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 ***REPEALED IN SPA 14-019 EFFECTIVE 7/1/2014***

12 VAC 30-90-21. Reimbursement for Individuals in a Disaster Struck Nursing Facility.

Reimbursement to a Disaster Struck Nursing Facility for individuals that must be temporarily evacuated to another facility (Resident Accepting Nursing Facility) may continue for up to 30 days after the disaster event. Reimbursement will be the same as if the individual was residing in the Disaster Struck Facility. No other reimbursement will be made to either the Disaster Struck Nursing Facility or the Resident Accepting Facility. The Disaster Struck Nursing Facility must meet the following conditions.

a. The Disaster Struck Nursing Facility must have a contract with the Resident Accepting Nursing Facility. The contract must (i) include terms of reimbursement and mechanisms to resolve any contract disputes; (ii) protocols for sharing care and treatment information between the two facilities, and (iii) requirements that both facilities meet all conditions of Medicaid participation determined by the Virginia Department of Health. The Virginia Long-Term Mutual Aid Plan Memorandum of Understanding is an acceptable contract.
b. The Disaster Struck Facility must notify DMAS of the disaster event, maintain records of evacuated individuals with names, dates and destinations of evacuated residents and update DMAS on the status of repairs.
c. The Disaster Struck Facility must determine within 15 days of the event whether individuals will be able to return to the facility within 30 days of the disaster event. If the Disaster Struck Facility determines that it is not able to reopen within 30 days, it must discharge the individuals and work with them to choose admission to other facilities or alternative placements. Nothing shall preclude an individual from asking to be discharged and admitted to another facility or alternative placement. Reimbursement to the Disaster Struck Facility shall cease when the individual is discharged.

12 VAC 30-90-22 through 12 VAC 30-90-27. Reserved.

12 VAC 30-90-28. Mid-year Fair Rental Value (FRV) rate determination.

A. New facilities and facilities undergoing a major renovation may apply for a mid-year FRV rate determination or change if putting into service a major renovation or new beds. Providers are allowed only one mid-year FRV rate change during a state fiscal year (SFY).

1. New Facilities. A new nursing facility is defined as a facility that is required to obtain a certificate of occupancy prior to the admittance of a resident. New nursing facilities should file their mid-year FRV report when the facility's certificate of occupancy has been issued. The nursing facility shall submit complete pro forma documentation at least 60 days prior to the certificate of occupancy effective date, and the new FRV rate shall be effective at the beginning of the month following the end of the 60 days subject to confirmation that the new beds are operational.

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a. For any facility whose FRV report has less than 12 months of experience, the department shall develop an occupancy schedule as defined in the Nursing Facility Capital Payment Methodology, in 4.19-D, Supp 1, beginning on page 15, that represents the average statewide occupancy by month of operation for use in calculating the per diem rate in lieu of a minimum occupancy requirement or actual occupancy. After the initial FRV report filing, actual occupancy data shall be used.
b. New facilities shall use the occupancy schedule developed by DMAS to estimate patient days for their first FRV report until actual patient days are available. The occupancy percentage used to calculate estimated patient days shall be based on the number of months remaining within the calendar year from the month of receipt of the certificate of occupancy. For example, if the certificate of occupancy is received in February, then the number of months remaining in the calendar year would be 11 and the occupancy percentage to use would be 85.84% (see Table 1 on p 16 of 4.19-D, Supp 1). The estimated patient days would be equal to the occupancy percentage times the annualized bed days available for the report period.
c. DMAS shall have 15 days from the date of the provider's submission to determine if the filing is complete for purposes of setting a rate for a new facility. The facility shall have 15 days from the date the filing is deemed incomplete to submit the required information. The deadline for setting the rate shall be extended for 30 days after the filing is deemed complete.

2. Major renovations. Facilities undergoing major renovations shall file a mid-year FRV report when there is an increase in capital expenditures of at least $3,000 per total number of beds. The nursing facility shall submit complete pro forma documentation at least 60 days prior to the effective occupancy date and the new rate shall be effective at the beginning of the month following the end of the 60 days subject to confirmation that the renovated beds are operational. No mid-year rate changes shall be made for an effective date after April 30 of the SFY.

a. Any new beds or major renovations placed in service between the reporting year and the rate year shall be treated as a mid-year rate adjustment. No new FRV rate change will be made after April 30. Rate updates that fall between May 1 and June 30 shall be effective as stated below.
b. DMAS shall have 15 days from the date of the provider's submission to determine if the filing is complete for purposes of setting a rate for a renovated facility. The facility shall have 15 days from the date the filing is deemed incomplete to submit the required information.
c. Providers may propose a phased major renovation subject to approval by DMAS. The phased major renovation may include reductions to available beds. Any modifications to the proposed renovation are also subject to approval by DMAS. Phased major renovations include construction or major renovations that span more than one FRV report period. Only one annual FRV report and one mid-year FRV report can be filed in a SFY to change the plant rate. A mid-year FRV report can be filed only if capital cost per bed increases by a minimum of $3000 per bed. Major renovation cost may only be included on Schedule R-1 as it is placed into service. Cost cannot be duplicated throughout the project on Schedule R-1. Major renovations for independent and assisted living are not allowed on the Schedule R-1.

