Virginia Regulatory Town Hall

Final Regulation
Agency Background Document

Agency Name:	Dept. of Medical Assistance Services; 12 VAC 30
VAC Chapter Number:	12VAC30-90
Regulation Title:	Methods and Standards for Establishing Payment Rates - Long Term Care
Action Title:	2000 Nursing Home Payment System
Date:	05/02/2001; Effective 07/01/2001

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Please provide a brief summary of the new regulation, amendments to an existing regulation, or the regulation being repealed.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or changes contained in the proposed new regulation, amendments to an existing regulation, or the regulation being repealed.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 is intended to achieve two main goals: implementation of increased payments for operating costs and implementation of a new capital payment methodology, both of which are authorized by the 2000 Appropriations Act.

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.

Changed Citation	Substance of Change	Purpose of Change
12 VAC 30-90-29.D.: After the last sentence of D, add:	For purposes of this provision, the number of facilities in a chain shall be determined by counting nursing facilities, hospitals, and any other health care facilities that are licensed to admit patients or residents, whether or not they participate in the Medicaid program. Facilities in Virginia and in other states shall be counted in determining the number of facilities in a chain. Facilities shall be considered to form a chain if there is common ownership of the physical assets, or a common operator, or both.	Commenters asked for more detail in the regulations concerning how DMAS would determine whether a facility is part of a chain of more than two facilities. The additional language provides this detail.
12 VAC 30-90-29.C.: Delete existing new language, and substitute:	Return on equity (ROE) capital for leased facilities shall be phased out along with the methodology described in Article 2. Leased facilities shall be eligible for ROE after July 1, 2001, only if they were eligible for ROE on June 30, 2000	Commenters objected to the immediate elimination of ROE, pointing out that if owners could no longer receive ROE they would sell their facilities and this could increase expenditures. DMAS agreed with this comment and changed the language to allow a gradual phase-out of ROE.
12 VAC 30-90-280.III.B.5.a, and c.: In view of 2 above, the following changes should be made.	In a, the sentence "Return on equity will be limited to 10%." should be changed to "Return on equity shall be equal to the rental rate percentage used in connection with the fair rental value (FRV) methodology described in Article 3." For the existing new language in c., substitute: "Leased facilities shall be eligible for ROE after July 1, 2001, only if they were eligible for ROE on June 30, 2000."	Having allowed the phase-out rather than the immediate elimination of ROE, DMAS wanted to simplify the administration of the capital payment system. This will be achieved by using the FRV rental rate rather than a different interest rate index. Also, DMAS does not want to permit new ROE arrangements during the capital transition period, so only existing ROE arrangements will be allowed during this time period.

12 VAC 30-90-29.D.: Beginning with the sentence that starts "Facilities changing ownership…" two passages from the remainder of the paragraph should be deleted, so that the remainder of the paragraph would then read:	Facilities changing ownership after June 30, 2000, if the seller is not part of a chain organization, or if it is part of a chain organization consisting of no more than two facilities, shall be paid the per diem rate described in Article 3. The additional language described in 1 above remains part of this paragraph.	Commenters asked whether the chain language applied to the buyer or the seller. This language change was made to make clear that it is applied to the seller.
12 VAC 30-90-20.D.:	Changes internal references from VAC cites to Article references.	Technical change.
12 VAC 30-90-36: After the sentence that says "Hospital based facilities shall continue to be reimbursed under the methodology contained in Article 2.", the following new sentence should be added.	For purposes of this provision a hospital based nursing facility shall be one for which a combined cost report is submitted on behalf of both the hospital and the nursing facility.	Commenters asked what was the definition of a hospital-based facility. This language was added to provide the definition.
12 VAC 30-90-51.E	Restore stricken language	A commenter correctly pointed out that the stricken language was deleted in error, so it is being restored.
12 VAC 30-90-60.C.: The first two sentences of this section are unchanged. Starting with the last sentence of this	A (change) <u>decline</u> in <u>the replacement facility's</u> total occupancy of 20 percent<u>age points, in the replacement facility's first cost reporting period,</u> shall be considered to indicate a substantial change when compared to <u>the lower of</u> the <u>old facility's</u> previous	Comments were received concerning this language. The changes are designed to clarify the intent.

