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TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **June 1, 2015**

SUBJECT: **Fast Track Regulations Regarding Nursing Facilities Price-Based Reimbursement (4263/7075)**

I am in receipt of the attached regulations to modify the reimbursement methodology for nursing facilities. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate these regulations and if they comport with state and federal law.

Based on that review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority; and these regulations comport with the authorization granted under Chapter 2, Item 301 KKK of the 2014 *Acts of the Assembly* and Chapter 665, Item 301 KKK of the 2015 *Acts of the Assembly*.

Pursuant to Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

Because these regulations will amend the State Plan, approval by CMS will also be required. If you have any questions or need additional information about these regulations, please contact me at 786-6005.

cc: Kim F. Piner, Esquire

Attachment

Project 4185 - Fast-Track

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NF Price-Based Reimbursement

Part I

Methods and Standards for Establishing Payment Rates for Long-Term Care

12VAC30-90-10. Methods and standards for establishing payment rates for long-term care.

The policy and the method to be used in establishing payment rates for nursing facilities listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs.

1. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan to the extent these are available to the general population.

2. Participation in the Program will be limited to providers of services who accept, as payment in full, the amounts so paid.

3. Payment for care of service will not exceed the amounts indicated to be reimbursed in accord with the policy and the methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.253(b)(2). ~~The state agency has continuing access to data identifying the maximum charges allowed. Such data will be made available to the Secretary of Health and Human Services upon request.~~

4. Payments for services to <u>non-state owned</u> nursing facilities shall be ~~on the basis of reasonable cost in accordance with the standards and principles set forth in 42 CFR~~

~~447.252 as follows:~~ based on methodologies set out in the Nursing Home Payment System (12 VAC 30-90-44) for nursing facilities and in Part XVII of the Nursing Home Payment System (12 VAC 30-90-264 et seq.) for specialized care facilities.

5. Facilities operated by the Department of Behavioral Health and Developmental Services and facilities operated by the Department of Veterans Services shall be reimbursed retrospectively based on cost.

6. Reimbursement to Intermediate Care Facilities for the Intellectually Disabled (ICF/ID) shall be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare principles of reimbursement but limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

7. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate methodologies. Allowable costs shall be classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270 through 12VAC30-90-276) and shall be identifiable and verifiable by contemporaneous documentation. All matters of reimbursement which are part of the DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence.

8. All nursing facilities and intermediate care facilities shall submit cost reports on the basis of reasonable cost in accordance with the standards and principles set forth in 42 CFR 447.252 as follows:

a. A uniform annual cost report which itemizes allowable cost will be required to be filed within 150 days of each provider's fiscal year end .

b. The determination of allowable costs will be in accordance with Medicare principles as established in the Provider Reimbursement Manual (PRM-15) except where otherwise noted in this Plan.

c. Field audits will be conducted on the cost data submitted by the provider to verify the accuracy and reasonableness of such data. Audits will be conducted for each facility on a periodic basis as determined from internal desk audits and more often as required. Audit procedures are in conformance with SSA standards set forth in PRM-13-2. Internal desk audits are conducted annually within six months of receipt of a completed cost report from the provider.

d. Reports of field audits are retained by the state agency for at least three years following submission of the report.

~~e. Facilities are paid on a cost-related basis in accordance with the methodology described in the Plan.~~

~~f.~~ e. Modifications to the Plan for reimbursement will be submitted as Plan amendments.

~~g.~~ f. Covered cost will include such items as:

(1) Cost of meeting certification standards.

(2) Routine services, which include items expense providers normally incur in the provision of services.

(3) The cost of such services provided by related organizations except as modified in the payment system at Part II ~~(12VAC30-90-20 et seq.)~~ (12 VAC 30-90-29 et seq.) of this chapter.

~~h.~~g. Bad debts, charity and courtesy allowances shall be excluded from allowable cost.

~~i.~~h. ~~Effective for facility cost reporting periods beginning on or after October 1, 1978, the reimbursable amount will be determined prospectively on a facility by facility basis, except that facilities operated by the Department of Behavioral Health and Developmental Services and by the Department of Veterans Services shall be reimbursed retrospectively. The prospective rate will be based on the prior period's actual cost (as determined by an annual cost report and verified by audit as set forth in subdivision 4 c of this section) plus an inflation factor.~~ Payments will be made to facilities no less than monthly based on claims submitted by the facility.

~~j.~~i ~~The payment level calculated by the prospective rate will~~ Payments shall be adequate to reimburse in full such actual allowable costs that an economically and efficiently operated facility must incur. ~~In addition, an incentive plan will be established as described in the payment system at 12VAC30-90.~~

~~k. Upper limits for payment within the prospective payment system shall be as follow:~~

~~(1) Allowable cost shall be determined in accordance with Medicare principles as defined in PRM-15, except as may be modified in this plan.~~

~~(2) Reimbursement for operating costs will be limited to regional ceilings.~~

~~(3) Reimbursement, in no instance, will exceed the charges for private patients receiving the same services. In accordance with § 1903(a)(2)(B) of the Social Security Act, nursing facility costs incurred in relation to training and competency evaluation of nurse aides will be considered as State administrative expenses and, as such, shall be exempted from this provision.~~

~~l.~~j. In accordance with 42 CFR 447.205, an opportunity for public comment was permitted before final implementation of rate setting processes.

~~m. A detailed description of the prospective reimbursement formula is attached for supporting detail.~~

~~n.~~k. ~~Item 398D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return~~ Return on equity capital to proprietary providers shall not be an allowable expense.