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B. The following are applicable to new facilities and facilities undergoing major renovation:
   1. DMAS shall annualize real estate taxes, property taxes, and property insurance costs that do not represent a full year's cost.
      a. Actual paid tax bills shall be provided to support real estate taxes and personal property taxes. When the taxing authority has not invoiced a new facility, building value per the most recent contractor invoice times the locality's tax rate shall be used to estimate real estate and tax liability for the period. Only the nursing facility's building value can be included in the calculation.
      b. Actual paid insurance premiums shall be provided to support property insurance. For newly constructed nursing facilities, a reasonable estimate from the insurance company can be used to document property insurance cost until the first insurance policy and the premium are incurred. Only the nursing facility's property insurance can be included on the schedule.
   2. Costs shall be based on currently available documentation at the time but are subject to audit. DMAS may use any reasonable method to estimate costs for which there is inadequate documentation. Reasonable method includes using tax rates from the taxing authority in the location of the facility, the most recent contractor's invoice to determine building cost, and estimates from insurance companies related to the nursing facility portion of the building. Any adjustments based on subsequent year documentation or audit for a current rate year shall be applied beginning July 1 of the next rate year.

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.

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B. Transition Policy. Nursing facilities enrolled in the Medicaid program prior to July 1, 2000, shall be paid for capital related costs under a transition policy from July 1, 2000, through June 30, 2012. Facilities and beds paid under the transition policy shall receive payments as follows:

1. During SFY2001, each facility's capital per diem shall be the facility's capital per diem on June 30, 2000. The methodology under which this per diem is determined shall be the plant cost reimbursement methodology in effect as of June 30, 2000.

2. During SFY 2002, each facility subject to the transition policy shall be paid for capital costs under the methodology described in Article 2.

3. During SFY 2003 through SFY 2012, each facility subject to the transition policy shall have a capital per diem that is a percentage of the per diem described in Article 2 plus a percentage of the per diem described in Article 3. The percentage associated with the per diem described in Article 2 shall be 90% for services provided in SFY 2003, 80% for services in SFY 2004, 70% for services in SFY 2005, and so on until the percentage is 0% for services in SFY 2012. The percentage associated with the per diem described in Article 3 shall be equal to 100% minus the percentage associated with the per diem described in Article 2. In SFY 2012, the capital per diem shall be based entirely on the per diem described in Article 3.

C. Return on equity (ROE) for leased facilities shall be phased out along with the methodology described in Article 2. Leased facilities shall be eligible for ROE after July 1, 2001, only if they were receiving ROE on June 30, 2000.

D. Beds Excluded from the Transition Policy. Effective July 1, 2001, newly constructed facilities and new and replacement beds of previously enrolled facilities, completed after July 1, 2000, shall be paid entirely under the methodology described in Article 3 (12VAC30-90-35 et seq.) of this subpart without application of the transition policy. However, facilities and beds with COPN applications submitted as of June 30, 2000, shall be subject to the transition policy. Facilities changing ownership after June 30, 2000, shall be paid the per diem rate described in Article 3 if it has been owned by the selling owner for a period of eight years prior to the sale and during that period the facility being sold has not been part of a chain organization, consisting of more than two health care facilities. For purposes of this provision, the number of facilities in a chain shall be determined by counting nursing facilities, hospitals, and any other health care facilities that are licensed to admit patients or residents, whether or not they participate in the Medicaid program. Facilities in Virginia and in other states shall be counted in determining the number of facilities in a chain. Facilities shall be considered to form a chain if there is common ownership of the physical assets, or a common operator, or both.

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E. Emergency regulations effective July 1, 2000, provided for a facility specific fixed capital per diem applicable to services in SFY 2001, that is not to be adjusted at settlement. After SFY 2001, the per diem that would have been applicable to SFY 2001, under the methodology in Article 2 shall be calculated. If there are two provider fiscal years that overlap SFY 2001, this per diem shall be a combination of the two applicable per diem amounts. If the per diem provided in the emergency regulations is lower than the per diem based on Article 2, the difference, multiplied by the days in SFY 2001, shall be paid to the facility. If the per diem provided in the emergency regulations is higher, the difference, multiplied by the days, shall be collected from the facility in the settlement of the provider year settled after the difference is calculated.

Article 2
Plant Cost Component

12VAC30-90-30. Plant cost.

A. This Article describes a capital payment methodology that will be phased out for most nursing facilities by SFY 2012. The terms and timing of the transition to a different methodology are described in Article 1. The methodology that will eventually replace this one for most facilities is described in Article 3.

B. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

C. Effective July 1, 2001, to calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as the required occupancy percentage of the daily licensed bed complement during the applicable cost reporting period. The required occupancy percentage means the ratio of nursing facility total patient days to total potential patient days for all available licensed beds. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90%, for dates of service on or after July 1, 2013 shall be 88%. For facilities with less than 12 months of occupancy experience, the required occupancy percentage shall be determined from the occupancy schedule in 4.19-D, Supp 1, p 16. For facilities that also provide specialized care services, see 4.19-D, Supp 1, page 56, #9, for special procedures for computing the number of patient days required to meet the occupancy requirement.

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are non-reimbursable plant costs.

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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. Attachment 4.19-D, Supp 1, pages 1-3, entitled Mid-year Fair Rental Value rate determination, provides cost documentation requirements for new and renovated nursing homes.

C. New NFs and bed additions to existing NFs must have prior approval under the state's Certificate of Public Need Law and Licensure regulations in order to receive Medicaid reimbursement.

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued (see 12VAC5-220-10 et seq.).

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12VAC30-90-32. Major capital expenditures.

A. Major capital expenditures include, but are not limited to, major renovations (without bed increase), additions, modernization, other renovations, upgrading to new standards, and equipment purchases. Major capital expenditures shall be any capital expenditures costing $100,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a one calendar year period (not necessarily the provider's reporting period).

B. Providers (including related organizations as defined in 12VAC30-90-51) shall be required to obtain three competitive bids and if applicable, a Certificate of Public Need before initiating any major capital expenditures. All bids must be obtained in an open competitive manner, and subject to disclosure to the DMAS prior to initial rate setting. (Related parties see 12VAC30-90-51.)

C. Useful life shall be determined by the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

D. Major capital additions, modernization, renovations, and costs associated with upgrading the NF to new standards shall be subject to cost limitations based upon the applicable components of the construction cost limits determined in accordance with 12VAC30-90-31 B.

12VAC30-90-33. Financing.

A. The DMAS shall continue its policy to disallow cost increases due to the refinancing of a mortgage debt, except when required by the mortgage holder to finance expansions or renovations. Refinancing shall also be permitted in cases where refinancing would produce a lower interest rate and result in a cost savings. The total net aggregate allowable costs incurred for all cost reporting periods related to the refinancing cannot exceed the total net aggregate costs that would have been allowable had the refinancing not occurred.

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1. Refinancing incentive. Effective July 1, 1991, for mortgages refinanced on or after that date, the DMAS will pay a refinancing incentive to encourage nursing facilities to refinance fixed-rate, fixed-term mortgage debt when such arrangements would benefit both the Commonwealth and the providers. The refinancing incentive payments will be made for the 10-year period following an allowable refinancing action, or through the end of the refinancing period should the loan be less than 10 years, subject to a savings being realized by application of the refinancing calculation for each of these years. The refinancing incentive payment shall be computed on the net savings from such refinancing applicable to each provider cost reporting period. Interest expense and amortization of loan costs on mortgage debt applicable to the cost report period for mortgage debt which is refinanced shall be compared to the interest expense and amortization of loan costs on the new mortgage debt for the cost reporting period.

2. Calculation of refinancing incentive. The incentive shall be computed by calculating two index numbers, the old debt financing index and the new debt financing index. The old debt financing index shall be computed by multiplying the term (months) which would have been remaining on the old debt at the end of the provider's cost report period by the interest rate for the old debt. The new debt index shall be computed by multiplying the remaining term (months) of the new debt at the end of the cost reporting period by the new interest rate. The new debt index shall be divided by the old debt index to achieve a savings ratio for the period. The savings ratio shall be subtracted from a factor of 1 to determine the refinancing incentive factor.

3. Calculation of net savings. The gross savings for the period shall be computed by subtracting the allowable new debt interest for the period from the allowable old debt interest for the period. The net savings for the period shall be computed by subtracting allowable new loan costs for the period from allowable gross savings applicable to the period. Any remaining unamortized old loan costs may be recovered in full to the extent of net savings produced for the period.

