12VAC30-70-311. Hospital specific operating rate per case.

A. The hospital specific operating rate per case shall be equal to the labor portion of the statewide operating rate per case, as determined in 12VAC30-70-331, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per case.

B. For rural hospitals, the hospital’s Medicare wage index used in this section shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher.

12VAC30-70-321. Hospital specific operating rate per day.

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12VAC30-70-341, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per day.

B. For rural hospitals, the hospital’s Medicare wage index used in this section shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher.

C. The hospital specific rate per day for freestanding psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases.

~~C~~ D. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases.

~~D~~ E. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals.

~~E~~ F. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from Medicare cost report.

12VAC30-70-341. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12VAC30-70-371, times the inflation values specified in 12VAC30-70-351 times the adjustment factor specified in subsection B or C of this section.

B. The adjustment factor for acute care ~~psychiatric cases and~~ rehabilitation cases shall be the one specified in subsection B of 12VAC30-70-331.

C. The adjustment factor for acute care psychiatric cases for Type Two hospitals shall be 0.8400. The adjustment factor for acute care psychiatric cases for Type One hospitals shall be the one specified in subsection B.1 of 12VAC30-70-331 times 0.8400 divided by the factor in subsection B.2 of 12VAC30-70-331.

12VAC30-70-391. Recalibration and rebasing policy.

A. The department recognizes that claims experience or modifications in federal policies may require adjustment to the DRG payment system policies provided in this part. The state agency shall recalibrate (evaluate and adjust the DRG relative weights and hospital case-mix indices) and rebase (review and update the base year standardized operating costs per case and the base year standardized operating costs per day) the DRG payment system at least every three years. Recalibration and rebasing shall be done in consultation with the Medicaid Hospital Payment Policy Advisory Council noted in 12VAC30-70-490. When rebasing is carried out, if new rates are not calculated before their required effective date, hospitals required to file cost reports and freestanding psychiatric facilities licensed as hospitals shall be settled at the new rates, for discharges on and after the effective date of those rates, at the time the hospitals' cost reports for the year in which the rates become effective are settled.

B. Rates for freestanding psychiatric facilities licensed as hospitals shall ~~continue to~~ be based on the 1998 base year ~~until rates for all inpatient hospitals are rebased subsequent to SFY 2005~~.

CERTIFIED:

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

_____	_____
Date	Patrick W. Finnerty, Director Dept. of Medical Assistance Services

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 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 (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:

(i) 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);

(ii) Obstetrical/Gynecological Services (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);

(iii) Pediatric Preventive Services (defined as Preventive E&M procedures, excluding those listed in (B)(2)(d)(i) above, as defined by the AMA's annual publication of the CPT manual for recipients under age 21);

(iv) Pediatric Primary Services (defined as Evaluation and Management (E&M) procedures, excluding those listed in (B)(2)(d)(i) and (B)(2)(d)(iii) above, as defined by the AMA's annual publication of the CPT manual for recipients under age 21);

(~~iv~~ v) Adult Primary and Preventive Services (defined as E&M procedures, excluding those listed in (B)(2)(d)(i) above, as defined by the AMA's annual publication of the CPT manual for recipients age 21 and over); and,

(~~v~~ vi) 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~~ July 1, ~~2006~~ 2007, fees for Emergency Room Services (defined in B(2)(d)(i) of this section) shall be increased by ~~3~~ 5 percent relative to the fees that would otherwise be in effect ~~on July 1, 2005~~.

C. Effective for dates of service on or after May 1, 2006, fees for Obstetrical/Gynecological Services (defined in (B)(2)(d)(ii) above) shall be increased by 2.5% relative to the fees in effect on July 1, 2005.

D. Effective for dates of service on or after July 1, ~~2006~~ 2007, fees for Pediatric Primary Services (defined in (B)(2)(d)(~~iii~~ iv) above) shall be increased by ~~5~~ 10 % relative to the fees that would otherwise be in effect ~~on May 1, 2006~~.

E. Effective for dates of service on or after July 1, 2007, fees for Pediatric Preventive Services (defined in (B)(2)(d)(iii) above) shall be increased by 10 % relative to the fees that would otherwise be in effect.

~~E~~ F. Effective for dates of service on or after ~~May~~ July 1, ~~2006~~ 2007, fees for Adult Primary and Preventive Services (defined in (B)(2)(d)(~~iv~~ v) above) shall be increased by 5 % relative to the fees that would otherwise be in effect ~~on July 1, 2005~~.

G. Effective for dates of service on or after July 1, 2007, fees for all other procedures set through the RBRVS process combined (defined in (B)(2)(d)(vi) above) shall be increased by 5 % relative to the fees that would otherwise be in effect.

CERTIFIED:

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

_____ _____

Date

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

12VAC30-90-31. New nursing facilities and bed additions.

A. Providers shall be required to obtain three competitive bids when (i) constructing a new physical plant or renovating a section of the plant when changing the licensed bed capacity, and (ii) purchasing fixed equipment or major movable equipment related to such projects.

All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see 12VAC30-90-51.)

B. Reimbursable costs for building and fixed equipment shall be based upon the 75th percentile square foot costs for NFs published annually in the R.S. Means Building Construction Cost Data as adjusted by the appropriate R.S. Means Square Foot Costs "Location Factor" for Virginia for the locality in which the NF is located. Where the specific location is not listed in the R.S. Means Square Foot Costs "Location Factor" for Virginia, the facility's zip code shall be used to determine the appropriate locality factor from the U.S. Postal Services National Five Digit Zip Code for Virginia and the R.S. Means Square Foot Costs "Location Factors." The provider shall have the option of selecting the construction cost limit which is effective on the date the Certificate of Public Need (COPN) is issued or the date the NF is licensed. Total cost shall be calculated by multiplying the above 75th percentile square foot cost by 385 square feet (the average per bed square footage). Effective July 1, 2007, the construction cost limit for children’s ICF/MR facilities having 50 or more beds shall be calculated using up to 750 square feet per bed.

Total costs for building additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data 75th percentile square foot costs for NFs.

CERTIFIED:

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

_____ _____

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