~~5.~~ 9. Reimbursement of nonenrolled long term care facilities.

a. Nonenrolled providers of institutional long term care services shall be reimbursed based upon the average per diem cost, updated annually, reimbursed to enrolled nursing facility providers.

b. Prior approval must be received from the DMAS for recipients to receive institutional services from nonenrolled long-term care facilities. Prior approval can only be granted:

(1) When the nonenrolled long-term care facility with an available bed is closer to the recipient's Virginia residence than the closest facility located in Virginia with an available bed;

(2) When long-term care special services, such as intensive rehabilitation services, are not available in Virginia; or

(3) If there are no available beds in Virginia facilities.

~~6. Specialized care services. The payment methodology for specialized care services is contained in Part XVII (12VAC30-90-350 et seq.) of the Nursing Home Payment System.~~

12VAC30-90-20. ~~Nursing home payment system; generally.~~ (Repealed.)

~~A. Effective July 1, 2001, the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in this part.~~

~~B. Three separate cost components are used: plant or capital, as appropriate, cost; operating cost; and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.~~

~~C. Effective July 1, 2001, in determining the ceiling limitations, there shall be direct patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA MSA, for NFs with less than 61 beds in the rest of the state, and for NFs with more than 60 beds in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Centers for Medicare and Medicaid Services (CMS). A nursing facility located in a jurisdiction which CMS adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.~~

~~D. Nursing facilities operated by the Department of Behavioral Health and Developmental Services and the Department of Veterans Services shall be exempt from the prospective payment system as defined in Articles 1 (12VAC30-90-29), 3 (12VAC30-90-35 et seq.), 4 (12VAC30-90-40 et seq.), 6 (12VAC30-90-60 et seq.), and 8 (12VAC30-90-80 et seq.) of this subpart. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable~~

~~costs in accordance with Medicare principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare principles of reimbursement but limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.~~

~~E. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270 through 12VAC30-90-276) and must be identifiable and verifiable by contemporaneous documentation.~~

~~All matters of reimbursement which are part of the DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.~~

THE TEXT OF THIS REGULATION IS IN DERAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-90-36. Nursing facility capital payment methodology.

A. Applicability. The capital payment methodology described in this article shall be applicable to freestanding nursing facilities and specialized care facilities but not to hospital-based facilities. Hospital-based facilities shall continue to be reimbursed under the methodology contained in Article 2 (12VAC30-90-30 et seq.) of this subpart. 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.

B. Definitions. The following words and terms when used in this article shall have the following meaning unless the context clearly indicates otherwise:

"Capital costs" means costs that include the cost elements of depreciation, interest, financing costs, rent and lease costs for property, building and equipment, property insurance and property taxes.

"Date of acquisition" means the date legal title passed to the buyer. If a legal titling date is not determinable for a nursing facility building, date of acquisition shall be considered to be the date a certificate of occupancy was issued by the appropriate licensing or building inspection agency of the locality where the nursing facility is located.

"Facility average age" means for a facility the weighted average of the ages of all capitalized assets of the facility, with the weights equal to the expenditures for those assets. The calculation of average age shall take into account land improvements, building and fixed equipment, and major movable equipment. The basis for the calculation of average age shall be the schedule of assets submitted annually to the department in accordance with the provisions of this section.

"Facility imputed gross square feet" means a number that is determined by multiplying the facility's number of nursing facility licensed beds licensed by the Virginia Department of Health by the imputed number of gross square feet per bed. The imputed number of gross square feet per bed shall be 461 for facilities of 90 or fewer beds, and 438 for facilities of more than 90 beds. The number of licensed nursing facility beds shall be the number on the last day of the provider's most recent fiscal year end for which a cost report has been filed.

"Factor for land and soft costs" means a factor equaling 1.429 that adjusts the construction cost amount to recognize land and capitalized costs associated with construction of a facility that ~~are~~ is not part of the R.S. Means construction cost amount.

"Fixed capital replacement value" means an amount equal to the R.S. Means 75th percentile nursing home construction cost per square foot, times the applicable R.S. Means historical cost

index factor, times the factor for land and soft costs, times the applicable R.S. Means location factor times facility imputed gross square feet.

"FRV depreciation rate" means a depreciation rate equal to 2.86% per year.

"Hospital-based facility" means one for which a single combined Medicare cost report is filed that includes the costs of both the hospital and the nursing home.

"Major renovation" means an increase in capital of $3,000 per bed.

"Movable capital replacement value" means a value equal to $3,475 per bed in SFY 2001, and shall be increased each July 1 by the same R.S. Means historical cost index factor that is used to calculate the fixed capital replacement value. Each year's updated movable capital replacement value shall be used in the calculation of each provider's rate for the provider year beginning on or after the date the new value becomes effective.

"R.S. Means 75th percentile nursing construction cost per square foot" means the 75th percentile value published in the 59th Annual Edition of the R.S. Means Building Construction Cost Data, 2001. In the 2000 edition of the R.S. Means publication this value is $110, which is reported as a January 2000 value.

"R.S. Means historical cost index factor" means the ratio of the two most recent R.S. Means Historical Cost Indexes published in the 59th Annual Edition of the R.S. Means Building Construction Cost Data, 2001. In the 2000 edition of this R.S. Means publication these two values are 117.6 (for 1999) and 115.1 (for 1998). The ratio of these values, and therefore the factor to be used, would be 1.022. This factor would be used to adjust the January 2000 value for the one year of change from January 2000 to January 2001, the mid-point of the prospective rate year (SFY 2001). The resulting cost value that would be used in SFY 2001 is $112.42. The indexes used in this calculation do not match the time period for which a factor is needed. They

relate to 1998 and 1999, while 2000 and 2001 would be ideal. However, R.S. Means does not publish index forecasts, so the most recent available indexes shall be used.