4. Calculation of incentive amount. The net savings for the period, after deduction of any unamortized old loan and debt cancellation costs, shall be multiplied by the refinancing incentive factor to determine the refinancing incentive amount. The result shall be the incentive payment for the cost reporting period, which shall be included in the cost report settlement, subject to per diem computations under 12VAC30-90-30 B and C, and 12VAC30-90-55 A.

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5. Where a savings is produced by a provider refinancing his old mortgage for a longer time period, the DMAS shall calculate the refinancing incentive and payment in accordance with subdivisions A 1 through A 4 of this section for the incentive period. Should the calculation produce both positive and negative incentives, the provider's total incentive payments shall not exceed any net positive amount for the entire incentive period. Where a savings is produced by refinancing with either a principal balloon payment at the end of the refinancing period, or a variable interest rate, no incentive payment will be made, since the true savings to the Commonwealth cannot be accurately computed.

6. All refinancings must be supported by adequate and verifiable documentation and allowable under DMAS regulations to receive the refinancing savings incentive.

7. Balloon loan reimbursement. This subdivision applies to the construction and acquisition of nursing facilities (as defined in 12VAC30-90-31 and 12VAC30-90-34) and major capital expenditures (as defined in 12VAC30-90-32) that are financed with balloon loans. A balloon loan requires periodic payments to be made that do not fully amortize the principal balance over the term of the loan; the remaining balance must be repaid at the end of a specified time period. Demand notes and loans with call provisions shall not be deemed to be balloon loans.

   a. Incurred interest. Reimbursement for interest of a balloon loan and subsequent re-financings shall be considered a variable interest rate loan under subsection B of this section.

      (1) A standard amortization period of 27 years, from the inception date of the original balloon loan, must be computed by the provider and submitted to DMAS and used as the amortization period for loans for renovation, construction, or purchase of a nursing facility.

      (2) A standard amortization period of 15 years, from the inception date of the original balloon loan, must be used as the amortization period for loans on furniture, fixtures, and equipment.

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(3) A loan which is used partially for the acquisition of buildings, land, and land improvements and partially for the purchase of furniture, fixtures, and equipment must be prorated for the purpose of determining the amortization period.

b. The allowable interest rate shall be limited to the interest rate upper limit in effect on the date of the original balloon loan, unless another rate is allowable under subsection B of this section.

c. Financing costs. The limitations on financing costs set forth in subsection B of this section shall apply to balloon loans. Financing costs exceeding the limitations set forth in these sections shall be allowed to the extent that such excess financing costs may be offset by any available interest savings.

(1) A 27-year amortization period must be used for deferred financing costs associated with the construction or purchase of a nursing facility.

(2) A 15-year amortization period must be used for deferred financing costs associated with financing of furniture, fixtures, and movable equipment.

(3) Financing costs associated with a loan used partially for the acquisition of buildings, land, and land improvements and partially for the purchase of furniture, fixtures, and equipment must be prorated for determination of the amortization period.

d. Cumulative credit computation. The computation of allowable interest and financing costs for balloon loans shall be calculated using the following procedures.

(1) A standard amortization schedule of allowable costs based upon the upper limits for interest and financing costs shall be computed by the provider and submitted to DMAS for the applicable 27-year or 15-year periods on the original balloon loan.

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(2) For each cost reporting period, the provider shall be allowed the lesser of loan costs (interest and financing costs) computed in accordance with subdivision 7.a. of this subsection, or the actual loan costs incurred during the period.

(3) To the extent that there is a "credit" created by the actual loan costs being less than the loan costs computed on the amortization schedule in some periods, the provider may recover any otherwise allowable costs which result from the refinancing, extension, or renewal of the balloon loan, and any loan costs which have been disallowed because the loan costs are over the limitation for some periods. However, the cumulative actual loan cost reimbursement may not exceed the cumulative allowable loan cost as computed on the amortization schedule to that date.

(4) In refinancing or re-financings of the original balloon loan which involve additional borrowings in excess of the balance due on the original balloon loan, the excess over the balance due on the balloon loan shall be treated as new debt subject to the DMAS financing policies and regulations. Any interest and financing costs incurred on the refinancing shall be allocated pro rata between the refinancing of the balloon loan and the new debt.

(5) In the event of a sale of the facility, any unused balance of cumulative credit or cumulative provider excess costs would follow the balloon loan or the refinancing of the balloon loan if the balloon loan or its refinancing is paid by the buyer under the same terms as previously paid by the seller. Examples of this are (i) the buyer assumes the existing instrument containing the same rates and terms by the purchaser; or (ii) the balance of the balloon loan or its re-financings is financed by the seller to the buyer under the same rates and terms of the existing loan as part of the sale of the facility. If the loan is otherwise paid in full at any time and the facility is sold before the full 27-year or 15-year amortization period has expired, the balance of unused cumulative credit or cumulative provider excess costs shall expire and not be considered an allowable cost.

