Table of Contents

State Name: Virginia

State Plan Amendment (SPA)#: 15-0013

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Three (3) SPA Pages

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

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

Financial Management Group

FEB 25 2016

Ms. Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond, VA 23219

RE: State Plan Amendment 15-0013

Dear Ms. Jones:

We have completed our review of State Plan Amendment (SPA) 15-0013. This SPA modifies Attachment 4.19D of Virginia's Title XIX State Plan. Specifically, the SPA makes a technical correction to an incorporated reference and updates nursing facility overpayment reporting to reflect current Medicaid policy.

We conducted our review of this SPA according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving state plan amendment 15-0013 effective October 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, or require additional information, please call Gary Knight at (304) 347-5723.

Sincerely yours,

/S/

Kristin Fan
Director

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 15-013

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: 10/1/2015

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 Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ -0-
b. FFY 2017 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Revision to Attachment 4.19-D, Supplement 1, pages 36 and 54.
New page- Attachment 4.19-D, Supplement 1, page 54.1

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same page

10. SUBJECT OF AMENDMENT: Cost Report Submission, Credit Balance Reporting

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2016
☐ 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: /S/

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 11/19/15

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:

18. DATE APPROVED: FEB 25 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

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-
LONG TERM CARE

5. Depreciation schedule;

6. Schedule of Assets as defined in Attachment 4.19-D, Supplement 1, page 19 (12 VAC 30-90-38).

7. Nursing facilities which are part of a chain organization must also file:

   a. Home office cost report;

   b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report and footnotes to the financial statements;

   c. The nursing facility'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), and a statement of cash flows;

   d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

   e. Schedule of investments by type (stock, bond, etc.) , amount, and current market value; and

8. Such other analytical information or supporting documentation that may be required by DMAS.

B. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. For example, for a September 30 fiscal year end, payments will be reduced starting with the payment on and after March 1.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
LONG TERM CARE

C. 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 such 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 that the provider paid to DMAS.

12 VAC 30-90-255. Reserved.
12 VAC 30-90-256. Reserved.

12 VAC 30-90-257. Credit balance reporting.

A. Definitions. The following words or terms when used in this regulation shall have the following meanings unless the context clearly indicates otherwise:

"Claim" means a bill consistent with Attachment 4.19-E, page 1 (12VAC30-20-180) submitted by a provider to the department for services furnished to a recipient;

"Credit balance" means an excess or overpayment made to a provider by Medicaid as a result of patient billings.

B. Credit balances may occur when a provider's reimbursement for services it provides exceeds the allowable amount or when the reimbursement has been for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid or another third party payer for the same services.

C. For a credit balance arising on a Medicaid claim within three years of the date paid by the department, the NF shall submit an adjustment claim. For credit balances arising on claims over three years old, the NF shall submit a check for the balance due and a copy of the original DMAS payment.

D. A periodic audit shall be conducted of the NFs' claim adjustments of Medicaid credit balance data. NFs shall maintain an audit trail back to the underlying accounts receivable records supporting each claim adjusted for credit balances.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
LONG TERM CARE

12 VAC 30-90-258. Reserved.
12 VAC 30-90-259. Reserved.

Subpart XVI
Revaluation of Assets

12 VAC 30-90-260. Repealed.

12 VAC 30-90-261 through 12 VAC 30-90-263. Reserved.

12 VAC 30-90-264. Specialized care services.

Specialized care services provided in conformance with Attachment 3.1-C, page 6 (12VAC30-60-40-E and H), Attachment 3.1-C, Supplement 1, page 16 (12VAC30-60-320) and Attachment 3.1-C, Supplement 1, page 17 (12VAC30-60-340) shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the category of Ventilator Dependent Care will be place in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in 12VAC30-90-271 and 12VAC30-90-272. To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days.

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article 5 of Part II of this chapter (Attachment 4.19-D, Supplement 1, page 26.8, 12VAC30-90-50 et seq.) and of Appendix III of Part II of this chapter (Nursing Home Payment System, Appendix III, page 2, 12VAC30-90-290) shall apply to specialized care cost and reimbursement.

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine