Virginia Regulatory Town Hall

Final Regulation
Agency Background Document

Agency Name:	Dept. of Medical Assistance Services; 12 VAC 30
VAC Chapter Number:	Chapter 90
Regulation Title:	Methods and Standards for Establishing Payment Rates-Long Term Care Nursing Home Payment System
Action Title:	NHPS: Resource Utilization Groups (RUGs)
Date:	; Effective 7/1/2002

Please refer to the Administrative Process Act (§ 9-6.14:9.1 *et seq.* of the *Code of Virginia*), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99) , and the *Virginia Register Form,Style and Procedure Manual* for more information and other materials required to be submitted in the final regulatory action package.

Summary

Please provide a brief summary of the new regulation, amendments to an existing regulation, or the regulation being repealed. There is no need to state each provision or amendment; instead give a summary of the regulatory action. If applicable, generally describe the existing regulation. Do not restate the regulation or the purpose and intent of the regulation in the summary. Rather, alert the reader to all substantive matters or changes contained in the proposed new regulation, amendments to an existing regulation, or the regulation being repealed. Please briefly and generally summarize any substantive changes made since the proposed action was published.

This regulatory action proposes to replace the current Patient Intensity Rating System (PIRS) method of classifying nursing facility residents with the Resource Utilization Groups-III methodology. The RUG-III methodology is a state of the art system developed by the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration).

Changes Made Since the Proposed Stage

Please detail any changes, other than strictly editorial changes, made to the text of the proposed regulation since its publication. Please provide citations of the sections of the proposed regulation that have been altered since the proposed stage and a statement of the purpose of each change.

VAC Cite	Proposed Text	Final Text	Source of Change
12VAC30-90-10	Not in PR	Added ref to Va Veterans Care Center	To have a way to reimburse Center
12VAC30-90-20	Not in PR	Added ref to Va Veterans Care Center	To have a way to reimburse Center
12VAC30-90-38	Not in PR	For purposes of capital expenditures, like items grouped.	Specific public comment submitted under rule making petition.
12VAC 30-90-41B	Inflation adjustments based on 2nd quarter data of current year	Inflation adjustments will be based on 4th quarter data of previous year	Specific public comment submitted
12VAC 30-90-271A	Not in PR	Added "MDS Coordinator" to definition of licensed nurses in supervisory positions	Specific public comment submitted
12VAC 30-90-280B	Stated that related party lease costs would be limited to DMAS allowable cost of ownership	Revised to state that related party lease costs would be adjusted to the DMAS allowable cost of ownership.	Specific public comment submitted under rule making petition.
12VAC30-90-305B	Not in PR	Inserted definition of "effective assessment date"	Specific public comment submitted
12VAC 30-90-306B	Not in PR	Added Table III of the 34 RUGs case mix indices.	Specific public comment submitted
12VAC 30-90-306C	Referenced assessment date of previous quarter	Deleted the "previous" reference	Specific public comment submitted
12VAC30-90-306D	Not in PR	Include monitoring	Specific public

		normalization and neutralization.	comment submitted

The changes to sections 10 and 20 concerning reimbursement to the Virginia Veterans Care Center are necessary because the operating lease presently held by a private company is due to expire May 31, 2002. Effective June 1, 2002, the Commonwealth will become the operator of this nursing facility. In order to have a consistent payment methodology across all facilities that are operated by the Commonwealth, DMAS is adding the Virginia Veterans Care Center as receiving retrospective reimbursement.

The changes to section 38 was a clarification of 'like kind' items for inclusion in the Schedule of Assets. DMAS uses the Schedule of Assets in determining the average nursing facility asset costs which is used in computing the fair rental value in the reimbursement methodology.

The changes to section 271 were clarifying in that DMAS always considered the MDS Coordinator as being part of the direct nursing service expenses. A commenter asked that this detail be included in the regulations.

The changes to subsections 305B and 306B were specifically requested as details to be added to the regulations. The change to subsection 306D provided that DMAS would review its calculations for the normalization and neutralization processes.

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency: including the date the action was taken, the name of the agency taking the action, and the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4007, of the Administrative Process Act.

Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Basis

Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory

or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority, shall be provided. If the final text differs from that of the proposed, please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the final regulation and that it comports with applicable state and/or federal law.

The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) §§ 2.2-4007 and 2.2-4013, for this agency's promulgation of proposed regulations subject to the Governor's review.

Chapter 1073 of the 2000 Acts of Assembly, Item 319 MM, directed DMAS to implement this Resource Utilization Groups methodology into its Nursing Home Payment System.

Title 42 of the Code of Federal Regulations Part 447, Payment for Services, prescribes State Plan requirements, Federal Financial Participation limitations and procedures concerning payments made by State Medicaid agencies for Medicaid services. States must provide sufficient detail in their plans about their reimbursement methodologies in order that CMS may determine if the methodologies conform to existing federal law and regulations and are therefore approvable for Federal Financial Participation (FFP).

Purpose

Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the final regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.

The purpose of this action is to change the Nursing Home Payment System to replace the current PIRS method of classifying residents into groups with the more up to date Resource Utilization Groups-III method of classifying residents. These changes will not have a direct impact on citizens' health, safety, and welfare. These changes, once implemented, will indirectly affect nursing facility residents' health and safety by providing reimbursement that more closely matches the costs of their care.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement of the regulatory action's detail.

The sections of the State Plan for Medical Assistance affected by this action are Methods and Standards for Establishing Payment Rates-Long Term Care (12 VAC 30 Chapter 90, Articles 4, 6, and Appendices I and IV).

This regulatory action is necessary to implement a case-mix payment system that will provide a more equitable method of reimbursement to nursing facilities (NFs). Under the current payment system, nursing facilities receive an average payment for Medicaid residents based on three levels of resident acuity. The resident classification system currently used is known as the Patient Intensity Rating System (PIRS), which was developed prior to 1990. This system groups residents with similar resource needs into three groups: Class A includes an Activity of Daily Living (ADL) impairment score of 0 to 6; Class B includes an ADL impairment score of 7 to 12; and Class C includes an ADL impairment score of 9 or more combined with specific clinical conditions. The PIRS requires the completion of a specific resident assessment instrument (Uniform Assessment Instrument (UAI)) by the providers and this assessment instrument is reviewed by the agency.