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e. In accordance with subdivision A 5 of this section, no refinancing incentive shall be available for re-financings, extensions, or renewals of balloon loans.
f. The balloon loan and refinancing of the balloon loan shall be subject to all requirements for allowable borrowing, except as otherwise provided by this subsection.

B. Interest rate upper limit. Financing for all NFs and expansions which require a COPN and all renovations and purchases shall be subject to the following limitations:

1. Interest expenses for debt financing which is exempt from federal income taxes shall be limited to:

The average weekly rates for Baa municipal rated bonds as published in Cragie Incorporated Municipal Finance Newsletter as published weekly (Representative re-offering from general obligation bonds), plus one percentage point (100 basis points), during the week in which commitment for construction financing or closing for permanent financing takes place.

2.a. Effective on and after July 1, 1990, the interest rate upper limit for debt financing by NFs that are subject to prospective reimbursement shall be the average of the rate for 10-year and 30-year U.S. Treasury Constant Maturities, as published in the weekly Federal Reserve Statistical Release (H.15), plus two percentage points (200 basis points).

This limit (i) shall apply only to debt financing which is not exempt from federal income tax, and (ii) shall not be available to NF's which are eligible for such tax exempt financing unless and until a NF has demonstrated to the DMAS that the NF failed, in a good faith effort, to obtain any available debt financing which is exempt from federal income tax. For construction financing, the limit shall be determined as of the date on which commitment takes place. For permanent financing, the limit shall be determined as of the date of closing. The limit shall apply to allowable interest expenses during the term of the financing.

b. The new interest rate upper limit shall also apply, effective July 1, 1990, to construction financing committed to or permanent financing closed after December 31, 1986, but before July 1, 1990, which is not exempt from federal income tax. The limit shall be determined as of July 1, 1990, and shall apply to allowable interest expenses for the term of the financing remaining on or after July 1, 1990.

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3. Variable interest rate upper limit.

a. The limitation set forth in subdivisions 1 and 2 of this subsection shall be applied to debt financing which bears a variable interest rate as follows. The interest rate upper limit shall be determined on the date on which commitment for construction financing or closing for permanent financing takes place, and shall apply to allowable interest expenses during the term of such financing as if a fixed interest rate for the financing period had been obtained. A "fixed rate loan amortization schedule" shall be created for the loan period, using the interest rate cap in effect on the date of commitment for construction financing or the date of closing for permanent financing.

b. If the interest rate for any cost reporting period is below the limit determined in subdivision 3 a above, no adjustment will be made to the provider's interest expense for that period, and a "carryover credit" to the extent of the amount allowable under the "fixed rate loan amortization schedule" will be created, but not paid. If the interest rate in a future cost reporting period is above the limit determined in subdivision 3 a above, the provider will be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or its actual cost, whichever is less.

c. The provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of interest claimed under the "carryover credit," and shall submit such a schedule with each cost report.

4. The limitation set forth in subdivisions 1, 2, and 3 of this subsection shall be applicable to financing for land, buildings, fixed equipment, major movable equipment, working capital for construction and permanent financing.

5. Where bond issues are used as a source of financing, the date of sale shall be considered as the date of closing.

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6. The aggregate of the following costs shall be limited to 5.0% of the total allowable project costs:

a. Examination Fees
b. Guarantee Fees
c. Financing Expenses (service fees, placement fees, feasibility studies, etc.)
d. Underwriters Discounts
e. Loan Points

7. The aggregate of the following financing costs shall be limited to 2.0% of the total allowable project costs:

a. Legal Fees
b. Cost Certification Fees
c. Title and Recording Costs
d. Printing and Engraving Costs e. Rating Agency Fees

C. DMAS shall allow costs associated with mortgage life insurance premiums in accordance with §2130 of the HCFA-Pub. 15, Provider Reimbursement Manual (PRM-15).

D. Interest expense on a debt service reserve fund is an allowable expense if required by the terms of the financing agreement. However, interest income resulting from such fund shall be used by DMAS to offset interest expense.

12VAC30-90-34. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider and must notify DMAS of the sale within 30 days of the date legal title passes to the purchaser. The notification shall include:

1. That a sale or transfer is about to be made or has already occurred;

2. The location and general description of the property;

3. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years;

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B The following reimbursement principles shall apply to the purchase of a NF:

1. The allowable cost of a bona fide purchase of an existing nursing facility (whether or not the parties to the sale are, were, or will be providers of Medicaid services) shall be the seller's allowable depreciated historical cost (net book value) as determined for Medicaid reimbursement. The amount of allowable debt or borrowing to finance such a purchase shall be limited to the greater of the amount of the seller's net book value of the assets purchased, or the seller's related allowable debt, both as determined for Medicaid reimbursement plus required financing costs limited in accordance with the provisions of 12 VAC 30-90-33 sections B.6. and B.7.