section, it should read as follows (new language is underlined):	two cost reporting periods. <u>The replacement facility shall receive the previous operator's operating rates if it does not qualify to be considered a new facility.</u>	
12 VAC 30-90-160.A.	. Restore stricken language	In response to comments received, DMAS has decided to return to the previous definition of change-of-ownership. This language change is consistent with this decision.
12 VAC 30-90-70.A.3.a	. At the end of the paragraph, "subdivision 6" should be changed to "subdivision 7.	Technical correction to internal cite.
12 VAC 30-90-34.	In new subsection 1, delete the following words that are in the parentheses: and whether or not the parties are related at the time of the sale Also revise the remainder of the sentence so it reads as follows (new language underlined): Shall be <u>the greater of</u> the seller's <u>allowable debt or the</u> allowable depreciated historical cost (net book value), as determined for Medicaid reimbursement. Also restore the previously deleted subsection 3, that starts "For purposes of Medicaid reimbursement, a "bona fide" sale…"	In response to comments received, DMAS has decided to return to the previous definition of change-of-ownership. This language change is consistent with this decision. In addition, one language change was needed to provide for the appropriate valuation of a facility after a sale, given that revaluation based on the sale itself is no longer permitted.
12 VAC 30-90-37.C.	Delete the last two sentences, that begin and end as follows: Changes of ownership for purposes …if there is a sale of stock, assets, or sales between related or unrelated	In response to comments received, DMAS has decided to return to the previous definition of change-of-ownership. This language change is consistent with this decision.

	parties.	
12 VAC 30-90-264 item 10	Added new text.	There is an adjustment to the occupancy requirement calculation that has been made for specialized care providers since the specialized care program began. However, the calculation has never been described in regulations. One commenter stated that the regulations should include this calculation, so it is included here.
12 VAC 30-90-19	New reg section added to final regulations.	In response to a public comment and at direction of Secretary's Office.

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 § 9-6.14:7.1, of the Administrative Process Act.

Date

C. Mack Brankley, Acting 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) §§9-6.14:7.1 and 9-6.14:9.1, for this agency's promulgation of proposed regulations subject to the Governor's review.

Subsequent to an emergency adoption action, the agency is initiating the public notice and comment process as contained in Article 2 of the APA. The emergency regulation became effective on July 1, 2000. The Code, at §9-6.14:4.1(C) requires the agency to file the Notice of Intended Regulatory Action within 60 days of the effective date of the emergency regulation if it intends to promulgate a permanent replacement regulation. The Notice of Intended Regulatory Action for this regulation was filed with the Virginia Register on August 15, 2000.

Title 42 of the Code of Federal Regulations Part 447 Subpart C regulates the reimbursement of institutional providers of services, such as nursing homes and inpatient hospitals.

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 promulgate new permanent regulations, to supersede the existing permanent regulations and the currently operating emergency regulations, to provide for the reimbursement methodology for nursing facility services. These permanent regulations establish the Fair Market Value methodology by phasing out the previous plant cost reimbursement policies and by revising the direct and indirect care ceilings. This regulatory action is not expected to directly affect the public's health, safety, or welfare.

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 affected by this action are the Nursing Home Payment System (Attachment 4.19-D, Supplement 1) (12 VAC 30-90-20 through 12 VAC 30-90-269), Appendices I (12 VAC 30-90-270 through 12 VAC 30-90-276) and II (12 VAC 30-90-280).

The existing nursing home payment system relies on direct and indirect cost ceilings that have not been updated except for inflation since 1991. Nursing home costs have increased faster than inflation and the 2000 – 2002 Appropriations Act (Chapter 1073) provided that:

1. Direct care ceilings are to be recalculated effective July 1, 2000, and set at 112% of the median of base year cost per day.

2. The use of a direct care efficiency incentive payment is to be eliminated.

3. The Department is to recalculate new ceilings, both direct and indirect, using a new base year at least every two years.