"R.S. Means location factors" means those published in the 22nd Annual Edition of the R.S. Means Square Foot Costs, 2001. The 2000 location factors are shown in the following Table 1. They will be updated annually and distributed to providers based upon the most recent available data.

TABLE 1.
R.S. MEANS COMMERCIAL CONSTRUCTION COST LOCATION FACTORS (2000).

Zip Code	Principal City	Location Factor
220-221	Fairfax	0.90
222	Arlington	0.90
223	Alexandria	0.91
224-225	Fredericksburg	0.85
226	Winchester	0.80
227	Culpeper	0.80
228	Harrisonburg	0.77
229	Charlottesville	0.82
230-232	Richmond	0.85
233-235	Norfolk	0.82
236	Newport News	0.82
237	Portsmouth	0.81
238	Petersburg	0.84
239	Farmville	0.74
240-241	Roanoke	0.77
242	Bristol	0.75
243	Pulaski	0.70
244	Staunton	0.76
245	Lynchburg	0.77
246	Grundy	0.70

"Rental rate" means for a prospective year a rate equal to two percentage points plus the yield on U.S. Treasury Bonds with maturity over 10 years, averaged over the most recent three calendar years for which data are available, as published by the Federal Reserve (Federal Reserve Statistical Release H.15 Selected Interest Rates (www.Federalreserve.gov/releases/)). The rate will be published and distributed to providers annually. Changes in the rental rate shall be effective for the providers' fiscal year beginning on or after July 1. Rental rates may not fall below 9.0% or exceed 11% and will be updated annually on or about July 1 each year. Effective July 1, 2010, through September 30, 2010, the floor for the nursing facility rental rates may not fall below 8.75%. Effective October 1, 2010, through June 30, 2011, the floor for the nursing facility rental rates may not fall below 9.0%. Effective July 1, 2011, through June 30, 2012, the floor for the nursing facility rental rates may not fall below 8.0%. Effective July 1, 2012, through June 30, 2014, the floor for the nursing facility rental rates may not fall below 8.5%. Effective July 1, 2014, the floor for the nursing facility rental rates may not fall below 8.0%. The rate will be published and distributed to providers annually. Changes in the rental rate shall be effective for the providers' fiscal year beginning on or after July 1. Effective July 1, 2014, the rental rate shall be effective for the state fiscal year.

"Required occupancy percentage" means the ratio of nursing facility total patient days to total potential patient days for all available licensed beds. The required occupancy percentage shall be 90% for dates of service on or before June 30, 2013. The required occupancy percentage for dates of service on or after July 1, 2013, shall be 88%.

"SFY" means State Fiscal Year (July 1 through June 30).

~~1.~~ C. Fair Rental Value (FRV) Payment for Capital.

1. Effective for dates of service on or after July 1, 2001, DMAS shall pay nursing facility capital related costs under a FRV methodology. The payment made under this methodology shall be the only payment for capital related costs, and no separate

payment shall be made for depreciation or interest expense, lease costs, property taxes, insurance, or any other capital related cost, including home office capital costs. This payment is considered to cover costs related to land, buildings and fixed equipment, major movable equipment, and any other capital related item. This shall be the case regardless of whether the property is owned or leased by the operator. ~~The department shall review the operation and performance of the FRV methodology every two years.~~

2. FRV Rate Year. The FRV payment rate shall be a per diem rate determined each year for each facility using the most recent available data from settled cost reports, or from other verified sources as specified herein. The per diem rate shall be determined prospectively and shall apply for the entire fiscal year. Each provider shall receive a new capital per diem rate each year effective at the start of the provider's fiscal year, except that the capital per diem rate shall be revised for the rental rate changes effective July 1, 2010, through June 30, 2012. Data elements that are provider specific shall be revised at that time and shall rely on the settled cost report and schedule of assets of the previous year. Data elements that are not provider specific, including those published by R.S. Means and the rental rate, shall be determined annually on or about July 1, and shall apply to provider fiscal years beginning on or after July 1. That is, each July 1 DMAS shall determine the R.S. Means values and the rental rate, and these shall apply to all provider fiscal years beginning on or after July 1. Effective July 1, 2014, the FRV rate year shall be the same as the state fiscal year.

3. Mid-year FRV rate change. Facilities may apply for a mid-year FRV payment rate change for rate years on or after SFY 2015 if putting into service a major renovation or new beds. The nursing facility may submit complete pro forma documentation at least 60 days prior to the effective date and the new rate shall be effective at the beginning of the month following the end of the 60 days. If the initial mid-year FRV rate is not based

on final documentation, the nursing facility shall submit final documentation within 60 days of the new rate effective date and DMAS shall review final documentation and modify the rate if necessary effective 90 days after the implementation of the initial new rate. Only one mid-year FRV rate change will be made in any one fiscal year. Mid-year rate changes for an effective date after April 30 of the fiscal year shall be made effective the following July 1.

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

THE TEXT OF THIS REGULATION IS IN DERAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-90-37. Calculation of FRV per diem rate for capital; calculation of FRV rental amount; change of ownership.

A. Calculation of FRV per diem rate for capital.

1. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of actual patient days or the required occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see subdivision 9 of 12VAC30-90-264 for special procedures for computing the number of patient days required to meet the required occupancy percentage requirement.

2. Effective July 1, 2014, facilities shall be required to submit a calendar year FRV report covering both NF and specialized care beds to be used to set a prospective FRV rate effective the following July 1st for both the NF and the specialized care facility. The calendar year FRV report shall be submitted by the end of February following the end of the calendar year. FRV

reports shall be settled within 90 days of filing the FRV report. For late FRV reports, the prospective rate may be effective 90 days after the date of filing even if after July 1st. No capital rate shall be paid between July 1st and the effective date of the prospective FRV rate for a late report.

