Table of Contents

State Name: Virginia

State Plan Amendment (SPA)#: 14-019

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Twenty-six (26) SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

MAY 04 2015

Mrs. Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond, VA 23219

RE: State Plan Amendment 14-019

Dear Mrs. Jones:

We have completed our review of State Plan Amendment (SPA) 14-019. This SPA modifies Attachment 4.19-D of Virginia's Title XIX State Plan. Specifically, the SPA adopts a price-based prospective payment system for Virginia nursing facility services that will transition from RUG-III 34 Medicaid grouper to the RUG-IV 48 grouper.

We conducted our review of this SPA according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving state plan amendment 14-019 effective July 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, or require additional information, please call Gary Knight at (304) 347-5723.

Sincerely yours,

/S/

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 14-019

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2014 $ 0.00
b. FFY 2015 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attach. 4.19-D,Suppl. 1, Page 15-18, 18.1, 19, 26.1-26.8, 46-47.1 and 57of 61.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Replacing: 15-18, 19, 26.1 26.2, 46-47 and 57 of 61.

Adding: 18.1, 26.3-26.8 and 47.1 of 61

10. SUBJECT OF AMENDMENT: Nursing Facility - Price-Based Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 9/23/2014

16. RETURN TO

Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 04 2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Kristin FAN

22. TITLE: Deputy Director, FMG

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

---

12 VAC 30-90-10.
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.

a. 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.

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

c. 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).

d. Payments for services to non-state nursing facilities shall be based on methodologies described in the Nursing Home Payment System supplement in 4.19-D, Supp. 1, p. 26.2-26.7 (12 VAC 30-90-44) for nursing facilities and in Part XVII of the Nursing Home Payment System, 4.19-D, Supp. 1, p. 54-57 (12 VAC 30-90-264 et seq.) for specialized care facilities. 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. Reimbursement to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) shall be reimbursed retrospectively on the basis of reasonable costs but limited to a ceiling based on the highest as filed rate paid to an ICF/IID institution, in SFY 12 and annually adjusted thereafter with the application of the NF inflation factor set out in 4.19-D, Supp. 1, p. 26.2-26.7 (12 VAC 30-90-44).

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 methodologies. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see Nursing Home Payment System, Appendix I, p. 2-16; 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

f. 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:

(1) 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.

(2) 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.

(3) 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.

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

(5) Modifications to the Plan for reimbursement will be submitted as Plan amendments.

(6) Covered cost will include such items as:

(a) Cost of meeting certification standards.

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

(c) The cost of such services provided by related organizations except as modified in the payment system supplement 4.19-D.

(7) Bad debts, charity and courtesy allowances shall be excluded from allowable cost.

(8) Payments will be made to facilities no less than monthly based on claims submitted by the facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

(9) Payments shall be adequate to reimburse in full such actual allowable costs that an economically and efficiently operated facility must incur.

(10) 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 the upper payment limit.

(11) In accordance with 42 CFR 447.205, an opportunity for public comment was permitted before final implementation of rate setting processes.

(12) Return on equity capital to proprietary providers is not an allowable cost.

g. Reimbursement of non-enrolled long term care facilities.

(1) Non-enrolled 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.

(2) Prior approval must be received from the DMAS for recipients to receive institutional services from non-enrolled long-term care facilities. Prior approval can only be granted:

(a) when the non-enrolled long term care facility with an available bed is closer to the recipient's Virginia residence than the closes facility located in Virginia with an available bed, or

(b) when long term care special services, such as intensive rehabilitation services, are not available in Virginia, or

(c) if there are no available beds in Virginia facilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

Part II – Nursing Home Payment System

12 VAC 30-90-20. REPEALED. (effective 7/1/2014 in SPA 14-019)

12 VAC 30-90-21 through 12 VAC 30-90-28. Reserved.

Subpart II
Rate Determination Procedures

Article 1. Transition to new capital payment methodology.

12 VAC 30-90-29.

A. This section provides for a transition to a new capital payment methodology. The methodology that will be phased out for most facilities is described in Article 2. The methodology that will be phased in for most facilities is described in Article 3. The terms and timing of the transition are described in this article.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

12 VAC 30-90-36. Nursing Facility Capital Payment Methodology. Applicability.

A. The capital payment methodology described in this article shall be applicable to freestanding nursing facilities but not to hospital based facilities. Hospital based facilities shall continue to be reimbursed under the methodology contained in Article 2. 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 regulation, 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 which adjusts the construction cost amount to recognize land and capitalized costs associated with construction of a facility, that is not part of the R.S. Means construction cost amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

"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 $3,475.00 per bed in SFY2001, and shall be increased each July 1st 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 most recent available edition of Building Construction Cost Data. 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 most recent available edition of Building Construction Cost Data. 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 (SFY2001). The resulting cost value that would be used in SFY2001 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, RSMeans does not publish index forecasts, so the most recent available indexes shall be used.