Over the past ten years, the types of residents and the delivery of care in nursing facilities have changed. CMS has sponsored research to develop a case mix classification system, Resource Utilization Groups (RUG), Version III, that is used for the Medicare Prospective Payment System and has been implemented by over one-half of the state Medicaid programs across the country. The RUG-III system classifies residents into a 34-group version for use with Medicaid nursing facility resident populations and can be used to objectively determine a facility's case mix. The case-mix index scores for this system are CMS-developed standard case-mix indices based on time studies performed during the middle to late 1990s, and these indices will be the basis for calculating the average case-mix index scores.

The RUG-III resident classification system is based on the CMS Minimum Data Set (MDS) Version 2, a resident assessment data system that is mandated for all Medicare and Medicaid participating facilities. The MDS is an assessment instrument and process that is much more refined than the PIRS assessment. Additionally, the use of the MDS data for case-mix classification will relieve the nursing facilities of the additional burden of completing the PIRS assessment for each Medicaid resident.

The RUG-III resident classification system and the CMS standard weights are the most widely accepted and recognized systems available. CMS continues to provide development and research support for the RUG-III system. By adopting the use of this system, the administrative effort that will be required by the agency in the future is minimized. Further, under the Resource Utilization Groups-III (RUGs III) case mix payment system, nursing facilities will be reimbursed

in a manner more directly commensurate with the particular residents that they serve and therefore, the particular costs that the NFs incur.

Converting to this RUGs III case mix payment system will not have any affect on the current Long Term Care database that DMAS has operated for more than the last ten years. The conversion to the MDS form will just mean that no new data will be added to this computer subsystem.

Issues

Please provide a statement identifying the issues associated with the final regulatory action. The term "issues" means: 1) the advantages and disadvantages to the public of implementing the new provisions; 2) the advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please include a sentence to that effect.

The proposed changes to operating reimbursement rates are beneficial to providers for several reasons. First, the RUG-III resident classification system will provide a more accurate and refined case mix index on which to base payments compared to the current PIRS system; thus paying NFs more appropriately for the resource utilization and costs of their residents. Second, the RUG-III resident classification system has a further advantage to providers in that it is based on the CMS Minimum Data Set (MDS). The MDS is a resident assessment that all Medicare and Medicaid participating providers must complete according to CMS rules.

The continued use of the PIRS system requires the completion of a second resident assessment instrument. The PIRS assessment will be eliminated upon full adoption of the proposed changes, relieving providers of the administrative burden of completing more than one assessment instrument on each resident. The proposed changes are beneficial to residents of nursing facilities because the RUG-III resident classification system captures the resource use and residents' costs of care more accurately, thus providing more of an incentive for nursing facilities to admit higher acuity residents. No disadvantages to the public have been identified.

The proposed changes to operating reimbursement rates are also beneficial to the agency and Commonwealth. First, the agency is promoting policies that provide accurate and appropriate payments to nursing facilities. The use of the RUG-III resident classification system increases the refinement of the resident classification groups and more appropriately pays nursing facilities for the resource utilization and costs of each facility's residents. Second, the use of the CMS supported RUG-III system and the standard case mix index scores provides the agency and the Commonwealth with the recognition of using the most highly regarded and accepted case mix system available at this time. Further, CMS continues to support research and to make refinements to the RUG-III system which relieves the agency and the Commonwealth of conducting research studies on an ongoing basis. Third, the use of the MDS in place of the PIRS assessment instrument provides the agency with assessment data that has been reviewed for accuracy and is closely monitored by both the Virginia Department of Health and the agency itself. The PIRS assessment data is monitored solely by the agency. This oversight will result in

more accurate and timely data on which to base the nursing facility payment rates. No disadvantages, excluding the costs of conversion to the RUGs system, to the agency have been identified.

There are no known disadvantages to either providers or the agency and the Commonwealth of implementing this RUGs system.

Public Comment

Please summarize all public comment received during the public comment period and provide the agency response. If no public comment was received, please include a statement indicating that fact.

DMAS' proposed regulations were published in the February 11, 2002, Virginia Register for their comment period from February 11 through April 12, 2002. Comments were received from the Virginia Health Care Association, Tandem Health Care, Eldercare of Virginia, Inc., and from Goodman and Company, L.L.P. A summary of the comments received and the agency's response follows:

Goodman and Company

One individual wrote with three comments:

(1) The direct care cost classification should include the MDS Coordinator. Additionally, staff development and in-service coordinators often perform direct care functions so where supported by documentation, these costs should be classified under direct care costs.

Withdrawn by individual who submitted the comment.

Since the other issues addressed by this commenter concerned 12 VAC 30-90-38 which was not part of the original regulations proposed by the agency for public comment period, he was requested to submit these concerns under the petition for rule making authority of the *Code* § 2.2-4007 A. The commenter resubmitted his comments under that authority and therefore those comments are included herein.

(2) Clarification should be made for all situations involving home offices and other related parties. The facility should be reimbursed the cost to the related party, regardless of the amount of payments made by the facility to the related party.

RESPONSE: The Department's regulations at 12 VAC 30-90-51 "purchased - related organizations" and at 12 VAC 30-90-240 "home office operating costs" basically provide that the costs of the related parties and/or home office will be allowed as costs of the provider, without reference to the amount of payments made by the facility to the related party or home office. This appears to be consistent with

the comment. Therefore, DMAS assumes the comment is directed to the regulation at 12 VAC 30-280.I.B dealing with the lease of facilities from a related party. This section states as follows. "Reimbursement of lease costs pursuant to a lease between parties which are related (as defined in 12 VAC 30-90-50) shall be limited to the DMAS allowable cost of ownership."