B. Calculation of FRV rental amount. The facility FRV rental amount shall be equal to the facility prospective year total value times the rental rate. Effective July 1, 2014, fair rental value per diem rates for the prospective state fiscal year shall be calculated for all freestanding nursing facilities based on the prior calendar year information aged to the state fiscal year and using RS Means factors and rental rates corresponding to the state fiscal year. There shall be no separate calculation for beds subject to and not subject to transition.

1. The facility prospective year total value shall be equal to the facility prospective year replacement value minus FRV depreciation. FRV depreciation equals the prospective year replacement value multiplied by the product of facility average age and the depreciation rate. FRV depreciation cannot exceed 60% of the prospective year replacement value.

2. The facility prospective year replacement value shall be equal to the fixed capital replacement value plus the movable equipment replacement value.

C. Change of ownership. As provided in connection with schedule of assets reporting, the sale of nursing facility assets after June 30, 2000, shall not result in a change to the schedule of assets or to the calculation of average age for purposes of reimbursement under the FRV methodology. Therefore, any sale or transfer of assets after this date shall not affect the FRV per diem rate.

THE TEXT OF THIS REGULATION IS IN DERAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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

A. Effective on and after July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group-III (RUG-III) System as defined in Appendix IV (12VAC30-90-305 through 12VAC30-90-307)." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12VAC30-90-305 through 12VAC30-90-307 for details on the Resource Utilization Groups.

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

2. Direct and indirect group ceilings and rates.

a. In accordance with 12VAC30-90-20 C, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in 12VAC30-90-271.

b. Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, for the rest of the state for facilities with less than 61 licensed beds, and for the rest of the state for facilities with more than 60 licensed beds.

3. Each facility's average case-mix index shall be calculated based upon data reported by that nursing facility to the Centers for Medicare and Medicaid Services (CMS)

(formerly HCFA) Minimum Data Set (MDS) System. See 12VAC30-90-306 for the case-mix index calculations.

4. The normalized facility average Medicaid CMI shall be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NFs subsequent fiscal year. See 12VAC30-90-306 D 2 for the calculation of the normalized facility average Medicaid CMI.

a. A NFs direct patient care operating cost prospective ceiling shall be the product of the NFs peer group direct patient care ceiling and the NFs normalized facility average Medicaid CMI. A NFs direct patient care operating cost prospective ceiling will be calculated semiannually.

b. A CMI rate adjustment for each semiannual period of a nursing facility's prospective fiscal year shall be applied by multiplying the nursing facility's normalized facility average Medicaid CMI applicable to each prospective semiannual period by the nursing facility's case-mix neutralized direct patient care operating cost base rate for the preceding cost reporting period (see 12VAC30-90-307).

c. See 12VAC30-90-307 for the applicability of case-mix indices.

5. Direct and indirect ceiling calculations.

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

cost reports for freestanding nursing facilities that have been completed as of September 1.

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

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

B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price

Index, updated quarterly, published by Standard & Poor's DRI. For state fiscal year 2003, peer group ceilings and rates for indirect costs will not be adjusted for inflation.

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

2. Provider specific costs shall be adjusted for inflation each year from the cost reporting period to the prospective rate period using the moving average as specified in subdivision 1 of this subsection. If the cost reporting period or the prospective rate period is less than 12 months long, a fraction of the moving average shall be used that is equal to the fraction of a year from the midpoint of the cost reporting period to the midpoint of the prospective rate period.

3. Ceilings shall be adjusted from the common point established in the most recent rebasing calculation. Base period costs shall be adjusted to this common point using moving averages from the DRI tables corresponding to the provider fiscal period, as specified in subdivision 1 of this subsection. Ceilings shall then be adjusted from the common point to the prospective rate period using the moving average(s) for each applicable second quarter, taken from the DRI table published for the fourth quarter of the year immediately preceding the calendar year in which the prospective rate years begin. Rebased ceilings shall be effective on July 1 of each rebasing year, so in their first application they shall be adjusted to the midpoint of the provider fiscal year then in progress or then beginning. Subsequently, they shall be adjusted each year from the common point established in rebasing to the midpoint of the appropriate provider fiscal

year. For example, suppose the base year is made up of cost reports from years ending in calendar year 2000, the rebasing year is SFY2003, and the rebasing calculation establishes ceilings that are inflated to the common point of July 1, 2002. Providers with years in progress on July 1, 2002, would receive a ceiling effective July 1, 2002, that would be adjusted to the midpoint of the provider year then in progress. In some cases this would mean the ceiling would be reduced from the July 1, 2002, ceiling level. The following table shows the application of these provisions for different provider fiscal periods.

Table I
Application of Inflation to Different Provider Fiscal Periods

Provider FYE	Effective Date of New Ceiling	First PFYE After Rebasing Date	Inflation Time Span from Ceiling Date to Midpoint of First PFY	Second PFYE After Rebasing Date	Inflation Time Span from Ceiling Date to Midpoint of Second PFY
3/31	7/1/02	3/31/03	+ 1/4 year	3/31/04	+ 1-1/4 years
6/30	7/1/02	6/30/03	+ 1/2 year	6/30/04	+ 1-1/2 years
9/30	7/1/02	9/30/02	- 1/4 year	9/30/03	+ 3/4 year
12/31	7/1/02	12/31/02	-0-	12/31/03	+ 1 year

The following table shows the DRI tables that would provide the moving averages for adjusting ceilings for different prospective rate years.