4. The Department is to adjust rates to restore funding for the negative impact of case mix adjustment on aggregate payments.

5. The Department is to adjust rates to incorporate the $21,700,000 (adjusted for inflation) provided by the 1999 Appropriations Act.

6. Direct care rates are to be set without application of an occupancy standard.

7. Indirect and capital rates are to be set with an occupancy standard of 90%.

8. The Department is to implement a revised capital payment policy. Furthermore, this was designated to a Fair Market Value system.

The Appropriations Act provided approximately $28 million per year (total funds), in addition to the $21.7 million per year (total funds) appropriated in 1999, to fund the implementation of these changes.

In addition, HB 2004 of the 1999 Session of the General Assembly provided that effective July 1, 2000, the recapture of depreciation expense payments by the Medicaid program is to be eliminated.

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 changes to operating reimbursement rules are beneficial to providers because they increase nursing home reimbursement rates. The higher rates necessarily commit the Commonwealth to a higher level of Medicaid expenditures; however, this has been addressed through the appropriation process. Furthermore, an advantage to the agency may be a reduction in the number of provider appeals of cost report adjustment issues during the cost settlement and review process. No disadvantages to the agency have been identified.

The changes to capital reimbursement rules are expected to be generally beneficial to providers. They are anticipated to increase capital payments to providers beginning in SFY2003. The estimated increase is based on the change in methodology is $1.3 million per year from 2003 through 2012. This means that estimated payments in 2012 would be $13 million higher than under the existing methodology. In addition, exceptions granted in the regulations to certain types of facilities are anticipated to cost another $1.3 million per year. This amount is not cumulative however, so the total combined impact of the change in reimbursement and the exceptions would be $2.6 million in 2002, and $14.3 million in 2012. In addition to increasing payments, the new methodology is expected to result in some providers receiving more and some less than under the existing methodology. Some of the changes, both plus and minus, are expected to be significant. In order to prevent undue disruption resulting from these provider specific payment changes, the new methodology is being gradually phased in over ten years (2003 through 2012). The changes to capital reimbursement are not expected to significantly affect the public or the agency.

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 January 29, 2001, Virginia Register for their public comment period from January 29th through March 30th. Comments were received on the letterhead of the following organizations:

- Smith-Packett Med-Com, Inc. (nine letters).
- Colonial Care, L.L.C. (ten letters).
- Tandem Health Care of Norfolk.
- Tandem Health Care of Windsor.
- Grayson Nursing and Rehabilitation Center.
- Shenandoah Manor of Clifton Forge.
- Medical Facilities of America, Inc.
- The Virginia Health Care Association (VHCA).
- American HealthCare, LLC.
- Crews & Hancock, P.L.C.
- Goodman & Company L.L.P. (one letter, one e-mail).

- Oak Springs of Warrenton Comprehensive Health Care Center.
- Pheasant Ridge Nursing and Rehabilitation Center.
- King's Daughters Community Health and Rehabilitation Center.
- Newport News Nursing and Rehabilitation Center.
- Augusta Nursing and Rehabilitation Center.
- Two individuals.

The Department would like to acknowledge the very able assistance it received from a work group composed of representatives of the nursing home industry. Members of this group gave generously of their time, meeting regularly from April 1999 through the present to review issue papers, modeling of various options, and regulatory language. Without their untiring commitment to this task, the present regulatory package and the progress it represents for the Virginia Medicaid Program, would not have been possible. The work group included representatives from the following organizations: The Virginia Health Care Association, The Virginia Hospital and Healthcare Association, The Virginia Association of Not for Profit Homes for Adults, Genesis Health Ventures, Riverside Convalescent Centers, Medical Facilities of America, Beth Shalom of Eastern Virginia, Sentara Life Care Corp., Virginia Department of Health, and Warrenton Overlook Health and Rehabilitation.

A summary of the comments received and the agency's responses follows.