2. For purposes of Medicaid reimbursement, a "bona fide" purchase shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See 12VAC30-90-51 C for definitions of common ownership," "control," "immediate family," and "significant ownership or control."

3. The useful life of the fixed assets of the facility shall be the seller's remaining depreciable lives as determined for Medicaid reimbursement.

4. The seller must file a final cost report within 150 days of the date of sale.

Article 3
Fair Rental Value Capital Payment System

12VAC30-90-35. General applicability. This article describes a capital payment methodology that will be phased in for most nursing facilities by SFY 2012. The terms and timing of the transition to a different methodology are described in Article 1. The methodology that this one will replace for most facilities is described in Article 2.

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

A. Applicability. The capital payment methodology described in this article shall be applicable to freestanding nursing facilities and specialized care facilities but not to hospital based facilities. Hospital based facilities shall continue to be reimbursed under the methodology contained in Article 2. For purposes of this provision a hospital based

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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 are not part of the R.S. Means construction cost amount.

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"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.

"Occupancy Schedule" means a table created to represent the average statewide occupancy by month of operation for use in calculating the per diem rate in lieu of a minimum occupancy requirement or actual occupancy for facilities with less than 12 months of experience. The occupancy schedule is shown in Table 1.

Table 1. Occupancy Schedule	
Initial Operating Period	Occupancy Percentage
3 Months	58.10%
4 Months	65.68%
5 Months	70.01%
6 Months	73.69%
7 Months	76.69%
8 Months	79.23%
9 Months	81.60%
10 Months	83.88%
11 Months	85.84%
12 Months	88.00%

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"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 2. The calculation will use the most recently available location factors, which will also be published on the DMAS website.

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TABLE 2.
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 provider's 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.

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"Required occupancy percentage" means the ratio of nursing facility total patient days to total potential patient days for all available licensed beds. The required occupancy percentage shall be 90% for dates of service on or before June 30, 2013. The required occupancy percentage for dates of service on or after July 1, 2013, shall be 88%. Facilities whose Fair Rental Value report indicates less than 12 months of experience must use the Occupancy Schedule to determine the required occupancy percentage.

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

A. Fair rental value (FRV) 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, except that the capital per diem rate was revised for the rental rate changes effective July 1, 2010 through June 30, 2012. Data elements that are provider specific shall be revised at that time and shall rely on the settled cost report and schedule of assets of the previous year. Data elements that are not provider specific, including those published by 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.

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1. Mid-year FRV rate change. Facilities requiring a mid-year FRV rate change must follow the procedures as specified in 4.19-D, Supp 1, pages 1-3.

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

3. Effective for dates of service on or after July 1, 2021, any nursing facility which thereafter loses its Medicaid capital reimbursement status as a hospital-based nursing facility because a replacement hospital was built at a different location and Medicare rules no longer allow the nursing home's cost to be included on the hospital's Medicare cost report shall have its first FRV capital payment rate set at the maximum FRV rental rate for a new free-standing nursing facility with the date of acquisition for its capital assets being the date the replacement hospital is licensed.

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 the required occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see 4.19-D, Supp 1, p 26 (12 VAC 30-90-264) section 10, for special procedures for computing the number of patient days required to meet the required occupancy percentage requirement.

Facilities shall be required to submit a calendar year FRV report covering both NF and specialized care beds to be used to set a prospective FRV rate effective the following July 1 for both the NF and the specialized care facility. The calendar year FRV report shall be submitted by the end of February following the end of the calendar year. FRV reports shall be settled within 90 days of filing the FRV report. For late FRV reports, the prospective rate may be effective 90 days after the date of filing even if after July 1. No capital rate shall be paid between July 1 and the effective date of the prospective FRV rate for a late report.

New nursing facilities or major renovations that qualify for mid-year FRV rate adjustments must follow pro forma submission procedures as specified in 4.19-D, Supp 1, pages 1-3.

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

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

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

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

12 VAC 30-90-38. Schedule of Assets Reporting.

A. For the calculation of facility average age the Department shall use a "schedule of assets" that lists, by year of acquisition, the allowable acquisition cost of facilities' assets, including land improvements, buildings and fixed equipment, and major movable equipment. This schedule shall be submitted annually by the provider on forms to be provided by the Department, and shall be audited by the Department. The principles of reimbursement for plant cost described in Article 2 shall be used to determine allowable cost.

B. The schedule of assets used in the calculation of average age shall be submitted with the provider's cost report.

C. Facilities failing to submit the schedule of assets timely shall have their nursing facility per diem rate set to zero.

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D. Capital expenditures are to be included on the schedule of assets. These do not include land purchases, but do include land improvements, renovations, additions, upgrading to new standards, and equipment purchases. Capital expenditures shall be capital related expenditures costing $50,000 or more each, in aggregate for like items, or in aggregate for a particular project. For facilities with 30 or fewer beds, an amount of $25,000, rather than $50,000, shall apply. The limits of $50,000 and $25,000 shall apply only to expenditures after July 1, 2000. For these purposes like items means those items acquired within a 12-month period that are classified in one of the categories of land improvements, or building improvements, or moveable equipment. Additionally, capital-related expenditures which are part of a particular project may be included on the schedule of assets for the cost reporting date which is after the date the assets have been placed into service, whether or not all the required $50,000 threshold of costs of the ongoing project have been incurred as of the reporting date.

E. Items reportable on the schedule of assets may be removed only when disposed of.

F. Acquisition costs related to any sale or change in the ownership of a nursing facility or the assets of a nursing facility shall not be included in the Schedule of Assets if the transaction occurred after June 30, 2000. Whether such a transaction is the result of a sale of assets, acquisition of capital stock, merger, or any other type of change in ownership, related costs shall not be reported on the Schedule of Assets.

G. In addition to verifying the Schedule of Assets, audits of NF allowable capital costs shall continue to be performed in accordance with regulations described in Article 2.

12 VAC 30-90-39. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider and must notify DMAS of the sale within 30 days of the date legal title passes to the purchaser. The notification shall include:

1. That a sale or transfer is about to be made or has already occurred;

2. The location and general description of the property;

3. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years;

B. The seller must file a final cost report within 150 days of the date of the facility sale.

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Article 4
Operating Cost Component

12VAC30-90-40. Operating cost.

A. Effective July 1, 2001, operating cost shall be the total allowable inpatient cost less plant cost or capital, as appropriate, and NATCEPs costs. See Subpart VII (12 VAC 30-90-170) for rate determination procedures for NATCEPs costs. Operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I (12 VAC 30-90-271). Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs or the actual charges by the Central Criminal Records Exchange for criminal records checks for nursing facility employees (see Appendix I (12 VAC 30-90-272)). For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or the occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period times the Medicaid utilization percentage. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90 percent, for dates of service on or after July 1, 2013 shall be 88 percent. For facilities that also provide specialized care services, see 12 VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the occupancy percentage requirement.

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

A. Effective on and after July I, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group (RUG) System as defined in Appendix IV (12 VAC 30-90-305 through 307)." The RUG model is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG 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 12 VAC 30-90-305 through 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.

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2. Direct and indirect group ceilings and rates.

   a. 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 12 VAC 30-90-271.

   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) Minimum Data Set (MDS) System. See 12 VAC 30-90-306 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 NF's subsequent fiscal year. See 12 VAC30-90-306 D 2 for the calculation of the normalized facility average Medicaid CMI.

   a. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NFs normalized facility average Medicaid CMI. A NF's 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 12 VAC 30-90-307).

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c. See 12VAC 30-90-307 for the applicability of case-mix indices.

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

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

6. Reimbursement for use of specialized treatment beds. Effective for services on and after January 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.

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.

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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 re-basing 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 averages 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 re-basing 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

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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. Non-operating costs. Plant or capital, as appropriate, costs shall be reimbursed in accordance with Articles 1, 2, and 3. 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.

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

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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. The reimbursement methodology described in this section shall be utilized for dates of service through June 30, 2014. Effective July 1, 2014, nursing facilities shall be reimbursed the price-based methodology described in 12 VAC 30-90-44 except, effective July 1, 2021, for nursing facilities operated by the Department of Veteran Affairs.

12VAC 30-90-41.1 Modifications to Nursing Facility Reimbursement Formula. Repealed. 12VAC30-90-42. Repealed. 12VAC30-90-43. Repealed.

12 VAC 30-90-44. Nursing Facility Price Based Payment Methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates in 12 VAC 30-90-41 to a price-based methodology except for nursing facilities operated by the Department of Veteran Affairs. 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.

b. The initial base year for calculating the cost per day shall be cost reports ending in calendaryear 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. Effective July 1, 2021 DMAS shall defer the next scheduled nursing facility rate rebasing for one year in order to utilize cost reports ending in 2021as the base year. The deferred year's rates would reflect the prior year rates inflated according to the existing reimbursement regulations. No adjustments will be made to the base year data for purposes of rate setting after September 1.

c. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost perday 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 fourth 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 prorating 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 Commonwealth of Virginia map with the coordinates: 37.4203914 Latitude, 82.0201219 Longitude and 37.1223664 Latitude, 76.3457773 Longitude.