Table II
Source Tables for DRI Moving Average Values

Provider FYE	Effective Date of New Ceiling	First PFYE After Rebasing Date	Source DRI Table for First PFY Ceiling Inflation	Second PFYE After Rebasing Date	Source DRI Table for Second PFY Ceiling Inflation
3/31	7/1/02	3/31/03	Fourth Quarter 2001	3/31/04	Fourth Quarter 2002
6/30	7/1/02	6/30/03	Fourth Quarter 2001	6/30/04	Fourth Quarter 2002
9/30	7/1/02	9/30/02	Fourth Quarter 2000	9/30/03	Fourth Quarter 2001

12/31	7/1/02	12/31/02	Fourth Quarter 2000	12/31/03	Fourth Quarter 2001

In this example, when ceilings are inflated for the second PFY after the rebasing date, the ceilings will be inflated from July 1, 2002, using moving averages from the DRI table specified for the second PFY. That is, the ceiling for years ending June 30, 2004, will be the June 30, 2002, base period ceiling, adjusted by 1/2 of the moving average for the second quarter of 2002, compounded with the moving average for the second quarter of 2003. Both these moving averages will be taken from the fourth quarter 2002 DRI table.

C. The RUG-III Nursing Home Payment System shall require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rate or prospective operating ceiling.

D. Nonoperating costs. Plant or capital, as appropriate, costs shall be reimbursed in accordance with Articles 1, 2, and 3 of this subpart. Plant costs shall not include the component of cost related to making or producing a supply or service.

NATCEPs cost shall be reimbursed in accordance with 12VAC30-90-170.

E. The prospective rate for each NF shall be based upon operating cost and plant/capital cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant or capital, as appropriate, costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. Effective July 1, 2001, for those NFs whose indirect operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable indirect operating cost rates and the indirect peer group ceilings.

1. The following table presents four incentive examples:

Peer Group Ceilings	Allowable Cost Per Day	Difference	% of Ceiling	Sliding Scale	Scale % Difference
$30.00	$27.00	$3.00	10%	$0.30	10%
30.00	22.50	7.50	25%	1.88	25%
30.00	20.00	10.00	33%	2.50	25%
30.00	30.00	0	0		

2. Efficiency incentives shall be calculated only for the indirect patient care operating ceilings and costs. Effective July 1, 2001, a direct care efficiency incentive shall no longer be paid.

G. Quality of care requirement. 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.

H. Sale of facility. In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

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

J. Effective July 1, 2005, the total per diem payment to each nursing home shall be increased by $3.00 per day. This increase in the total per diem payment shall cease effective July 1, 2006. Effective July 1, 2006, when cost data that include time periods before July 1, 2005, are used to set facility specific rates, a portion of the $3.00 per day amount identified above, based on the percentage of patient days in the provider's cost reporting period that fall before July 1, 2005, adjusted for appropriate inflation and multiplied times the provider's

Medicaid utilization rate, shall be allocated to the facility specific direct and indirect cost per day prior to comparison to the peer group ceilings. For purposes of this subsection, $1.68 of the $3.00 shall be considered direct costs and $1.32 of the $3.00 shall be considered indirect costs.

K. Effective July 1, 2008, and ending after June 30, 2009, the operating rate for nursing facilities shall be reduced by 1.329%.

L. Effective July 1, 2009, through June 30, 2010, there will be no inflation adjustment for nursing facility operating rates and ceilings and specialized care operating rates and ceilings. Exempt from this are government-owned nursing facilities with Medicaid utilization of 85% or greater in provider fiscal year 2007.

M. Effective July 1, 2010, through June 30, 2012, there shall be no inflation adjustment for nursing facility and specialized care operating rates. Nursing facility and specialized care ceilings shall freeze at the same level as the ceilings for nursing facilities with provider fiscal year ends of June 30, 2010.

N. Effective July 1, 2010, through September 30, 2010, the operating rate for nursing facilities shall be reduced 3.0% below the rates otherwise calculated.

O. Effective July 1, 2012, through June 30, 2014, the inflation adjustment for nursing facility and specialized care operating rates shall be 2.2%. Nursing facility and specialized care ceilings in effect in SFY 2012 shall be increased 3.2% in SFY 2013 and 2.2% in SFY 2014.

P. The reimbursement methodology described in this section shall be utilized for dates of service through June 30, 2014. Effective July 1, 2014, nursing facilities shall be reimbursed the price-based methodology described in 12 VAC 30-90-44. The last cost report with a fiscal year end before June 30, 2014, shall be used to establish the operating per diem rates for payment for the remainder of state fiscal year 2014. The last cost report with a fiscal year end on or after June 30, 2014, shall be used to settle reimbursement for plant costs, NATCEPs and criminal

records check costs for periods in state fiscal year 2014. Reimbursement for these components shall be prorated based on the number of cost report months prior to July 1, 2014, as a percentage of total months in the cost report. Settlement for these components will be based on two months of run-out from the end of the provider's fiscal year. Claims for services paid after the cost report run-out period will not be settled.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPOIN FOR LEGAL INTERPRETATION.

12VAC30-90-44. Nursing facility price based reimbursement methodology.

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

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

2. The initial base year for calculating the cost per day shall be cost reports ending in calendar year 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent, reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1st. No adjustments will be made to the base year data for purposes of rate setting after that date.

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

4. Costs per day shall be inflated to the midpoint of the fiscal year rate period using the moving average Virginia Nursing Home inflation index for the 4th quarter of each year (the midpoint of the fiscal year). Costs in the 2011 base year shall be inflated from the midpoint of

the cost report year to the midpoint of fiscal year 2012 by pro-rating fiscal year 2012 inflation and annual inflation after that. Annual inflation adjustments shall be based on the last available report prior to the beginning of the fiscal year and corrected for any revisions to prior year inflation.