Comment: One commenter addressed the regulation located at 12 VAC 30-90-51 E. The commenter stated the belief that the deletion of this language concerning related organizations and the three competitive bid requirement was the result of an administrative error. The commenter believed that it was an oversight on DMAS' part stemming from the previous emergency regulations. It is this commenter's position that related party builders should continue to be exempted from the three competitive bid requirement.

Agency response: The commenter is correct. The stricken language will be restored.

Comment: Three commenters addressed the proposed change to regulations at 12 VAC 30-90-29.C and 12 VAC 30-90-280.III.B.5.c. The commenters disagreed with the elimination of return on equity (ROE) for leased facilities. They stated that ROE should be phased out along with the rest of the existing capital methodology, instead of being eliminated immediately. They believe this is appropriate because: 1) the rest of the existing methodology is being phased out rather than eliminated, 2) ROE is not profit but simply recognizes a financing cost, 3) ROE is similar to the rental rate under FRV, and 4) eliminating ROE will force the sale of facilities and thereby increase capital expenditures. One commenter also believed ROE should continue to be allowed for new lease arrangements entered into after July 1, 2000.

Agency response: The agency agrees that return on equity (ROE) will not be eliminated immediately, but will be phased out along with the previous capital reimbursement system. However, the ROE calculation will use the FRV rental rate as the rate of return, and ROE will only be available to leased facilities already receiving ROE on June 30, 2000. The regulations will be revised accordingly.

Comment: Twenty-eight letters of comment were received from employees of, and individual facilities owned by, a single nursing home chain. They all wrote essentially the same comment concerning the regulations at 12 VAC 30-90-29. They objected to the provision requiring that facilities that are sold be paid the lesser of the transition period payment or the FRV rate. They expressed the concern that sold facilities would receive less reimbursement and therefore would lose value. This would result in their being unable to proceed with a sale of the facility. The commenters suggested that this issue could be avoided by stating that the buyer retains the seller's plant reimbursement payment and transition policy and rate. The commenters felt that this would result in the desirable outcome that plant reimbursement would not affect the decision to sell or buy and that this decision would be impacted only by circumstances outside the reimbursement system. They also felt this approach would result in fewer disputes and appeals, ultimately saving the Commonwealth time and money.

These commenters, along with three others, identified questions they believed needed to be addressed if the state retained the provision concerning change of ownership. The questions related to 1) the definition of change of ownership and 2) the definition of a chain for purposes of the exception provided in 12 VAC 30-90-29.D. Change of ownership questions asked what would happen in the case of transfer of stock, whether the percent of stock sold would have an impact, what would happen in the event of sale of a partner's share, etc. Questions about the definition of a chain asked what types of businesses were counted as entities in a chain, whether location of related facilities in Virginia affected membership in a chain, whether it was the seller or the buyer or both that will be considered in applying the exception, how lease arrangements are affected, and whether it is the owner or operator that defines a chain.

Agency response: The agency agrees that in the event of a sale it would be better to allow the new owner to remain on the transition payment of the previous owner. The regulations will be revised to provide that the sale will not change reimbursement under the transition. The new owner will receive the same reimbursement as the old owner would have received if the sale had not taken place. Note that there is still an exception to this for non-chain facilities and facilities in chains of no more than two health care providers. These facilities, if sold, will be paid the FRV rate. In addition, the definition of change of ownership will be revised to be largely the same as it was before the proposed regulations, therefore many of the questions about change of ownership are no longer relevant. Regarding the definition of a chain, the intent is that the number of facilities in a chain be determined by counting not only nursing facilities, but also hospitals and any other type institutional health care provider. It was also intended that facilities be counted whether or not they are located in Virginia, and that facilities be counted as a chain if the facilities have a common owner or operator or both. It is the seller not the buyer that is to be considered in applying this exception. The regulatory language will be revised to ensure that this intent is made clear.

Comment: One commenter noted that the regulations provide that property tax and insurance will be paid prospectively based on the actual cost in the previous year, and stated that an inflation factor should be applied to these items in setting the prospective amount. The DRI factor was suggested as a possibility.

