12VAC30-70-331. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12VAC30-70-361, times the inflation values specified in 12VAC30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals:

1. For Type One hospitals the adjustment factor shall be a calculated percentage that causes the Type One hospital statewide operating rate per case to equal the Type Two hospital statewide operating rate per case;

2. Effective July 1, ~~2005~~ 2006, for Type Two hospitals the adjustment factor shall be ~~0.7600~~ 0.7800.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

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Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-80-190. State agency fee schedule for RBRVS.

A. Reimbursement of fee-for-service providers. Effective for dates of service on or after July 1, 1995, the Department of Medical Assistance Services (DMAS) shall reimburse fee-for-service providers, with the exception of home health services (see 12VAC30-80-180) and durable medical equipment services (see 12VAC30-80-30), using a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS).

B. Fee schedule.

1. For those services or procedures which are included in the RBRVS published by the Centers for Medicare and Medicaid Services (CMS) as amended from time to time, DMAS' fee schedule shall employ the Relative Value Units (RVUs) developed by CMS as periodically updated.

2. DMAS shall calculate the RBRVS-based fees using conversion factors (CFs) published from time to time by CMS. DMAS shall adjust CMS' CFs by additional factors so that no change in expenditure will result solely from the implementation of the RBRVS-based fee schedule. DMAS shall calculate a separate additional factor for obstetrical/gynecological procedures (defined as maternity care and delivery procedures, female genital system procedures, obstetrical/gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT)

manual). DMAS may revise the additional factors when CMS updates its RVUs or CFs so that no change in expenditure will result solely from such updates. Except for this adjustment, DMAS' CFs shall be the same as those published from time to time by CMS. The calculation of the additional factors shall be based on the assumption that no change in services provided will occur as a result of these changes to the fee schedule. The determination of the additional factors required above shall be accomplished by means of the following calculation:

a. The estimated amount of DMAS expenditures if DMAS were to use Medicare's RVUs and CFs without modification, is equal to the sum, across all relevant procedure codes, of the RVU value published by the CMS, multiplied by the applicable conversion factor published by the CMS, multiplied by the number of occurrences of the procedure code in DMAS patient claims in the most recent period of time (at least six months).

b. The estimated amount of DMAS expenditures, if DMAS were not to calculate new fees based on the new CMS RVUs and CFs, is equal to the sum, across all relevant procedure codes, of the existing DMAS fee multiplied by the number of occurrences of the procedures code in DMAS patient claims in the period of time used in (B)(2)(a) above.

c. The relevant additional factor is equal to the ratio of the expenditure estimate (based on DMAS fees in (B)(2)(b) above) to the expenditure estimate based on unmodified CMS values in (B)(2)(a) above.

d. DMAS shall calculate a separate additional factor for:

(1) Emergency room services (defined as the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) codes 99281, 99282, 99283, 99284, and 99285);

(2) Reserved;

(3) Pediatric Services (defined as Evaluation and Management (E&M) procedures, excluding those listed in (B)(5) below, as defined by the AMA's annual publication of the CPT manual for recipients under age 21);

(4) Reserved; and

(5) All other procedures set through the RBRVS process combined.

3. For those services or procedures for which there are no established RVUs, DMAS shall approximate a reasonable relative value payment level by looking to similar existing relative value fees. If DMAS is unable to establish a relative value payment level for any service or procedure, the fee shall not be based on a RBRVS, but shall instead be based on the previous fee-for-service methodology.

4. Fees shall not vary by geographic locality.

5. Effective for dates of service on or after May 1, 2006, fees for Emergency Room Services (defined in B(2)(d)(i) of this section) shall be increased by 3 percent relative to the fees in effect on July 1, 2005.