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

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

(i) Northern Virginia

(ii) Other MSAs

(iii) Northern Rural

(iv) Southern Rural

7. The following definitions shall apply to indirect peer groups. The indirect peer group for Northern Virginia is the same as the direct peer group for Northern Virginia. Rest of state peer groups shall be defined as any localities other than localities in the Northern Virginia peer group for nursing facilities with greater than 60 beds or 60 beds or less. Rest of state greater than 60

beds shall be further subdivided into Other MSA, Northern Rural and Southern Rural peer groups using the locality definitions for direct peer groups. Indirect Peer Groups:

(i) Northern Virginia MSA

(ii) Rest of State - Greater than 60 Beds

(iii) Other MSAs

(iv) Northern Rural

(v) Southern Rural

Rest of State - 60 Beds or Less

8. Any changes to peer group assignment based on changes in bed size or MSA will be implemented for reimbursement purposes the July 1 following the effective date of the change.

9. The direct and indirect price for each peer group shall be based on the following adjustment factors:

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

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

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

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

12. Resource Utilization Group (RUG) is a resident classification system that groups nursing facility residents according to resource utilization and assigns weights related to the resource utilization for each classification. The department shall use RUGs to determine facility case mix for cost neutralization as defined in 12VAC30-90-306 in determining the direct costs used in setting the price and for adjusting the claim payments for residents.

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

b. The department shall utilize RUG-III, version 34 groups and weights in fiscal years 2015-17 for claim payments.

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

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

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

1. Based on a four-year transition, the rate will be based on the following blend:

a. Fiscal year 2015 - 25 percent of the adjusted price-based rate and 75 percent of the cost-based rate.

b. Fiscal year 2016 - 50 percent of the adjusted price-based rate and 50 percent of the cost-based rate.

c. Fiscal year 2017 - 75 percent of the adjusted price-based rate and 25 percent of the cost-based rate.

d. Fiscal year 2018 - 100 percent of the adjusted price-based (fully implemented).

2. During the first transition year for the period July 1, 2014 through October 31, 2014, DMAS shall case-mix adjust each facility's direct cost component of the rates using the average facility case-mix from the two most recent finalized quarters (September and December 2013) instead of adjusting this component claim by claim.

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

C. Prospective capital rates shall be calculated in the following manner:

1. Fair rental value per diem rates for the fiscal year shall be calculated for all freestanding nursing facilities based on the prior calendar year information aged to the fiscal year and using RS Means factors and rental rates corresponding to the fiscal year as prescribed in 12VAC30-90-36. There will be no separate calculation for beds subject to and not subject to transition.

2. Nursing facilities that put into service a major renovation or new beds may request a mid-year fair rental value per diem rate change.

a. A major renovation shall be defined as an increase in capital of $3,000 per bed. The nursing facility shall submit complete pro forma documentation at least 60 days prior to the effective date and the new rate shall be effective at the beginning of the month following the end of the 60 days.

b. The provider shall submit final documentation within 60 days of the new rate effective date and the department shall review final documentation and modify the rate if necessary effective 90 days after the implementation of the new rate. No mid-year rate changes shall be made for an effective date after April 30 of the fiscal year.

3. These FRV changes shall also apply to specialized care facilities.

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

12 VAC 30-90-45 to

to 12VAC30-90-49. [Reserved]

12VAC30-90-55. Provider payments.

A. Limitations and effective for dates of service between July 1, 2001, and June 30, 2014:

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii) nonpublic provider whose charges are 60% or less of the allowable reimbursement represented by the charges and that demonstrates its charges are less than allowable reimbursement because its customary practice is to charge patients based on their ability to pay. Nominal charge shall be defined as total charges that are 60% or less of the allowable reimbursement of services represented by these charges. Providers qualifying in this section shall receive allowable reimbursement as determined in this Plan.

2. Allowable reimbursement in excess of charges may be carried forward for payment in the two succeeding cost reporting periods. A new provider may carry forward unreimbursed allowable reimbursement in the five succeeding cost reporting periods.

3. Providers may be reimbursed the carry forward to a succeeding cost reporting period (i) if total charges for the services provided in that subsequent period exceed the total allowable reimbursement in that period (ii) to the extent that the accumulation of the carry forward and the allowable reimbursement in that subsequent period do not exceed the providers' direct and indirect care operating ceilings plus allowable plant cost.

B. Payment for service shall be based upon the rate in effect when the service was rendered.

C. For cost reports filed on or after August 1, 1992, and used for cost reimbursement or rate setting based on cost, an interim settlement shall be made by DMAS within 180 days after receipt and review of the cost report. The word "review," for purposes of interim settlement, shall include verification that all financial and other data specifically requested by DMAS is submitted with the cost report. Review shall also mean examination of the cost report and other required submission for obvious errors, inconsistency, inclusion of past disallowed costs, unresolved prior year cost adjustments and a complete signed cost report that conforms to the current DMAS requirements herein.

However, an interim settlement shall not be made when one of the following conditions exists:

1. Cost report filed by a terminated provider;

2. Insolvency of the provider at the time the cost report is submitted;

3. Lack of a valid provider agreement and decertification;

4. Moneys owed to DMAS;

5. Errors or inconsistencies in the cost report; or

6. Incomplete/nonacceptable cost report.

Article 6

New Nursing Facilities

12VAC30-90-60. Interim rate.

A. A new facility shall be defined as follows:

1. A facility that is newly enrolled and new construction has taken place through the COPN process; or

2. A facility that is newly enrolled that was previously denied payments for new admissions and was subsequently terminated from the program.