Agency response: It is not a foregone conclusion that these items increase by a predictable amount each year, or that they necessarily increase every year. Property tax normally changes based on change in the appraised value of the facility, and while there are measures of change in the cost of construction, we know of no measure of the net change in property value once depreciation and any other factors are accounted for. As stated, appraised value could sometimes go down. Insurance also is affected by many factors for which there are no published forecasts, such as changes in the insurance market itself. It too could be reduced in some years. The agency believes that the annual changes in these items are small and relatively unpredictable, and is aware of no appropriate published measures of change for these items. These are also relatively small items in the context of nursing home payment rates, and the difficulty of developing a way to adjust them appropriately outweighs the benefit of making what would be a relatively small adjustment.

Comment: Two commenters disagreed with the transition-period rule (at 12 VAC 30-90-29.D.) that provided that facilities sold after June 30, 2000 would be paid the lesser of the FRV per diem or the transition policy payment. These commenters believe that during the transition period all bona fide changes of ownership should result in the facility being paid entirely based on the FRV method. One of these commenters suggested DMAS should work with individual providers that might be in financial jeopardy relative to changes of ownership.

Agency response: This comment is directly at odds with that of the thirty-seven comments (from one chain) reported above. That comment also objected to the "lesser of" language but recommended that sold facilities receive the previous owner's transition payment. As stated in response to those comments, the agency does not intend to retain the requirement that facilities that are sold be paid the lower of the transition payment or FRV. However, it also is not proposing to pay them all FRV. The intent is to revise the language to provide for most to continue to be paid the transition payment of the previous owner. As already provided in the proposed regulations, facilities that are not part of a chain, or are part of a chain of two or fewer health care facilities, will be paid the FRV rate instead of the transition payment. The agency is unwilling to provide that all facilities that are sold be paid the FRV rate. This would be too likely to provide an incentive for the sale of all facilities with FRV rates higher than transition rates. If this were to occur the increased expenditures by the program could become a serious problem. If all facilities that gain from FRV (and none of those that lose) were paid strictly under FRV, the cost to the state would be an estimated $17.4 million (total funds) per year.

Comment: One commenter pointed out that the change in the occupancy requirement applicable to capital payments is stated as being effective July 1, 2001, at 12 VAC 30-90-29.D., while it understood this change was to be effective July 1, 2000.

Agency response: Emergency regulations adopted effective July 1, 2000 provided for the 90% occupancy requirement to be in effect during SFY2001, and these proposed regulations do not change that. The present regulations are themselves effective July 1, 2001, and if they stated effective dates sooner than that date the provisions would be considered retroactive. This is not permissible under federal requirements nor permitted by the Virginia Registrar of Regulations.

Comment: One commenter wished to see clarification at 12 VAC 30-90-36.B.1. Specifically the referenced language states that the FRV payment shall be the only payment for capital related costs, including costs of property related taxes and insurance. The commenter stated that it understood taxes and insurance would be paid based on facility specific costs and that language at 12 VAC 30-90-37.A. supports this.

Agency response: The language at 12 VAC 30-90-37.A. provides, among other things, that facility specific taxes and insurance costs will be included in the FRV per diem rate. This makes these costs part of the FRV payment. Therefore the language at 12 VAC 30-90-36.B.1. is correct when it says that payments under the FRV methodology shall be the only payments for any capital related costs. It should be noted that the provision related to taxes and insurance states that payment shall be, in effect, the provider's previous year's settled costs for these items, converted to a prospective per diem.

Comment: Two commenters pointed out that there is no provision in the regulations specific to the issue of home office capital costs. One recommended that language be added to provide for continued recognition and payment of these costs. Both recommended that home office capital renovations should be recognized in the FRV methodology, as otherwise the calculation may yield a higher average age.

Agency response: There are two distinct issues that appear to be raised in this comment. The first question is whether some type of payment, in addition to the FRV rates already provided, should be made for home office capital costs. The agency does not believe such an additional payment is appropriate for two reasons. First, it is estimated that the FRV method as presently designed will increase payments by $13 million per year compared to existing rates that included home office capital. If additional home office capital payments are added to FRV rates, the increased cost to the state would exceed what has already been estimated. Secondly, a separate additional payment of home office capital costs is inconsistent with the principles on which fair rental payment for capital is based. The FRV method assumes that for each nursing home bed there are a given number of square feet of construction needed. The assumed square footage used to calculate the FRV payment includes all space associated with a nursing home, including hallways, common areas, and administrative office space. If a nursing home chain has a home office, this means it has centralized some of the administrative function from each nursing home to a shared location. The space needed by the home office should be offset by a reduction in the space required at the individual nursing homes. This should result in an economy of scale, not higher costs and a need for an additional payment. Therefore if Medicaid's policy is to pay a rental amount for each nursing home bed it uses, then the rental amount should not be affected by whether the owner has a home office. In addition, the value Medicaid derives from the use of the bed is not increased by the existence of a home office. If the home office allows the owner to operate more efficiently within the rental rate paid for all beds, then the benefit of that efficiency will automatically return to the owner without the need for any action to separately recognize home office capital cost. The agency does not intend to revise the regulations with respect to this issue.

The second question is whether the Schedule of Assets should include costs related to home office capital costs. If home office capital costs are to be included as suggested, the Schedule of Assets will need to include 1) all home office capital costs from the date the home office was first constructed, and 2) a method to allocate home office capital costs among nursing homes and among any other businesses operated from the home office, including those in other states. If home office costs are to be accurately captured, this allocation would have to be calculated separately for each year in which there were home office capital costs, using allocation statistics specific to the year. The agency does not intend at this time to capture home office costs on the Schedule of Assets. First, DMAS believes the very significant administrative cost (for both DMAS and providers) of capturing home office capital costs on the Schedule of Assets would be much greater than any possible benefit from having that information. Secondly, DMAS does not believe it is a foregone conclusion that capturing home office costs would necessarily have a significant effect on the average age calculation. A home office built at about the same time as the associated facilities, and renovated on approximately the same schedule, would have about the same average age, and would not significantly affect the calculation. It also seems likely that the inclusion of home office costs could as easily increase average age as decrease it. Therefore it does not appear that it is necessarily in providers' interest to include home office costs.

Comment: Three commenters disagree with the provision, at 12 VAC 30-90-60.D., which states that a change in ownership or bankruptcy or both does not change whether a facility is considered a new facility. The commenters believe the ability to grant new facility status to a provider experiencing financial difficulties should not be eliminated. One stated that the requirement that new facility status apply only when the facility has been terminated from the program will sometimes result in facilities allowing this to occur rather than forego the opportunity to achieve new facility status. The commenter recommends alternative standards for a facility to qualify for new facility status.

Agency response: The agency does not believe it is appropriate for the state to assume an increased cost burden due to the financial difficulties of an individual provider. In the case of bankruptcy the courts may still choose to intervene on behalf of the provider. The agency does not believe new facility status should be used simply to provide financial assistance to a provider with financial troubles. DMAS does not plan to change the proposed language.

Comment: One commenter recommends that the "small facility" capital expenditure threshold of $25,000, stated in 12 VAC 30-90-98.D. be applied to facilities of 60 beds or less, rather than 30 beds or less as presently provided. In the operating payment methodology a threshold of 60 beds is used to define small facilities.

Agency response: The agency is aware that different bed size thresholds are used for different purposes in the regulations. A threshold of 60 beds is used for indirect cost ceilings in most of the state, while a threshold of 90 beds is used to determine assumed square feet per bed for purposes of the FRV method. The threshold of 30 beds was previously used to define a different occupancy requirement for small facilities than for larger ones. The agency proposed 30 beds as the threshold for a specific expenditure threshold for reporting capital expenditures. No compelling rationale has been presented for using a different threshold. Therefore, the agency still believes this is a reasonable threshold. No change is proposed at this time.

Comment: One commenter states that the use of RSMeans and rental rate values that are changed each July first, and then applied to fiscal years beginning in the following year, will result in providers receiving higher or lower payment due to their year-end. They believe this is unfair and will lead to most providers choosing June 30 as their year-end. This comment relates to 12 VAC 30-90-36.B. The commenter recommends using quarterly updates.