DMAS agrees that clarification is needed in the regulation language to more clearly indicate that the allowable costs of ownership of the related party will be allowed as the costs of ownership of the provider, the effect is to treat the lessor and lessee as the same party. This is consistent with the interpretation issued in the Medicaid Memo dated October 28, 1992. Therefore, DMAS is changing the language of the second sentence in the regulation at 12VAC30-90-280 to substitute the word "adjusted" in place of the word "limited" and as corrected shall read as follows. "Reimbursement of lease costs pursuant to a lease between parties which are related (as defined in 12VAC30-90-50) shall be adjusted to the DMAS allowable cost of ownership."

(3) Recommendations were made concerning the definition of a 'qualifying project' as contained in 12 VAC 30-90-38.

RESPONSE: This recommendation is for the addition of clarifying language to the existing regulation at 12 VAC 30-90-38. DMAS generally concurs with the recommendations and proposes the following revised wording of the regulation at 12 VAC 30-90-38.D:

> "D. Capital expenditures are to be included on the schedule of assets. These do not include land purchases, but do include land improvements, renovations, additions, upgrading to new standards, and equipment purchases. Capital expenditures shall be capital related expenditures costing $50,000 or more each, in aggregate for like items, or in aggregate for a particular project. For facilities with 30 or fewer beds, an amount of $25,000, rather than $50,000, shall apply. The limits of $50,000 and $25,000 shall apply only to expenditures after July 1, 2000. For these purposes like items means those items acquired within a 12 month period that are classified in one of the categories of land improvements, or building improvements, or moveable equipment. Additionally, capital related expenditures which are part of a particular project may be included on the schedule of assets for the cost reporting date which is after the date the assets have been placed into service, whether or not all the required $50,000 threshold of costs of the ongoing project have been incurred as of the reporting date**."**

Tandem Health Care

One individual wrote with two comments:

(1) It appears that the mechanics of the Direct Cost Rate adjustment and Direct Ceiling Adjustment are identical to those under the PIRS system. The difference is the clinical tool to measure the acuity and the timing of the data used. This commenter provided a detailed example calculation to support his conclusion.

RESPONSE: The comment compares the quarterly timing of the clinical data scores used to compute the direct cost rate adjustment factor under the existing PIRS methodology with that of the quarterly timing of the clinical data used to compute the direct cost rate adjustment under the proposed RUGs methodology. The comment notes that there was an apparent one quarter shift backwards of the quarterly data used under the RUGs methodology as compared to the PIRS methodology. The comment found the timing of the PIRS methodology acceptable but questioned the timing for the RUGs methodology. The quarterly shift in clinical scores used is a one quarter backwards shift as the commenter pointed out but in reality there is only a one day difference in the picture date used to gather this data from the data base of information. The PIRS methodology used the first day of the quarter as the picture date for determining the PIRS score for the previous quarter whereas the RUGs methodology uses the last day of the quarter as the picture date for the current quarter for determining the RUGs score. Thus the RUGs case mix index score for a quarter is at the end of the quarter and is relevant to the cost incurred in the succeeding quarter in that the patients representing the case mix score are most likely to continue as patients into the succeeding quarter which begins only one day later based on picture dates.

(2) There is no language governing the calculation of an acuity measure for a period less than 12 months. This commenter further stated that in the past, there had been inconsistent applications of the SII statistics to compute cost rate adjustments for cost report periods less than a full year.

RESPONSE: The Department recognizes that due to changes in ownership and other events, providers submit cost reports that cover periods of less than a full year. There are a small number of these occasions and a very large number of variations on the short period. The Department does not think that it is possible to cover all situations in the regulations but will work with providers to address their questions on specific occurrences of this issue as they arise.

Virginia Health Care Association

(1) General comments and observations

The word “patient” should be replaced with “resident” to be consistent with other federal terminology.

RESPONSE: The usage of the term "patient" is consistent with the usage in the Medicare rules and regulations at PRM-1 §§ 2102.2 and 202.2 which defines as one of the elements of necessary costs that the costs be "related to patient care." Therefore we believe the terms "patient" and “resident”, are both appropriate terminology for these regulations.

The regulations include many examples that encumber the regulations and in order to be changed require substantial effort. Examples should be supported by policy statements and provider manual discussion.

RESPONSE: DMAS agrees with the comment that such examples as that at 12 VAC 30-90-306.F do tend to add significant volume to the regulations and when changes are made require extra effort to make such changes. But DMAS also believes that having clarifying examples, which apply the provisions of the basic language of the regulations, as an integral part of the regulations is most helpful to the user of the regulation to interpret its meaning and application. DMAS believes this lessens the potential for dispute and appeals resulting from the misinterpretation of the regulations. Therefore, DMAS believes that the use of the examples in the regulations should remain.

The VHCA requested that the Department (DMAS) focus resources on the development of a fair and objective RUGs validation program to include informing providers how DMAS intends to validate the case-mix assessment process. Specifically, the VHCA recommended that DMAS, in conjunction with the Department of Health, develop a Virginia Medicaid Case Mix Handbook as a reference document and establish a training program for providers.

RESPONSE: To date, DMAS has provided the nursing facility providers with a document, “RUG Item Review Guidelines.” This document provides general guidelines and definitions for specific MDS items. This material has been taken from the MDS assessment form and the Resident Assessment Instrument (RAI) Manual, Version 2.0.

The Virginia Department of Health is responsible for routine training of all nursing facilities regarding the Resident Assessment Instrument. DMAS will participate in provider training sessions that are provided by the Department of Health.

The VHCA encouraged DMAS to use electronic capabilities to improve provider communications and information dissemination with respect to regulations, regulatory interpretations, cost ceilings, required forms, facility-specific data and reports, and other provider communications.

RESPONSE: DMAS agrees with the comment. The DMAS home page on the World Wide Web at www.dmas.state.va.us has a direct link to the web site of the Virginia Administrative Code and the specific DMAS regulations included therein. Additionally the DMAS home page includes electronic versions of the providers' Medicaid manuals, Medicaid Memos to Providers, nursing facility cost reimbursement ceilings and other provider specific information that can be accessed with the free "Acrobat Reader" software. Additionally DMAS has an e-mail subscription service that providers and other individuals may subscribe to in order to be on a list of users who automatically receive e-mail announcements from the Department. The Department continues to seek ways to utilize the internet to facilitate its communication with providers. DMAS welcomes recommendations of specific items that providers might desire to access via the internet.