C. Effective for dates of service on or after September 1, 2004, fees for obstetrical/gynecological procedures (defined as maternity care and delivery procedures, female genital system procedures, obstetrical/gynecological-related radiological procedures, and mammography procedures, as defined by the American Medical Association's (AMA) annual publication of the Current Procedural Terminology (CPT) manual) shall be increased by 34% relative to the fees in effect on July 1, 2004. This 34% increase shall be a one-time increase, but shall be included in subsequent calculations of the relevant additional factor described in subdivision 2 of this subsection.

D. Effective for dates of service on or after July 1, 2006, fees for Pediatric Services (defined in (B)(2)(d)(3) above) shall be increased by 5 % relative to the fees in effect on May 1, 2006.

E. Reserved.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

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Date	Patrick W. Finnerty, Director Dept. of Medical Assistance Service

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. ~~Effective for services on and after July 1, 2002, the following changes shall be made to the direct and indirect payment methods.~~ Direct and indirect ceiling calculations.

a. ~~The~~ Effective for services on and after July 1, 2006, the direct patient care operating ceiling shall be set at ~~112%~~ 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 ~~103.9%~~ 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 12 VAC30-60-350, and the additional reimbursement must be preauthorized as provided in 12 VAC30-60-40. 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 12 VAC30-90-41B, 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.~~, at which time an increase of $3.00 per day, adjusted for one year's inflation, shall be allocated between the direct care and indirect care ceilings for nursing facilities. The amount of $1.68 plus one year of inflation shall be allocated to the direct ceiling, and $1.32 plus one year of inflation to the indirect ceiling. This increase in the ceilings shall continue until ceilings are rebased using cost report data from fiscal years ending in the calendar year 2006 or later. In addition, effective~~ 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 ~~amounts~~ 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 ~~between~~ 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.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_______________________ _______________________________________
Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Service

12VAC30-90-290. Cost reimbursement limitations.

A. This appendix outlines operating, NATCEPs and plant cost limitations that are not referenced in previous sections of these regulations.

All of the operating cost limitations are further subject to the applicable operating ceilings.

B. Directors' fees.

1. Although Medicaid does not require a board of directors (Medicare requires only an annual stockholders' meeting), the Program will recognize reasonable costs for directors' meetings related to patient care.

2. It is not the intent of DMAS to reimburse a facility for the conduct of business related to owner's investments, nor is it the intent of the Program to recognize such costs in a closely held corporation where one person owns all stock, maintains all control, and approves all decisions.

3. To receive reimbursement for directors' meetings, the written minutes must reflect the name of the facility for which the meeting is called, the content and purpose of the meeting, members in attendance, the time the meeting began and ended, and the date. If multiple facilities are discussed during a meeting, total allowable director fees, as limited herein, shall be pro-rated between such facilities.

4. Bona fide directors may be paid an hourly rate of $125 up to a maximum of four hours per month. These fees include reimbursement for time, travel, and services performed.

5. Compensation to owner/administrators who also serve as directors shall include any director's fees paid, subject to the above referenced limit set forth in these regulations.

C. Membership fees.

1. These allowable costs will be restricted to membership in health care organizations and appropriate professional societies which promote objectives in the provider's field of health care activities.

2. Membership fees in health care organizations and appropriate professional societies will be allowed for the administrator, owner, and home office personnel.

3. Comparisons will be made with other providers to determine reasonableness of the number of organizations to which the provider will be reimbursed for such membership and the claimed costs, if deemed necessary.

D. Management fees.

1. External management services shall only be reimbursed if they are necessary, cost effective, and nonduplicative of existing nursing facility internal management services.

2. Costs to the provider, based upon a percentage of net and/or gross revenues or other variations thereof, shall not be an acceptable basis for reimbursement. If allowed, management fees must be reasonable and based upon rates related to services provided.

3. Management fees paid to a related party may be recognized by the Program as the owner's compensation subject to administrator compensation guidelines.

4. A management fees service agreements exists when the contractor provides nonduplicative personnel, equipment, services, and supervision.

5. A consulting service agreement exists when the contractor provides nonduplicative supervisory or management services only.