Agency response: The agency believes that the commenter's proposed change would introduce too much added complexity for the limited benefit that might result. There is sufficient time to monitor any impact the annual adjustment of these factors might have on provider selection of fiscal periods, and to act accordingly.

Comment: One commenter asks: "The FRV methodology does not apply to hospital-based facilities. What happens when a hospital-based facility replaces itself on its campus in a separate facility in a manner which would qualify for it to be under common certification with the hospital and remain hospital-based, although it may be separately licensed as a nursing facility? Do the old plant cost rules continue to apply, or do the FRV rules apply?" This question is in connection with 12 VAC 30-90-36.A.

Agency response: The definition of "hospital-based nursing facility" is being included in the regulations, and means a nursing facility that files a combined cost report with the related hospital. As noted in this comment, hospital-based facilities are excluded from the FRV payment system. Therefore the answer to this question would depend on whether the facility being replaced on its campus were to file a combined cost report with the related hospital.

Comment: One commenter asks whether "freestanding nursing facilities", in 12 VAC 30-90-36.A., includes ICFs/MR.

Agency response: 12 VAC 30-90-20.D. exempts ICFs/MR from 12 VAC 30-90-35. To make this more explicit the regulations will be revised to say that ICFs/MR are exempt from Articles 1 and 3.

Comment: One commenter states that 12 VAC 30-90-60.C. is unclear regarding the specific changes that would result in a facility being deemed to have a 20% change in occupancy.

Agency response: The agency will make changes to the language to make it more explicit. DMAS believes it is reasonably clear that a replacement facility or one with a changed location would have to have a 20% drop in occupancy if it were to be considered a "new facility".

Comment: One commenter recommends that 12 VAC 30-90-160.B. and C., and 12 VAC 30-90-165.B. and C. should be eliminated due to the repeal of depreciation recapture.

Agency response: The referenced language does not relate to depreciation recapture which was repealed. The language will be retained.

Comment: One commenter stated that the regulations need to provide for the patient shortfall calculation for facilities that are specialized care providers.

Agency response: The agency will add language to clarify the referenced calculation.

Comment: One commenter stated that the regulation should provide for increased reimbursement to local government-owned nursing homes based on a transfer agreement and subsequent transfer of funds.

Agency response: The agency agrees with this comment and, subject to federal approval, will amend the regulations and the State Plan for Medical Assistance accordingly.

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.

DETAILS OF CHANGES

VAC Citation	Substance of the Suggested Change
12VAC 30-90-19	Establishes the new methodology for additional reimbursement for locally owned nursing facilities.
12 VAC 30-90-20	General introduction; establishes the NHPS' four basic components; ceiling limitation/divisions; policies for reimbursement of institutions for mental disease.
12 VAC 30-90-21 th 90-28	Reserved.
12 VAC 30-90-29	Contains transition policies from old plant cost to new capital payment methodologies.
12 VAC 30-90-30	Establishes a new occupancy standard for computation of NF per diem rates.
12 VAC 30-90-31	Technical changes.
12 VAC 30-90-32 th 90-33	No changes.
12 VAC 30-90-34	Establishes provider notification requirement in old plant cost article in the event of sale of NF;

	establishes cost report filing requirement for NF seller; repeals depreciation recapture policies. This section also defines allowable cost basis and allowable financing for purchases of existing nursing facilities.
12 VAC 30-90-35	Establishes the new capital costs (Fair Rental Value) payment method for capital costs related to owning and operating NFs; establishes a ten-year transition policy.
12 VAC 30-90-36	Establishes the method to calculate the Fair Rental Value per diem rate and amount and how ownership changes affect this. Also sets forth providers to which FRV is applicable and defines terms used in FRV regulations.
12 VAC 30-90-37	Also establishes the method to calculate the Fair Rental Value per diem rate and amount and how ownership changes affect this. Also sets forth providers to which FRV is applicable and defines terms used in FRV regulations.
12 VAC 30-90-38	Establishes the use of a schedule of assets to determine allowable plant costs.
12 VAC 30-90-39	Establishes provider notification requirements in the new Fair Market Value article in the event of the sale of the NF.
12 VAC 30-90-40	Establishes the two components of operating cost as direct patient care operating cost and indirect patient care operating cost and provides for how these cost components are to be calculated.
12 VAC 30-90-41	Repeals indirect payment methods and different ceiling adjustment levels based on licensed bed size; changes to direct/ indirect patient care operating ceilings; elimination of direct care efficiency incentive
12 VAC 30-90-42 th 12 VAC 30-90-43	Repealed.
12 VAC 30-90-44 th 90-49	Reserved.