(2) REGULATION-SPECIFIC COMMENTS AND OBSERVATIONS

i. 12 VAC30-90-41 A.

The VHCA recommended language modification to insert “as defined in Appendix IV” at the end of the first sentence.

RESPONSE: The Department will make the suggested change.

ii. 12 VAC30-90-41 A.3.

The VHCA suggested sentence revision to read “Each facility’s average Medicaid case mix index shall be calculated as of the end of each calendar quarter based upon MDS data reported by that nursing facility to the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA) Minimum Data Set (MDS) System.”

RESPONSE: The Department believes that the currently proposed language is satisfactory. This is a general statement; details of the case mix index are found in Appendix IV.

iii. 12 VAC30-90-41 A.4.b.

The VHCA questioned what data period would be used for the calculation of nursing facilities’ normalized facility average Medicaid CMI and pointed to some language inconsistencies between this section and the illustrations found at 12 VAC30-90-302 F.

RESPONSE: The proposed regulations show that 12 VAC30-90-302 has been repealed. DMAS believes that the citation should be 12 VAC30-90-307 F. DMAS requested clarification from the VHCA on the inconsistencies that are referenced in this comment. DMAS has not received further clarification from the VHCA.

iv. 12 VAC30-90-41 A.4.c.

Following the last sentence of this section, the VHCA suggested the addition of the following referencing text: "The Medicaid CMI applicable to each prospective semiannual period will be determined as outlined in Table IV, Appendix IV (12 VAC30-90-302 D.)".

RESPONSE: There is only one sentence in 12 VAC30-90-41 A.4.c. The sentence reads: "See 12 VAC30-90-307 for the applicability of case-mix indices." DMAS does not believe that any regulation change is needed in response to this comment.

v. 12 VAC30-90-41 A.5.a. and 12 VAC30-90-41 A.5.b.

The VHCA suggested that the term "most recent base year" be defined within the discussion of the calculation of the direct patient care and indirect operating ceilings. Additionally, the VHCA recommended that the phrase used in both sections "using more recent cost data" be replaced with "the most recently filed cost report data for which an audit or desk settlement has been performed".

RESPONSE: The term base year has been defined in the regulations at 12 VAC 30-90-305 B and the phrase "cost-settled" has been added to that definition in response to the comment.

In regard to the second comment, the Department will change the third sentence in 12 VAC30-90-41 A.5.a. to read as follows: "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."

The Department also will change the third sentence in 12 VAC30-90-41 A.5.b. to read as follows: "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."

vi. 12 VAC30-90-41 B.

The VHCA recommended that DMAS proceed to enhance the accuracy of the Virginia-Specific Nursing Home Input Price Index, published by Standard & Poor's DRI (DRI). Recently, DMAS distributed a survey to all Medicaid nursing facility providers seeking current cost data in the areas of nursing salaries and wages, including the cost related to the use of staffing agencies, benefits, and liability insurance.

The VHCA understood that the results of this survey will be provided to DRI to improve the accuracy of its Virginia nursing home price index. Given the documented and significant variances between DRI-measured cost increases and historical increases in per patient day operating costs of nursing facilities, the VHCA recommended that the DRI methodology be modified to incorporate the results of the provider cost surveys at the earliest possible date.

As previously discussed with representatives of DMAS, the VHCA recommended that the weighting used for the various expense components within the DRI nursing home price index be recalculated to reflect shifts in costs that have occurred since the weighting was originally determined.

RESPONSE: DMAS will provide the results of the referenced survey to DRI as discussed. DMAS expects to provide the results to DRI in May and anticipates that any impact on inflation factors will be available in June, to be used in the rate calculation for July 1, 2002. DMAS also intends to develop data needed to update the weighting as soon as possible. DMAS is researching this, but does not know if the data will be available prior to July 1, 2002. The procedures DRI uses to develop inflation factors are not part of the Virginia Administrative Code and are not addressed in the proposed regulations. Therefore there is no change to the proposed regulations that needs to be considered as a result of this comment.

vii. 12 VAC30-90-41 B.1.

The VHCA urged DMAS to reconsider the methodology proposed to adjust ceilings and rates for inflation. The VHCA suggested that the provision stipulating the use of the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year be modified so that the regulations reflect what the VHCA believes to be both DMAS' intent as well as the approach desired by nursing facility providers.

Specifically, the VHCA recommended that the regulations state that DMAS will use a common inflation factor for all facilities, regardless of fiscal year end, and that the factor will be the 4th quarter index published in the 4th quarter of that year.

Furthermore, under this approach, the VHCA suggested that DMAS update the inflation factor in the following year to reflect differences between the original value used and the

newer published index information for the same time period. Thus, corrections made by DRI in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming fiscal year.

As is now proposed, the regulations should stipulate the utilization of quarterly adjustment factors to translate the 4th quarter index to the mid-point of a provider's fiscal year. This approach is consistent with discussions between DMAS and the nursing facility payment workgroup members.

For purposes of the *initial* implementation of this recommended approach, the VHCA recommended that DMAS use the 2002:1 DRI values modified to reflect the results of the provider cost survey now in process. In subsequent periods, the VHCA's recommendation is to use the factor for the 4th quarter index published in the 4th quarter of that year as discussed previously in this letter.

RESPONSE: DMAS does not object in principle to the recommendation in this comment that rates should be adjusted each year using the moving average for the 4th quarter of the previous calendar year rather than the one for the 2nd quarter of the prospective year. In either case the moving average would be from the DRI table for the 4th quarter of the previous calendar year. However, at the present time such a change would be expected to increase expenditures, and would require increased appropriation. Therefore DMAS is not able to make this change at this time. DMAS will discuss this issue further with the industry and consider a budget request for next year.

DMAS agrees that it makes sense to update the inflation factor in the second year after re-basing, to reflect not only one more year's inflation, but also any revisions in inflation estimates from the base year through the year prior to the new prospective year. This would involve recalculating ceilings in the second year after re-basing by inflating again from the base period to the new rate period with the more recent DRI table's applicable inflation factors. However, at the present time this change would require an increased appropriation. Therefore DMAS is not able to make this change at this time. It will discuss this issue further with the industry and consider a budget request that would be necessary to accommodate this recommended change for next year.

A second type of correction of inflation factors, addressed by this comment, would be to adjust the coming year's inflation factor to compensate for differences between the inflation factor used in the previous year and the more recent estimate of inflation in the previous year. This too is estimated to involve the need for additional funds, and so the Department is unable to act on it at this time. In addition, the Department is concerned that the fiscal impact may be unpredictable and that this type of correction could result in very large changes, either up or down, in rates from one year to the next. However, the Department wishes to discuss this further with the industry for consideration in a future year.

Based on subsequent discussion with the individual submitting the comment, the comment concerning use of quarterly adjustment factors to translate the 4th quarter index to the mid-point of a provider's fiscal year is in support of the proposed regulation. Therefore no response is needed.

DMAS intends that DRI factors used for setting rates effective July 1, 2002, should reflect the results of the provider cost survey. However, it expects that this will be accomplished through a revision of the fourth quarter 2001 table. Therefore, it does not believe there is a need to use the first quarter 2002 table to set rates for July 1, 2002.

viii. 12 VAC30-90-41 C.

While RUGs is used in casual and informal reference to the Virginia Medicaid payment system for operating costs, the VHCA suggested that DMAS clarify within the final regulations that the RUG-III method applies to the direct care components of the methodology and recommended the following change:

> The RUG-III method shall require comparison of the prospective *direct* operating cost rates to the prospective *direct* operating ceilings.

RESPONSE: The response suggested by the comment addresses only the direct portion of the operating rates and ceilings. The text at 12 VAC30-90-41 C. addresses both the direct and indirect operating rates and ceilings. To clarify this statement, the Department will change the first sentence of 12 VAC30-90-41 C. to read as follows: "The RUGS Nursing Home Payment System shall require comparison of the prospective operating cost rates to the prospective operating ceilings.

ix. 12 VAC30-90-41 E.

It is the understanding of the VHCA that the federal requirements which previously stipulated that state Medicaid programs include lower of cost or charge provisions are no longer in effect. The VHCA recommended that DMAS remove the lower of cost or charge language within the first sentence of this regulatory section.

RESPONSE: DMAS is of the opinion that the federal regulations have not directed the removal of the lower of cost or charges provisions from the Medicaid regulations as relates to providers reimbursed based on costs incurred. The lower of cost or charges provisions continue to be applicable to Medicaid providers reimbursed based on costs incurred. Any change to the Medicaid regulations in this regard would have to be studied further as to the effect on provider reimbursement,

budgetary impact, and funding requirements. Any findings would be discussed with the ongoing nursing facility payment workgroup.

x. 12 VAC30-90-41 G.

1. The term "not in conformance" needs to be defined in terms that are consistent with certification survey findings – i.e. substantial compliance or not in substandard quality of care, no deficiencies in the level of immediate jeopardy, etc.

2. The term "quality of care" standards should be defined. Does it apply to industry standards, standards set by the Medicaid Program or does it reference the group of federal regulations for certification that CMS has defined as quality of care?

3. The term "prorated period of time" should also be defined. Does it apply to the specific number of days that the facility is "not in conformance"? Depending on how "conformance" is defined, there could be significant impact on nursing facilities having survey problems. If determined to be out of conformance, who determines when the facility is in conformance (i.e. DMAS, VDH or CMS)? If the survey outcome is to be used, it should be stated.

RESPONSE: DMAS agrees that the language at 12 VAC30-90-41 G is not specific and will change the sentence following "Quality of care requirement" to read as follows: A cost efficiency incentive shall not be paid for the number of days for which a facility is out of substantial compliance according to the Virginia Department of Health survey findings as based on federal regulations.

xi. 12 VAC30-90-270 Uniform Expense Classification (Appendix I.)

Subsequent to the July 1, 2002, implementation of the RUGs III Medicaid payment system, the VHCA recommended that DMAS reconvene the nursing facility payment workgroup to comprehensively review the individual expense categories comprising the direct care and indirect cost components. One key objective would be the issuance of revised guidance by DMAS, to NF providers, which clearly establishes proper classification and reporting of all nursing facility operating and capital costs. The VHCA believes this will benefit both DMAS and providers by significantly reducing the subjectivity inherent in the cost reporting process and correspondingly reducing the likelihood for appeals activity.

RESPONSE: The Department is amenable to future consultation with the nursing facility payment wo rkgroup to address issues of concern to the provider community such as here noted by the comment.

xii. 12 VAC30-90-271 A.1.

The definitions of 'supervisory positions' should not be limited simply to those listed. In some large facilities, the MDS Coordinator may oversee licensed or clerical staff who assist in meeting MDS completion and transmission requirements; the facility is required to have a RN as the MDS Coordinator. Definitions of supervisory positions should be broader and each facility should be able to demonstrate on an organizational chart those nurses who have supervisory roles.

RESPONSE: The Department will specify "MDS Coordinator" in 12 VAC30-90-271 A.1. in the list of supervisory positions.

xii. 12 VAC30-90-271 A.5.

1. Can a facility employ more than one quality assurance (QA) nurse?

RESPONSE: There is no limitation on the number of QA nurses that a facility can employ. To make this clearer in the proposed regulations, the first complete sentence of 12 VAC30-90-271 A.5. will be changed to read as follows: "Gross salary of licensed nurses who function as quality assurance coordinators and are responsible for quality assurance activities and programs."

2. Can the facility claim position(s) within the nursing facility as well as a portion of the "corporate" QA nurse?

RESPONSE: There is nothing in the proposed regulations that limit the number of positions for QA nurses, whether they are employed by the facility or by the corporate office. There is nothing to be changed in the proposed regulations as a result of this comment. The comment is regarding information and interpretation rather than suggesting a change to the proposed regulation language.

3. Will consulting fees incurred for QA activities be allowed as direct cost?

RESPONSE: The comment/question is asking for information and interpretation rather than suggesting a change to the proposed regulation language. The regulations state that consulting fees are allowable as indirect costs.

xiv. 12 VAC30-90-271 A.8.

Will the cost of Quality Assurance supplies be allowed as direct cost? While these cost are typically incurred for forms and manuals, they can be costly.

RESPONSE: Quality Assurance supplies used by quality assurance nurses in the monitoring and oversight of direct patient care activities will be allowable as direct

costs. Such supply costs should be included with Nursing Services supplies as identified by the regulations section 12 VAC 30-90-271.A.8.

xv. 12 VAC30-90-271 C.

The terms in this listing are generic in nature and do not reflect current technologies or the potential for new technology. The VHCA suggested that the language be modified to read "diagnostic tests that are covered by Medicaid" and list some examples followed by "etc."

RESPONSE: The listings of the Chart of Account items in 12 VAC30-90-271 and 12 VAC30-90-272 are related to the Medicaid Cost Report, instructions to the Cost Report, and to the billing system. While DMAS agrees there have been changes in the usage of preferred terminology, changes in terminology that have further ramifications in other documents and systems are not administratively warranted at this time. Note the response to xi regarding 12 VAC30-90-270 Uniform Expense Classification which says the Department is amenable to future consideration of review of the individual expense categories. Such a change as requested by this comment could be considered at the time of review of the individual expense categories.

Rehabilitative therapy services (physical, occupational and speech) should be defined in this section or by a listing of definitions within the regulations.

RESPONSE: These services are defined in the DMAS Nursing Home Manual. The Department does not believe that the therapy service definitions should be included in the proposed regulations. This request can be discussed in the future with the nursing facility payment workgroup.

xvi. 12 VAC30-90-271 C.3.

1. The term "inhalation therapy" should be defined. From a clinical perspective, it is a generic term that may be used when administering oxygen, or medications via a nebulizer or inhaler, or in some cases it may be used interchangeably with "respiratory therapy".

RESPONSE: The Department will change the term "inhalation therapy" to read "respiratory therapy", a term that is used more frequently today. The definition for "Respiratory therapy" will be added in the DMAS Nursing Home Manual. This issue can be discussed in the future with the nursing facility payment workgroup.

2. The regulations should identify who can administer inhalation therapy. According to the MDS (Section P/1) the nursing facility may code for respiratory therapy provided by a qualified nurse or respiratory therapist.

RESPONSE: The Department will include this information in the DMAS Nursing Home Manual. The issue of including this information in regulations can be discussed in the future with the nursing facility payment workgroup.

APPENDIX III.

xvii. 12 VAC30-90-290

Within the indirect cost center, costs incurred for administrator salaries and medical director fees are subject to additional cost "caps". These caps serve only to financially penalize facilities that acquire these services in an open, competitive market. The denied payment resulting from this provision affects facilities' ability to attract and retain highly qualified administrators and medical directors during a time when strong leadership is critically important. The VHCA believes that there is no appropriate place for either of these caps in today's environment and recommended their elimination.

RESPONSE: These limits on administrator salaries and medical director fees were developed in the past when the Department identified costs incurred by several providers that appeared to be greater than a reasonable amount. These limits on the allowable amounts of these costs for reimbursement purposes continue to serve this purpose. The Department is not opposed to reviewing these limits as compared to costs that are actually being incurred in arms length transactions. The results of any such review would need to be discussed with the nursing facility payment workgroup. Any proposed changes to regulations must be assessed for their budgetary impact and adequacy of funding to cover any such changes.

APPENDIX IV.

xviii. 12 VAC30-90-300
(Note that 12 VAC30-90-300 has been repealed in the proposed regulations. It is assumed that the citation being addressed is at 12 VAC30-90-305.)

The VHCA recommended that DMAS modify the regulations to include a more comprehensive definition of RUGs; one that discusses the basic concepts of grouping ADL scores (including which ADLs will be used) in combination with other conditions/diagnosis/treatments taken from the MDS.

RESPONSE: The Department does not believe that this type of discussion is appropriate in regulations. The Resource Utilization Groups III is a resident classification system that was developed under contract to CMS and continues to be supported and revised by CMS. In addition to published documents, the CMS web

site maintains information on the classification system and the Resident Assessment Instrument that includes the Minimum Data Set.

xix. 12 VAC30-90-301 B.
(Note that 12 VAC30-90-301 has been repealed in the proposed regulations. It is assumed that the citation being addressed is at 12 VAC30-90-306 B.)

The VHCA suggested that the language be modified to include the specific case mix indices for each of the 34 RUG-III groups. In lieu of this information, a reference to published data sources for the indices could be provided.

RESPONSE: A table will be added to the regulations that provides the list of specific case-mix indices for each of the 34 RUG-III groups as developed by CMS for the Medicaid population and referred to as BO1. A copy of this table is provided below.

RUG CATEGORY	RUG Description	CMS "Standard" B01 CMI Set
RAD	Rehabilitation All Levels / ADL 17-18	1.66
RAC	Rehabilitation All Levels / ADL 14-16	1.31
RAB	Rehabilitation All Levels / ADL 9-13	1.24
RAA	Rehabilitation All Levels / ADL 4-8	1.07
SE3	Extensive Special Care 3 / ADL >6	2.10
SE2	Extensive Special Care 2 / ADL >6	1.79
SE1	Extensive Special Care 1 / ADL >6	1.54
SSC	Special Care / ADL 17-18	1.44
SSB	Special Care / ADL 15-16	1.33
SSA	Special Care / ADL 4-14	1.28
CC2	Clinically Complex with Depression / ADL 17-18	1.42
CC1	Clinically Complex / ADL 17-18	1.25
CB2	Clinically Complex with Depression / ADL 12-16	1.15
CB1	Clinically Complex / ADL 12-16	1.07
CA2	Clinically Complex with Depression / ADL 4-11	1.06
CA1	Clinically Complex / ADL 4-11	0.95
IB2	Cognitive Impairment with Nursing Rehab / ADL 6-10	0.88
IB1	Cognitive Impairment / ADL 6-10	0.85
IA2	Cognitive Impairment with Nursing Rehab / ADL 4-5	0.72

RUG CATEGORY	RUG Description	CMS "Standard" B01 CMI Set
IA1	Cognitive Impairment / ADL 4-5	0.67
BB2	Behavior Problem with Nursing Rehab / ADL 6-10	0.86
BB1	Behavior Problem / ADL 6-10	0.82
BA2	Behavior Problem with Nursing Rehab / ADL 4-5	0.71
BA1	Behavior Problem / ADL 4-5	0.60
PE2	Physical Function with Nursing Rehab / ADL 16-18	1.00
PE1	Physical Function / ADL 16-18	0.97
PD2	Physical Function with Nursing Rehab / ADL 11-15	0.91
PD1	Physical Function / ADL 11-15	0.89
PC2	Physical Function with Nursing Rehab / ADL 9-10	0.83
PC1	Physical Function / ADL 9-10	0.81
PB2	Physical Function with Nursing Rehab / ADL 6-8	0.65
PB1	Physical Function / ADL 6-8	0.63
PA2	Physical Function with Nursing Rehab / ADL 4-5	0.62
PA1	Physical Function / ADL 4-5	0.59

xx. 12 VAC30-90-301 C.

(Note that 12 VAC30-90-301 has been repealed in the proposed regulations. It is assumed that the citation being addressed is at 12 VAC30-90-306 C.)

1. The VHCA recommended that the second sentence in this section be revised to read as follows:

   Each resident in each Medicaid-certified nursing facility on the picture date with a completed assessment that has an effective assessment date within the ~~preceding~~ quarter, shall be assigned a case mix index based on the resident's most recent assessment ~~for~~ on file as of the picture date as available in the DMAS MDS data base.

   RESPONSE: The Department will revise the section to delete the term "preceding". However the second recommended change will not be made since it implies that the most recent assessment on file is a valid assessment,

i.e. has been completed within the time period specified in federal regulations and is effective on the picture date.

2. The regulations should include a definition of what type of assessments will be used to calculate the RUGs score. It is the VHCA's understanding that a quarterly assessment does not contain all of the variables used to determine an accurate RUGs score. If the most current admission, annual, or significant change assessment is to be used, it should be so stated along with an indication that in some cases the same assessment would be used over multiple quarters.

RESPONSE: The Department believes that all data elements necessary to determine the RUG-III, 34-group resident classification are found on the version of the quarterly MDS that nursing facility providers in the Commonwealth are required to submit. There should be no cases when the same assessment would be used over multiple quarters.

3. There also needs to be clear delineation of which assessments will not be used. For example, those that are coded for Medicare PPS purposes only; those in which Medicaid is not listed as a current payment source (Section A/7 of the MDS).

   a. Would an assessment be used for a Medicaid eligible resident (current Medicaid number in Section AA/7) who is coded as "Medicaid resident liability or Medicare co-payment" but not coded as Medicaid being the current payment source? This could apply to Medicaid residents who have other coverage but where Medicaid is covering some services.

RESPONSE: The Department does not use MDS assessment items to determine whether the resident is considered Medicaid for calculation of the facility average Medicaid case-mix index for rate calculation purposes.

The process that is used by the Department is as follows: 1) The Department first checks the eligibility file and determines whether the resident was in the nursing facility on the picture date. 2) If the resident was in the facility on the picture date, the system will check for a match with personal identifying information on the MDS and the eligibility file (a match must be made on the Medicaid Identification number OR the Social Security number AND on the date of birth) for the resident to be considered Medicaid. 3) If the match in step 2) is made, the eligibility file is examined to determine the resident's "Effective Date" and "End Date". These define the time period(s) for which Medicaid payment is approved. The resident's "Effective Date" and "End Date" must include the picture date for the quarter for the resident to be identified as Medicaid for case-mix calculation purposes.

xxi. 12 VAC30-90-301 D.3.
(Note that 12 VAC30-90-301 has been repealed in the proposed regulations. It is assumed that the citation being addressed is at 12 VAC30-90-306 D.3.)

The VHCA suggested that DMAS reconsider the wording of this section. Even after considerable discussion with DMAS representatives regarding the provisions addressed in this section, the intent of the language remains less than fully understood.

Previous discussions related to the possible July 1, 2004, revision to the methodology addressed in this section focused on an accompanying change which would eliminate the case-mix normalization adjustment now utilized and addressed at 12 VAC30-90-306 D.2. The VHCA suggested that DMAS modify the language to indicate that such a change, if implemented, would be based upon support of the workgroup and would be accompanied by the elimination of the case-mix normalization adjustment.

RESPONSE: The Department agrees with the principle of this comment and will revise the language to reflect that any review of the neutralization process will also include review of the normalization process. The Department further believes that the action referenced in the regulatory language (at 12 VAC30-90-306 D.3.) is not anticipated until July 2004 at the soonest and there is ample time to consider changes to the language with the nursing facility payment workgroup during that time period.

xxii. 12 VAC30-90-301 D.4.
(Note that 12 VAC30-90-301 has been repealed in the proposed regulations. It is assumed that the citation being addressed is at 12 VAC30-90-306 D.4.)

In order to submit a corrected MDS assessment, the nursing facility may have to complete an entirely new assessment and transmit the assessment to the State database. A 30-day time frame is appropriate when there are few corrections that need to be made, however if the facility identifies significant errors in MDS coding, the corrections should be coordinated with the state RAI Coordinator's office and the facility may have multiple assessments to correct. This is a potentially complex and time-consuming process. The VHCA suggested that DMAS consider an allowance for exception to the 30-day limitation with prior approval by the Department.

RESPONSE: CMS has in the past emphasized and continues to emphasize to nursing facilities that there should be no errors in MDS coding. Federal regulations require that nursing facility providers submit corrections without delay to any MDS when the error(s) is discovered. The Department does not believe that there should be an exception to allow additional time for submitting corrections.

xxiii. 12 VAC30-90-301 D.5.

In lieu of assigning the lowest case-mix score, the VHCA suggested that DMAS consider using a one-year grace period for RUG-III classification problems arising from errors in assessment submissions. Within this grace period which would expire on June 30, 2003, the Department could either assign the average facility case-mix score, ignore the erroneous assessment, or allow an extended correction period.

RESPONSE: CMS has mandated that nursing facility providers electronically submit MDS data since June 22, 1998. The Virginia Department of Health (VDH) has worked diligently with providers before implementation of the electronic submission and VDH continues to work diligently with providers regarding the completion and submission of the MDS. DMAS has provided MDS data reports to nursing facilities for three shadow rate periods to give facilities an opportunity to review their data. Additional reports have been available through the VDH/CMS system since 1998. DMAS does not believe that further time is required as a grace period for errors in assessment submissions.

xxiv. 12 VAC30-90-305 and 12 VAC30-90-306

The MDS has several fields for date insertion. As indicated in the RAI Manual, each date has a distinct definition. Confusion may result at both the facility and state level when analyzing/monitoring Case Mix Indicator impact.

The VHCA recommended that DMAS add a definition for "effective assessment date" to 12 VAC 30-90-305.B. Resource or clarify exactly what section of the MDS is considered for inclusion/exclusion for Case Mix.

- Section A. 3.a. (The Assessment Reference Date)
- Section R. 2.b. (Date RN Assessment Coordinator signed as Complete)
- Section V. B. 2 (Date the RN Coordinator completed the trigger RAPS and the Location and Date of the RAP Assessment Documentation section.)

Additionally, the VHCA would also like to see clarification on how modification assessments would be treated.

RESPONSE: The Department will add a definition at 12 VAC30-90-305 B. that identifies the section of the MDS (A.3.a.) used as the "effective assessment date". The second comment requested clarification regarding the use of modifications to assessments. DMAS will use the most recent assessment (per A.3.a.) in the case mix calculation regardless of whether it is a regular submission or a more recent modification.

xxv. 12 VAC30-90-306 D.1.

Specific written definitions defining whether the resident meets the qualifications to be considered Medicaid-eligible for purposes of inclusion in the facility Medicaid CMI calculations would significantly increase the accuracy of the CMI.

RESPONSE: Please see the third response for item xx. 12 VAC30-90-301 C.

The VHCA suggested that DMAS consider the use of a Medicaid Change Tracking Form that would allow each facility to communicate throughout the quarter any changes to/from Medicaid status. This would be transmitted to the State database timely as principal payer sources change. This process could greatly decrease labor intensive activity during the currently defined 30-day correction time frame for both the facility and DMAS.

RESPONSE: Please see the third response for item xx. 12 VAC30-90-301 C.

xxvi. 12 VAC30-90-306 D.4.

The VHCA encouraged DMAS to adopt some form of electronic communication to allow for speedier completion/resolutions during the correction period. Direct communication with the facility MDS Coordinators on the MDS State Bulletin Page works well in other states to alert the facilities to immediate issues concerning Picture Dates.

RESPONSE: DMAS will provide a telephone number, fax number, and email address to be used for providers to report any problems. See also the response to the fifth general comment found under Virginia Health Care Association, (1) General Comments and Observations.

OTHER COMMENTS AND OBSERVATIONS

xxvii. 12 VAC30-90-38 Fair Rental Value Schedule of Assets Reporting.

Although not addressed within the proposed regulations, the VHCA would like to indicate our support for clarifications recently issued by DMAS related to the Fair Rental Value Schedule of Assets Reporting. In a April 3, 2002 letter from N. Stanley Fields to Goodman & Company, L.L.P, Mr. Fields indicated that the Department will adopt the recommendation that the interpretation of "like items" be all items that would be included in one of the three general classes of fixed assets, i.e. (1) Land Improvements; (2) Buildings and (3) Major Movable Equipment. This interpretation is intended to assist providers to more readily determine what specific items acquired in a 12-month period will meet the $50,000 in aggregate limit criteria to be included on the Schedule of Assets.($25,000 for facilities with 30 or fewer beds).

The VHCA suggested that the changes agreed to by DMAS be reflected within the final regulations.

RESPONSE: See response under Goodman and Company, (3).

Approximately a year and a half ago, the Department hosted meetings with nursing facility representatives to discuss the development of a quality incentive award program. The VHCA were encouraged about the potential benefits, in terms of improvements in quality of care, that such a program might bring to Medicaid providers in Virginia. Unfortunately, it appears that this effort has stalled. Recognizing the fiscal limitations facing both the Department and the VHCA, the VHCA urged DMAS to continue to explore this important area.

RESPONSE: The Department is very amenable to continuing to explore this important area. Due to budget constraints, the quality incentive award program was not funded in FY03.

Detail of Changes

Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or crosswalk - of changes implemented by the proposed regulatory action. Include citations to the specific sections of an existing regulation being amended and explain the consequences of the changes.

The proposed changes to the nursing facility reimbursement formula are beneficial to all affected parties since the new methodology will result in more appropriate operating payment rates to nursing facilities. Details of substantive changes to the existing regulations are as follows:

VAC Citation	Substance of the Suggested Change
12VAC30-90-41A.	Changes the use of the Patient Intensity Rating System (PIRS) to the use of the Resource Utilization Group (RUG) III as the resident classification system
12VAC30-90-41A3 and A4	Changes the use of the Service Intensity Index (SII) and statements related to the SII, establishes the use of the case mix index (CMI) and the CMS Minimum Data Set (MDS) Version 2.
12VAC30-90-41A5a	Technical changes.

12VAC30-90-41A5c	Technical changes.
12VAC30-90-41B	Technical changes
12VAC30-90-41B1	Replaces 12VAC30-90-41B1 through B2. Establishes new method through B2 for calculating inflation for rate and ceiling setting.
12VAC30-90-41C	Technical changes.
12VAC30-90-305 through 90-307	Contains examples, calculations, definitions, tables to demonstrate the application of the RUGs methodology.

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the impact on the institution of the family and family stability including the extent to which the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

This regulatory action will not have any negative effects on the institution of the family or family stability. It will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, or the assumption of family responsibilities.