to specialized care providers.

14. Effective July 1, 2020 through June 30, 2022, specialized care operating rates shall be increasedannually by inflation based on the section of the state plan called the Nursing Facility Price Based Payment Methodology, which starts on page 26.2 of 4.19D, Supplement 1.

15. DMAS shall increase nursing facility per diem rates by $15 per day effective July 1, 2021.

12 VAC 30-90-265. Reserved.

12VAC30-90-266. Traumatic Brain Injury (TBI) payment.

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. 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 rate add-on for any qualifying provider's fiscal year shall be reviewed annually to determine the appropriateness of the amount, not to exceed $50 per patient day, and any changes will be published and distributed to the providers. (Refer to NHPS, Appendix VII, page 1 (12VAC30-90-330), Traumatic brain injury diagnoses, for related resident and provider requirements.)

12 VAC 30-90-267. Private room differential.

A. Payment shall be made for a private room or other accommodations more expensive than semi-private (two or more bed accomodations) only when such accommodations are medically necessary. Private rooms will be considered necessary when the resident's condition requires him/her to be isolated for his/her own health or that of others.

B. Physician certification justifying the private room must be on file prior to the resident's discharge from the semi-private room. The term 'isolation' applies when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the resident for certain periods. Private room accommodations may also be necessary for residents whose symptoms or treatments are likely to alarm or disturb others in the same room.

C. Reimbursement for private rooms will only be made when authorized by the Virginia Department of Medical Assistance Services (DMAS).

D. The Medicaid private room differential shall be calculated by applying the percent difference between the facility's private and semi-private room charges to the total case mix neutral Medicaid rate for the facility.

12 VAC 30-90-268 through 12 VAC 30-90-269. Reserved.