12VAC30-70-425. ~~Supplemental payments to nonstate government-owned hospitals for inpatient services.~~ **Certified public expenditures for nonstate government-owned hospitals for inpatient services.**

A. ~~DMAS shall provide lump sum supplemental payments to participating nonstate government-owned hospitals for furnished inpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to all nonstate government-owned hospitals for services to Medicaid patients and the maximum amount allowable under applicable federal regulations in accordance with 42 CFR 447.272. A participating hospital is one with respect to which a transfer agreement has been made and implemented.~~ 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 nonstate government-owned hospital is owned or operated by a unit of government other than a state. ~~The payment amount for a participating hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's Medicaid days provided during the most recent fiscal year by the total Medicaid days provided by all participating nonstate government-owned hospitals for the same fiscal year.~~

~~C. A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified in 42 CFR 447.271 or the limit specified in 42 USC §1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other participating hospitals in the same manner and subject to the same limitations as set forth above.~~

~~D. For the period from December 16, 2001, through May 13, 2002, aggregate payments to nonstate government-owned hospitals shall not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. For the period beginning May 14, 2002, aggregate payments to these hospitals shall not exceed 100% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles.~~

~~E. To determine the reasonable estimate of the amount that would be payable under Medicare payment principles, a hospital-specific per diem will be determined by dividing all inpatient hospital costs for acute, psychiatric and rehabilitation services by the total number of patient days. The hospital-specific per diem will be multiplied by the hospital's Medicaid bed days. The reasonable estimate will be the sum of the calculations for all hospitals. The calculation will use data from the last settled cost report for all nonstate~~

~~government-owned hospitals at the beginning of the state fiscal year for which calculations are made. However, for state fiscal year 2002, only data from the last settled cost report at the beginning of state fiscal year 2003 will be used. Charges and Medicaid payments will be trended forward using the Virginia-specific DRI hospital inflation factors. Medicare payments will be trended forward using CMS Medicare inflators. Additional adjustments will be made for any statutory changes in Medicare or Medicaid payments. The most recently available Medicaid DSH data will be used.~~

12VAC30-70-426. Supplemental payments to state government-owned hospitals for inpatient services. **(Repealed effective July 1, 2005)**

~~A. In addition to payments for inpatient hospital services provided for elsewhere in this State Plan, DMAS makes supplemental payments to state government-owned or operated hospitals for services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be part of a state academic health system or part of an academic health system that operates under a state authority.~~

~~B. The amount of the supplemental payment made to each qualifying state government-owned or operated hospital is determined by:~~

~~1. Calculating for each hospital the annual difference between the upper payment limit attributed to each qualifying hospital calculated according to subsection D of this section and the amount otherwise actually paid for the services by the Medicaid program;~~

~~2. Dividing the difference determined in subdivision 1 of this subsection for each qualifying hospital by the aggregate difference for all such qualifying hospitals; and~~

~~3. Multiplying the proportion determined in subdivision 2 of this subsection by the aggregate upper payment limit amount for all such hospitals as determined in accordance with 42 CFR 447.272 less all payments made to such hospitals other than under this section.~~

~~C. Payments under this section may be made in one or more installments at such time, within the fiscal year or thereafter, as is determined by DMAS.~~

~~D. To determine the aggregate upper payment limit amount as referred to in subdivision B 3 of this section, the following methodology will be used. For cost-reimbursed hospitals, the upper payment limit is costs. By definition, cost-reimbursed hospitals have no net impact on the upper payment limit and will be excluded from the calculation. For Medicaid DRG-reimbursed hospitals, a ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment-to-charge ratio will be multiplied by Medicaid charges for each DRG-reimbursed hospital. The upper payment limit will be the sum of the product of that multiplication for all DRG-reimbursed hospitals. The calculation will use data from the last settled cost report for all state government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.~~

12VAC30-80-20. Services that are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program with the exception provided for in subdivision D 2 d. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable 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), and a statement of changes in financial position;

4. Schedules that reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

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

D. The services that are cost reimbursed are:

1. Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals.