"R.S. Means Location Factors" means those published in the most recent available edition of Square Foot Costs. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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 US 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 shall 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 1st. Rental rates may not fall below 9% or exceed 11% and will be updated annually on or about July 1st 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 provider's fiscal year beginning on or after July 1. Effective July 1, 2014, the rental rate shall be effective for the state fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

"Required occupancy percentage" means an occupancy percentage of 90%.

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

C. Fair Rental Value Payment for Capital.

1. Effective for dates of service on or after July 1, 2001, the DMAS shall pay nursing facility capital related costs under a Fair Rental Value (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.

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. 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 RSMeans and the rental rate, shall be determined annually on or about July 1st, and shall apply to provider fiscal years beginning on or after July 1st. That is, each July 1st DMAS shall determine the RSMeans values and the rental rate, and these shall apply to all provider fiscal years beginning on or after July 1st. Effective July 1, 2014, the FRV rate year shall be the same as the state fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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. Onl7y 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.

12 VAC 30-90-37. 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. 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 90 percent of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see 4.19-D, Supp. 1, p 56 (12 VAC 30-90-264) section 10, for special procedures for computing the number of patient days required to meet the 90 percent occupancy requirement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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 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 period 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 providers' 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, 2010, the operating rate for nursing facilities shall be reduced by 1.329 percent.

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 be frozen 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 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 percent. Nursing facility and specialized care ceilings in effect for SFY 2012 shall be increased 3.2 percent in SFY 2013 and 2.2 percent in SFY 2014.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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 this page, below (12VAC30-90-44). 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, NATCEPs and criminal records checks 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 2 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.

12VAC 30-90-41.1 Repealed.
12VAC30-90-42. Repealed.
12VAC30-90-43. Repealed.

12VAC30-90-44. Nursing Facility Price Based Payment Methodology.

A. Effective July 1, 2014, the Department of Medical Assistance Services shall convert nursing facility operating rates in 12 VAC 30-90-41 (page 21 of Supplement 1 to Attachment 4.19-D) to a price-based methodology.

1. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

a. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

b. 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 1. No adjustments will be made to the base year data for purposes of rate setting after that date.

c. 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.

d. 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.

e. 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.

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 State of Virginia map with the coordinates: 37.4203914 Latitude, -82.0201219 Longitude and 37.1223664 Latitude, --76.3457773 Longitude.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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.

Direct Peer groups
- Northern Virginia
- Other MSAs
- Northern Rural
- Southern Rural

Indirect Peer Groups
- Northern Virginia MSA
- Rest of State - Greater than 60 Beds
  - Other MSAs
  - Northern Rural
  - Southern Rural
- Rest of State - 60 Beds or Less

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.

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

g. 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.

h. 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.

i. 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 the Nursing Home Payment System, Supp. 1, Appendix IV, page 3 (12VAC30-90-306) in determining the direct costs used in setting the price and for adjusting the claim payments for residents.

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

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

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

4) 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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 4.19-D, Supp. 1, p. 21-26 (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 4.19-D, Supp. 1, p. 21-26 (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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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 4.19-D, Supp. 1, p. 15-18 (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.

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

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

12 VAC 30-90-45 to 12VAC30-90-49. Reserved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

Article 5
Allowable Cost Identification

12VAC30-90-50. Allowable costs.

A. Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see the Nursing Home Payment System, Appendix I, p. 2; 12VAC30-90-270).

B. Certification. The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

12VAC30-90-54. Rent/Leases.

Rent or lease expenses shall be limited by the provisions of the Nursing Home Payment System, Appendix II, p. 2-5 (12VAC30-90-280).

12VAC30-90-55. Provider payments.

A. Limitations.

1. Effective for dates of service between July 1, 2001, and June 30, 2014, 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, 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/non-acceptable cost report.

12VAC30-90-56. Legal fees/accounting.

A. Costs claimed for legal/accounting fees shall be limited to reasonable and customary fees for specific services rendered. Such costs must be related to patient care as defined by Medicare principles of reimbursement and subject to applicable regulations herein. Documentation for legal costs must be available at the time of audit.

B. Retainer fees shall be considered an allowable cost up to the limits established in the Nursing Home Payment System, Appendix III, p. 2-7 (12VAC30-90-290).

C. As mandated by the Omnibus Budget Reconciliation Act of 1990, effective November 5, 1990, reimbursement of legal expenses for frivolous litigation shall be denied if the action is initiated on or after November 5, 1990. Frivolous litigation is any action initiated by the nursing facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.

12VAC30-90-57. Documentation.

Adequate documentation supporting cost claims must be provided at the time of interim settlement, cost settlement, audit, and final settlement.

12VAC30-90-58. Fraud and abuse.

Previously disallowed costs which are under appeal and affect more than one cost reporting period shall be disclosed in subsequent cost reports if the provider wishes to reserve appeal rights for such subsequent cost reports. The reimbursement effect of such appealed costs shall be computed by the provider and submitted to DMAS with the cost report. Where such disclosure is not made to DMAS, the inclusion of previously disallowed costs may be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General.

12VAC30-90-59. Reserved.

Article 6
New Nursing Facilities

12VAC30-90-60. Interim rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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 which 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 the 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.

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.

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.

4. Effective July 1, 2001, for all new NFs the 90% occupancy requirement for indirect and capital costs shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 13 months from the date of the NF's certification.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

5. The 90% occupancy requirement 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 90% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 90% occupancy at any point in time during the first cost reporting period.

a. The Department may grant an exception to the minimum occupancy requirement for reimbursement purposes for beds taken out of service for renovation. In this case, the occupancy requirement shall be calculated as 90% of available bed days for the period of the exception plus 90% of licensed bed days for the remainder of the cost report year.

b. The provider must notify DMAS and the Division of Long Term Care Services Office of Licensure and Certification in advance and present a plan including a reasonable timetable for when the beds will be placed back into service.

c. The provider must 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 letter to the Division of Long Term Care Services Office of Licensure and Certification notifying them of the number-of-beds not in use for the defined period-of-time should be submitted with the filing of the provider's cost report, as applicable.

6. A new NFs 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.

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 90% of the potential number of patient days for all licensed beds during the first cost reporting period.

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.

12 VAC 30-90-61 through 12 VAC 30-90-64. Reserved.

12VAC30-90-65. Final rate.

Effective for dates of service between July 1, 2001, and June 30, 2014, 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 above in 4.19-D, Supp 1, p. 33-34 (12 VAC 30-90-60 E, F, and H).

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.

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 4.19-D, Supp. 1, p. 26 (12 VAC 30-90-41 F).)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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 non-reimbursable NATCEPs costs shall be reflected in the year in which the non-reimbursable 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 4.19-Supp. 1, p. 31 (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 4.19-D, Supp. 1, p. 26.2-26.7 (12VAC30-90-44). 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 cost 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.

12 VAC 30-90-171 to 12 VAC 30-90-179. Reserved.

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).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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. 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 4.19-D, Supp. 1, p. 26.2 (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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

12. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with the current NHPS, except that the occupancy requirement shall be 70% rather than 90%.

13. The cost reporting requirements of 12 VAC 30-90-70 and 12 VAC 30-90-80 shall apply to specialized care provides.

12 VAC 30-90-265. Reserved.
12VAC30-90-266. Traumatic Brain Injury (TBI) payment.

DMAS shall provide a fixed per day payment for nursing facility residents with TBI served in the program in accordance with resident and provider criteria, in addition to the reimbursement otherwise payable under the provisions of the Nursing Home Payment System. Effective for dates of service on and after August 19, 1998, a per day rate add-on shall be paid for recipients who meet the eligibility criteria for these TBI payments and who are residents in a designated nursing facility TBI unit of 20 beds or more that meets the provider eligibility criteria. The rate add-on for any qualifying provider's fiscal year shall be reviewed annually to determine the appropriateness of the amount, not to exceed $50 per patient day, and any changes will be published and distributed to the providers. (Refer to 12VAC30-90-330, Traumatic brain injury diagnoses, for related resident and provider requirements.)

12 VAC 30-90-267. 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.

12 VAC 30-90-268 through 12 VAC 30-60-269. Reserved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

"Minimum data set (MDS)" means a federally required resident assessment instrument. Information from the MDS is used to determine the facility's case-mix index.

"Normalization" means the process by which the average case mix for the state is set to 1.0.

"Nursing facility" means a facility, not including intermediate care facilities for the mentally retarded, licensed by the Department of Health and certified as meeting the participation requirements of the Medicaid program.

"Rebasing" means the process of updating cost data used to calculate peer group ceilings for subsequent base years.

12 VAC 30-90-306. Case-mix index (CMI).

Effective for dates of service on or after July 1, 2014, nursing facility reimbursement described in 4.19-D, Supp. 1, p. 26.2-26.7 (12 VAC 30-90-44) shall be based on the case-mix indices or RUG weights listed in subsection B.

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:

A. 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.