6. Limits will be based upon comparisons with other similar size facilities and/or other DMAS guidelines and information.

Effective for all providers' cost reporting periods ending on or after October 1, 1990, a per patient day ceiling for all full service management service costs shall be established. The ceiling limitation for cost reporting periods ending on or after October 1, 1990, through December 31, 1990, shall be the median per patient day cost as determined from information contained in the most recent cost reports for all providers with fiscal years ending through December 31, 1989. These limits will be adjusted annually by a Consumer Price Index effective January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published

and distributed to providers annually. Effective July 1, 2006, these limits apply only to related parties.

E. Pharmacy consultants fees. Costs will be allowed to the extent they are reasonable and necessary.

F. Physical therapy fees (for outside services). Limits are based upon current PRM-15 guidelines.

G. Inhalation therapy fees (for outside services). Limits are based upon current PRM-15 guidelines.

H. Medical directors' fees. Costs will be allowed up to the established limit per year to the extent that such fees are determined to be reasonable and proper. This limit will be escalated annually by the CPI-U January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually. Effective July 1, 2006, these limits apply only to related parties. The following limitations apply to the time periods as indicated:

Jan. 1, 1988—Dec. 31, 1988 $6,204

Jan. 1, 1989—Dec. 31, 1989 $6,625

I. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the nursing facility or any other available source,

and provided further, that this amendment shall in no way diminish any obligation of the nursing facility to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

J. Personal automobile.

1. Use of personal automobiles when related to patient care will be reimbursed at the maximum of the allowable IRS mileage rate when travel is documented.

2. Flat rates for use of personal automobiles will not be reimbursed.

K. Seminar expenses.

These expenses will be treated as allowable costs, if the following criteria are met:

1. Seminar must be related to patient care activities, rather than promoting the interest of the owner or organization.

2. Expenses must be supported by:

a. Seminar brochure,

b. Receipts for room, board, travel, registration, and educational material.

3. Only the cost of two persons per facility will be accepted as an allowable cost for seminars which involve room, board, and travel.

L. Legal retainer fees. DMAS will recognize legal retainer fees if such fees do not exceed the following:

BED SIZE	LIMITATIONS
0 - 50	$100 per month
51 - 100	$150 per month
101 - 200	$200 per month
201 - 300	$300 per month
301 - 400	$400 per month

The expense to be allowed by DMAS shall be supported by an invoice and evidence of payment.

M. Architect fees. Architect fees will be limited to the amounts and standards as published by the Virginia Department of General Services.

N. Administrator/owner compensation.

DMAS ADMINISTRATOR/OWNER COMPENSATION SCHEDULE

JANUARY 1, 1989—DECEMBER 31, 1989

BED SIZE	NORMAL ALLOWABLE FOR ONE ADMINISTRATOR	MAXIMUM FOR 2 OR MORE ADMINISTRATORS
1 - 75	32,708	49,063
76 - 100	35,470	53,201
101 - 125	40,788	61,181
126 - 150	46,107	69,160
151 - 175	51,623	77,436
176 - 200	56,946	85,415
201 - 225	60,936	91,399
226 - 250	64,924	97,388
251 - 275	68,915	103,370
276 - 300	72,906	108,375
301 - 325	76,894	115,344

326 - 350	80,885	121,330
351 - 375	84,929	127,394
376 & over	89,175	133,763

These limits will be escalated annually by the CPI-U effective January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually. Effective July 1, 2006, these limits apply only to related parties.

O. Kinetic therapy. For specialized care reimbursement effective December 1, 1996, a limitation per patient day on kinetic therapy shall be established based on historical data. This limit shall be reviewed annually by January 1 of each calendar year and compared to actual cost data, then revised if appropriate, to be effective for all providers' cost reporting periods ending on or after that date. The limit will be published and distributed to providers annually. It shall be:

December 1, 1996—December 31, 1997 $102 per day

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

______________________ ______________________________________
Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Service