B. Effective for dates of service between July 1, 2001, and June 30, 2014:

1. Upon a showing of good cause, and approval of DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate or being treated as a new NF.

~~C.~~ 2. A replacement facility or one that has changed location may not be considered a new facility if it serves the same inpatient population. An exception may be granted by DMAS if the provider can demonstrate that the occupancy substantially changed as a result of the facility being replaced or changing location. A decline in the replacement facility's total occupancy of 20 percentage points, in the replacement facility's first cost reporting period, shall be considered to indicate a substantial change when compared to the lower of the old facility's previous two prior cost reporting periods. The replacement facility shall receive the previous operator's operating rates if it does not qualify to be considered a new facility.

~~D.~~ 3. A change in either ownership or adverse financial conditions (e.g., bankruptcy), or both, of a provider does not change a nursing facility's status to be considered a new facility.

~~E.~~ 4. Effective July 1, 2001, for all new NFs the required occupancy percentage for indirect and capital costs shall be waived for establishing the first cost reporting period interim rate. The required occupancy percentage for dates of service on or before June 30, 2013, shall be 90%, and for dates of service on or after July 1, 2013, shall be 88%. This first cost reporting period shall not exceed 13 months from the date of the NF's certification.

~~F.~~ 5. The required occupancy percentage for indirect and capital costs shall be applied to the first and subsequent cost reporting periods' actual indirect and capital costs for establishing such NFs second and future cost reporting periods' prospective reimbursement rates. The required occupancy percentage shall be considered as having been satisfied if the new NF achieved the required occupancy percentage at any point in time during the first cost reporting period.

~~1.~~ a. The department may grant an exception to the minimum occupancy requirement for reimbursement purposes for beds taken out of service for the purpose of renovation. In this case, the occupancy requirement shall be calculated as the required occupancy percentage of available bed days for the period of the exception plus the required occupancy percentage of licensed bed days for the remainder of the cost report year.

~~2.~~ b. The provider shall notify DMAS and the Virginia Department of Health (VDH), Division of Long Term Care Services, Office of Licensure and Certification in advance and present a renovation plan including a reasonable timetable for when the beds will be placed back into service.

~~3.~~ c. The provider shall keep the appropriate documentation of available beds and days during the renovation period, which will provide the evidence of the beds and days taken out of service for renovation purposes. This supporting documentation, along with a copy of the provider's notification letter to the VDH Division of Long Term Care Services, Office of Licensure and Certification shall be submitted with the filing of the provider's cost report, as applicable. The provider's notification letter shall account for the number of beds not in use for the defined period of time.

~~G.~~ 6. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by DMAS, or the appropriate operating ceilings or charges.

~~H.~~ 7. Effective July 1, 2001, on the first day of its second cost reporting period, a new nursing facility's interim plant or capital, as appropriate, rate shall be converted to a per diem amount by dividing its allowable plant/capital costs for its first cost reporting period by the required occupancy percentage of the potential number of patient days for all licensed beds during the first cost reporting period.

~~I.~~ 8. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned CMI based upon its peer group's normalized average Medicaid CMI for direct patient care. An expanded NF receiving new NF treatment shall receive the CMI calculated for its last semiannual period prior to obtaining new NF status.

12VAC30-90-65. Final rate and effective for dates of services between July 1, 2001, and June 30, 2014.

A. DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined in 12VAC30-90-60 E, F, and H.

B. Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If indirect costs are below the ceiling, an efficiency incentive shall be paid at settlement of the first year cost report.

C. This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable indirect operating cost and the peer group ceiling used to set the interim rate. (Refer to 12VAC30-90-41 F.)

Subpart VII

Nurse Aide Training and Competency Evaluation Programs (NATCEPs)

THE TEXT OF THIS REGULATION IS IN DERAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-90-170. NATCEPs costs.

A. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended § 1903(a)(2)(B) of the Social Security Act to fund actual NATCEPs costs incurred by NFs separately from the NF's medical assistance services reimbursement rates.

B. NATCEPs costs shall be as defined in Appendix I (12VAC30-90-270 through 12VAC30-90-276).

C. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.

D. The NATCEPs interim reimbursement rate determined in subsection C of this section shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.

E. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs which are properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in subsection C of this section times the Medicaid patient days from the DMAS MMR-240.

F. Disallowance of nonreimbursable NATCEPs costs shall be reflected in the year in which the nonreimbursable costs were claimed.

G. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in 12VAC30-90-55 A.

H. Effective July 1, 2014, prospective NATCEPs per diem rates for each facility shall be the NATCEPs per diem rate in the base year inflated to the rate year based on inflation in 12 VAC 30-90-44. To calculate the NATCEPs per diem rate, NATCEPs costs in the base year shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days. In non-rebasing years, the prospective rate calculation shall be revised

annually using costs from the next available year. The NATCEPs reimbursement rate determined above shall be added to the prospective operating cost, criminal records checks and plant cost components.

THE TEXT OF THIS REGULATION IS IN DERAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

Subpart VIII

Criminal Records Checks for Nursing Facility Employees

12VAC30-90-180. Criminal records checks.

A. This section implements the requirements of § 32.1-126.01 of the Code of Virginia and Chapter 994 of the Acts of Assembly of 1993 (Item 313 T).