2. Outpatient hospital services excluding laboratory.

a. Definitions. The following words and terms when used in this regulation shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§et seq.) of Title 32.1 of the Code of Virginia.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments that DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 2 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 2 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

c. Limitation to 80% of allowable cost. Effective for services on and after July 1, 2003, reimbursement of Type Two hospitals for outpatient services shall be at 80% of allowable cost, with cost to be determined as provided in subsections A, B, and C of this section. For hospitals with fiscal years that do not begin on July 1, 2003, outpatient costs, both operating and capital, for the fiscal year in progress on that date shall be apportioned between the time period before and the time period after that date, based on the number of calendar months in the cost reporting period, falling before and after that date. Operating costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Capital costs apportioned before that date shall be settled according to the principles in effect before that date, and those after at 80% of allowable cost. Operating and capital costs of Type One hospitals shall continue to be reimbursed at 94.2% and 90% of cost respectively.

d. Outpatient reimbursement methodology prior to July 1, 2003. DMAS shall continue to reimburse for outpatient hospital services, with the exception of direct graduate medical education for interns and residents, at 100% of reasonable costs less a 10% reduction for allowable capital costs and a 5.8% reduction for allowable operating costs. This methodology shall continue to be in effect after July 1, 2003, for Type One hospitals.

e. Payment for direct medical education costs of nursing schools, paramedical programs and graduate medical education for interns and residents.

(1) Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

(2) Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis. See 12VAC30-70-281 for prospective payment methodology for graduate medical education for interns and residents.

3. Rehabilitation agencies operated by community services boards. For reimbursement methodology applicable to other rehabilitation agencies, see 12VAC30-80-200. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

4. Comprehensive outpatient rehabilitation facilities.

5. Rehabilitation hospital outpatient services.

~~6. Supplemental payments to nonstate government-owned hospitals for outpatient services.~~

~~a. The department provides lump sum supplemental payments to participating nonstate government-owned hospitals for furnished outpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to all nonstate government-owned hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321. A participating hospital is one with respect to which a transfer agreement has been made and implemented.~~

~~b. A nonstate government-owned hospital is owned or operated by a unit of government other than a state. The payment amount for a participating hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all participating nonstate government-owned hospitals for the same fiscal year.~~

~~c. A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified in 42 USC §1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other participating hospitals in the same manner and subject to the same limitations as set forth above.~~

~~d. For the period from December 16, 2001, through May 13, 2002, aggregate payments to nonstate government-owned hospitals shall not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. For the period beginning May 14, 2002, aggregate payments to these hospitals shall not exceed 100% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles.~~

~~e. To determine the reasonable estimate of the amount that would be paid under Medicare payment principles, each hospital's outpatient cost to charge ratio will be calculated and~~

~~applied to its Medicaid outpatient charges. The reasonable estimate will be the sum of the calculations for all hospitals. The calculation will use data from the last settled cost report for all nonstate government-owned hospitals at the beginning of the state fiscal year for which calculations are made. However, for state fiscal year 2002, only data from the last settled cost report at the beginning of state fiscal year 2003 will be used. Charges and Medicaid payments will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any statutory changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.~~

~~7. Supplemental payments to state government-owned hospitals for outpatient services.~~

~~a. In addition to payments for services set forth elsewhere in this State Plan, DMAS provides supplemental payments to qualifying state government-owned or operated hospitals for outpatient services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be part of a state academic health system or part of an academic health system that operates under a state authority.~~

~~b. The amount of the supplemental payment made to each qualifying hospital is determined by:~~

~~(1) Calculating for each hospital the annual difference between the upper payment limit attributed to each qualifying hospital calculated according to this subdivision 7d and the amount otherwise actually paid for the services by the Medicaid program;~~

~~(2) Dividing the difference determined in subdivision 7 b (1) for each qualifying hospital by the aggregate difference for all such qualifying hospitals; and~~