12 VAC 30-90-50	Establishes allowable costs, deleting references to protecting employees from blood borne pathogens and Hepatitis B immunizations.
12 VAC 30-90-51	No change to this section in the final regs. Previous 3 bid requirement restored.
12 VAC 30-90-52 th 90-58	No changes.
12 VAC 30-90-59	Reserved.
12 VAC 30-90-60	New facilities defined; changes to occupancy percentage standard.
12 VAC 30-90-61 th 12 VAC 30-90-64	Reserved.
12 VAC 30-90-65	Minor updates.
12 VAC 30-90-66 th 90-69	Reserved.
12 VAC 30-90-70	Minor changes.
12 VAC 30-90-71 th 90-74	Reserved.
12 VAC 30-90-75	No changes.
12 VAC 30-90-76 th 90-79	Reserved.
12 VAC 30-90-80	Increases time for DMAS to conduct field audits.
12 VAC 30-90-81 th 12 VAC 30-90-89	Reserved.
12 VAC 30-90-90	No changes.
12 VAC 30-90-91 th 90-109	Reserved.
12 VAC 30-90-110	No changes.
12 VAC 30-90-111 th 90-119	Reserved.
12 VAC 30-90-120 th 90-125	Minor change to scope of audit.
12 VAC 30-90-126 th 90-129	Reserved.
12 VAC 30-90-130 th 90-133, 90-135	Repealed.

12 VAC 30-90-134	No changes.
12 VAC 30-90-136	Elements of capital payment method excluded from appeals.
12 VAC 30-90-137 th 90-139	Reserved.
12 VAC 30-90-140, 90-150	No changes.
12 VAC 30-90-160 cost.	Limits costs of stock acquisitions as not allowable
12 VAC 30-90-165	Establishes stock acquisition policies applicable in the new capital methodology; establishes policies for regulating related and unrelated parties.
12 VAC 30-90-166 th 90-169	Reserved.
12 VAC 30-90-170 th 90-210	No changes.
12 VAC 30-90-171 th 90-179	Reserved.
12 VAC 30-90-220	No changes.
12 VAC 30-90-221	Editorial changes.
12 VAC 30-90-222	No changes.
12VAC 30-90-223 th 90-229	Reserved.
12 VAC 30-90-230	No changes.
12 VAC 30-90-240	Minor change.
12 VAC 30-90-250	Minor change.
12 VAC 30-90-251 th 90-254	Minor to no changes.
12 VAC 30-90-255 th 90-259	Reserved.
12 VAC 30-90-260	Repealed.
12 VAC 30-90-261 th 90-263	Reserved.

12 VAC 30-90-264	Changes to capital cost allowances, occupancy standards, and discontinuing efficiency incentives related to Specialized Care services; minor changes.
12 VAC 30-90-265	Reserved.
12 VAC 30-90-266	Elimination of the originally effective add-on payment amount.
12 VAC 30-90-267 th 90-269	Reserved.
12 VAC 30-90-270	Applicability of entire Appendix I to previous Part II.
12 VAC 30-90-271	No change.
12 VAC 30-90-272	Addition of liability insurance as an authorized indirect patient care operating cost.
12 VAC 30-90-273 th 90-276	No changes.
12 VAC 30-90-280	Appendix II applicability to Subpart II, Article 2; return on equity capital limited to those facilities receiving ROE at 6/30/2000.

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.