B. A licensed nursing facility shall not hire for compensated employment persons who have been convicted of:

1. Murder;

2. Abduction for immoral purposes as set out in § 18.2-48 of the Code of Virginia;

3. Assaults and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title 18.2 of the Code of Virginia;

4. Arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2 of the Code of Virginia;

5. Pandering as set out in § 18.2-355 of the Code of Virginia;

6. Crimes against nature involving children as set out in § 18.2-361 of the Code of Virginia;

7. Taking indecent liberties with children as set out in §§ 18.2-370 or 18.2-370.1 of the Code of Virginia;

8. Abuse and neglect of children as set out in § 18.2-371.1 of the Code of Virginia;

9. Failure to secure medical attention for an injured child as set out in § 18.2-314 of the Code of Virginia;

10. Obscenity offenses as set out in § 18.2-374.1 of the Code of Virginia; or

11. Abuse or neglect of an incapacitated adult as set out in § 18.2-369 of the Code of Virginia.

C. The provider shall obtain a sworn statement or affirmation from every applicant disclosing any criminal convictions or pending criminal charges for any of the offenses specified in subsection B of this section regardless of whether the conviction or charges occurred in the Commonwealth.

D. The provider shall obtain an original criminal record clearance or an original criminal record history from the Central Criminal Records Exchange for every person hired. This information shall be obtained within 30 days from the date of employment and maintained in the employees' files during the term of employment and for a minimum of five years after employment terminates for whatever reason.

E. The provider may hire an applicant whose misdemeanor conviction is more than five years old and whose conviction did not involve abuse or neglect or moral turpitude.

F. Reimbursement to the provider will be handled through the cost reporting form provided by the DMAS and will be limited to the actual charges made by the Central Criminal Records Exchange for the records requested. Such actual charges will be a pass-through cost which is not a part of the operating or plant cost components.

G. Effective July 1, 2014, a prospective per diem rate shall be calculated. In a rebasing year, the calculation shall be based on the base year described in 12VAC30-90-44. In non-rebasing years, the prospective rate calculation shall be revised annually using the next available year. No adjustment for inflation shall be made. The criminal records checks rate shall be added to the prospective operating rate, nurse aide training and competency evaluation programs (NATCEPs) and plant cost components.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-90-267. Private room differential.

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

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

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

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

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-90-306. Case-mix index (CMI).

A. Effective for dates of service between July 1, 2001, and June 30, 2014, nursing facility case-mix indices shall be applied in the following manner: ~~Each~~ each resident in a Virginia Medicaid certified nursing facility on the last day of the calendar quarter with an effective assessment date during the respective quarter shall be assigned to one of the RUG-III 34-groups.

B. Effective for dates of service on or after July 1, 2014, nursing facility reimbursement described in 12 VAC 30-90-44 shall be based on the case-mix or RUG weights as follows: ~~Standard~~ standard case-mix indices, developed by CMS for the Medicaid population (B01), shall be assigned to each of the RUG-III 34 groups as indicated in Table III.

Table III
Case Mix Indices (CMI)

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 10-13	1.24
RAA	Rehabilitation All Levels / ADL 4-9	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
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

C. There shall be four "picture dates" for each calendar year: March 31, June 30, September 30 and December 31. Each resident in each Medicaid-certified nursing facility on the picture date with a completed assessment that has an effective assessment date within the quarter shall be assigned a case-mix index based on the resident's most recent assessment for the picture date as available in the DMAS MDS database.

D. Using the individual Medicaid resident case-mix indices, a facility average Medicaid case-mix index shall be calculated four times per year for each facility. The facility average Medicaid

case-mix indices shall be used for case-mix neutralization of resident care costs and for case-mix adjustment.

1. During the time period beginning with the implementation of RUG-III up to the ceiling and rate setting effective July 1, 2004, the case-mix index calculations shall be based on assessments for residents for whom Medicaid is the principal payer. The statewide average Medicaid case-mix index shall be a simple average, carried to four decimal places, of all case-mix indices for nursing facility residents in Virginia Medicaid certified nursing facilities for whom Medicaid is the principal payer on the last day of the calendar quarter. The facility average Medicaid case-mix index shall be a simple average, carried to four decimal places, of all case-mix indices for nursing facility residents in the Virginia Medicaid-certified nursing facility for whom Medicaid is the principal payer on the last day of the calendar quarter.

2. The facility average Medicaid case-mix index shall be normalized across all of Virginia's Medicaid-certified nursing facilities for each picture date. To normalize the facility average Medicaid case-mix index, the facility average Medicaid case-mix index is divided by the statewide average Medicaid case-mix index for the same picture date.

3. The department shall monitor the case-mix, including the case mix normalization and the neutralization processes, indices during the first two years following implementation of the RUG-III system. Effective July 1, 2004, the statewide average case-mix index may be changed to recognize the fact that the costs of all residents are related to the case mix of all residents. The statewide average case-mix index of all residents, regardless of principal payer on the effective date of the assessment, in a Virginia Medicaid certified nursing facility may be used for case-mix neutralization. The use of the facility average Medicaid case-mix index to adjust the prospective rate would not change.

4. There shall be a correction period for Medicaid-certified nursing facilities to submit correction assessments to the CMS MDS database following each picture date. A report that details the picture date RUG category and CMI score for each resident in each nursing facility shall be mailed to the facility for review. The nursing facility shall have a 30-day time period to submit any correction assessments to the MDS database or to contact the Department of Medical Assistance Services regarding other corrections. Corrections submitted in the 30-day timeframe shall be included in the final report of the CMI scores that shall be used in the calculation of the nursing facility ceilings and rates. Any corrections submitted after the 30-day timeframe shall not be included in the final report of the CMI scores that shall be used in the calculation of the nursing facility ceilings and rates.

5. Assessments that cannot be classified to a RUG-III group due to errors shall be assigned the lowest case-mix index score.

6. Assessments shall not be used for any out-of-state nursing facility provider that is enrolled in the Virginia Medical Assistance Program and is required to submit cost reports to the Medicaid program.