~~(3) Multiplying the proportion determined in subdivision 7 b (2) by the aggregate upper payment limit amount for all state owned or operated hospitals as determined in accordance with 42 CFR 447.321 less all payments made to such hospitals other than under this section.~~

~~(4) A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified at 42 USC §1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other qualifying hospitals in the same manner and subject to the same limitations as set forth above.~~

~~c. Payments for furnished services under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.~~

~~d. To determine the aggregate upper payment limit amount referred to in subdivision 7 b (3), the following methodology will be used. A ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment-to-charge ratio will be multiplied by the Medicaid charges for each hospital. The upper payment limit will be the sum of the product of that multiplication for all hospitals. The calculation will use data from the most recently settled cost report for all state~~

~~government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.~~

12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services (12VAC30-80-160 has obstetric/pediatric fees). Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public), except that reimbursement rates for designated physician services when performed in hospital outpatient settings shall be 50% of the reimbursement rate established for those services when performed in a physician's office. The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms when used in this subdivision 1 shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments that DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

2. Dentists' services.

3. Mental health services including: (i) community mental health services; (ii) services of a licensed clinical psychologist; or (iii) mental health services provided by a physician.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric or licensed marriage and family therapists shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME).

a. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge.

b. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

c. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to,

oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services, including services paid to local school districts.

8. Laboratory services (other than inpatient hospital).

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-Ray services.

11. Optometry services.

12. Medical supplies and equipment.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

~~16. Supplemental payments to state government-owned or operated clinics.~~

~~a. In addition to payments for clinic services specified elsewhere in this state plan, DMAS provides supplemental payments for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is~~

~~organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Supplemental payments will be made to Children's Specialty Services, a state government-owned and operated clinic.~~

~~b. The amount of the supplemental payment made to Children's Specialty Services is determined by calculating for all state government-owned or operated clinics the annual difference between the aggregate upper payment limit specified in 42 CFR 447.321 and determined according to the method described in subdivision 16 d and the amount otherwise actually paid for the services by the Medicaid program.~~

~~c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.~~

~~d. To determine the aggregate upper payment limit, Medicaid payments to state government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B) in regard to the state agency fee schedule for Resource Based Relative Value Scale (RBRVS). Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.~~

~~17~~ 16. Supplemental payments for services provided by Type I physicians.

~~18~~ 17. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a ~~A~~ qualifying clinic is a clinic operated by a Community Services Board. The state share for supplemental clinic payments will be funded by general fund appropriations. ~~clinic with estimated Medicaid payments in 2003 (including primary payments and copayments) of more than $100,000 other than under this section and that serve areas covered by managed care prior to January 1, 1998.~~

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 18 d and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 18 b (1) for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision (2) of this subdivision 18 b by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

12VAC30-90-19. ~~Additional reimbursement~~ Certified public expenditures for locally-owned nursing facilities.

A. ~~Subject to legislative authorization as required and the availability of local, state, and federal funds, and based upon a transfer agreement and the subsequent transfer of funds, DMAS makes additional payments to local government nursing facilities. 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.~~ 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.

(Former methodology repealed July 1, 2005)

~~B. DMAS uses the following methodology to calculate the additional Medicaid payments to local government nursing facilities:~~

~~1. For each state fiscal year, DMAS calculates the maximum additional payments that it can make to the local government nursing facilities in conformance with~~

~~2. DMAS determines a total additional payment amount to be made in a manner not to exceed the maximum additional payment amount calculated in subdivision 1 of this subsection.~~

~~3. Using the latest fiscal period for which the local government nursing facilities have completed cost reports on file with DMAS, the department determines the total Medicaid days reported by each local government nursing facility for that fiscal period.~~

4. ~~DMAS divides the total Medicaid days for each local government nursing facility by the total Medicaid days for all local government nursing facilities to determine the supplementation factor for each.~~

~~5. For each local government nursing facility, the department multiplies the local government nursing facility's supplementation factor determined in subdivision 4 of this subsection by the total additional payment amount identified in subdivision 2 of this subsection to determine the additional payment to be made to each local government nursing facility.~~