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Direct peer groups are:
a. Northern Virginia;
b. Other MSAs,
c. Northern Rural, and
d. Southern Rural.

f. 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 Sate peer goups shall be defined as any localities other than localities in the Northern Virginia peer group for nursing faciltiies 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. Indirct peer groups are:
a. Northern Virginia MSA,
b. Rest of State-Greater than 60 beds,
c. Other MSAs,
d. Northern Rural, and
e. Southern Rural- 60 Beds or Less.

g. Any changes to peer gorup assignment based on changes in bed size or MSA will beimplemented for reimbursement purposes the July 1 following treh effective date of the change.

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

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

- Effective July 1, 2021, the direct adjustment factor shall be 109.3% of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities.

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

- Effective July 1, 2021, the indirect adjustment factor shall be 103.3% of the peer group day-weighted median inflated cost per day for freestanding nursing facilities.

i. Facilities with costs projected to the rate year below 95% of the price shall have an adjusted price equal to the price minus the difference between the facility's cost and 95% 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.

j. Special circumstances.

1. Effective July 1, 2022, DMAS shall establish a new direct and indirect peer group for nursing facilities operating with at least 80% of the resident population has one or more of the following diagnoses: quadriplegia, traumatic brain injury, multiple sclerosis, paraplegia, or cerebral palsy. In addition, a qualifying facility must have at least 90% Medicaid utilization and a nursing facility case-mix index of 1.15 or higher in fiscal year 2014.

- The department shall utilize the data from the most recent rebasing to make this change effective for fiscal year 2023 and subsequent rate years until this change is incorporated into the next scheduled rebasing.

2. For rebasings effective on or after July 1, 2020, DMAS shall move nursing facilities located in the former Danville Metropolitan Statistical Area to the Other MSAs peer group.

k. 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.

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l. 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 12 VAC 30-90-306 in determining the direct costs in setting the price and for adjusting the claim payments for residents.

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

b. The department shall utilize RUG-III, version 34 groups and weights in fiscal years 2015 through 2017 for claim payments.

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

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

m. DMAS shall increase nursing facility per diem rates by $10.49 per day effective July 1, 2022.

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

1. 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 costdata. If there is no settled cost report at the beginning of a fiscal year, then 100% of the price-based rate shall be used for that fiscal year. Facilities placed in service after June 30, 2013, shall be paid 100% of the price-based rate.

2. Effective July 1, 2015, nursing facilities whose licensed bed capacity decreased by at least 30 beds after 2011 and whose occupancy increased from less than 70 percent in 2011 to more than 80 percent in 2013 shall be reimbursed the price-based operating rate rather than the transition operating rate.

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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 12 VAC 30-90-36. There will be no separate calculation for beds subject to or not subject to transition.

2. FRV per diem rates for new nursing facilities or major renovations that qualify for mid-year rate adjustments shall be calculated as prescribed in 4.19-D, Supp 1, pages 1-3.

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

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

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

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12 VAC 30-90-45. Supplemental payments for state-owned nursing facilities.

A. Effective July 1, 2018, DMAS shall make supplemental payments to state-owned nursing facilities. Quarterly supplemental payments for each facility shall be calculated in the following manner:

B. Reimbursement Methodology. The supplemental payment shall equal inpatient hospital claim payments times the Upper Payment Limit (UPL) gap percentage.

1. The annual UPL gap percentage is the percentage calculated where the numerator is the difference for each nursing facility between a reasonable estimate of the amount that would be paid under Medicare payment principles for nursing facility services provided to Medicaid patients calculated inaccordance with 42 CFR 447.272 and what Medicaid paid for such services and the denominator is Medicaid payments to each nursing facility for nursing facility services provided to Medicaid patients in the same year used in the numerator,

2. The UPL gap percentage will be calculated annually for each nursing facility using data for the most recent year for which comprehensive annual data are available and inflated to the state fiscalyear for which payments are to be made.

3. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available UPL. If nursing facility payments for state nursing facilities would exceed the UPL, thenumerator in the calculation of the UPL gap percentage shall be reduced proportionately,

C. Quarterly Payments. After the close of each quarter, beginning with the July 1, 2018 to September 30, 2018 quarter, each qualifying nursing facility shall receive supplemental payments for the nursing facility services paid during the prior quarter. The supplemental payments for each qualifying nursing facility shall be calculated by multiplying Medicaid nursing facility payments paid in that quarter by the annual UPL gap percentage.

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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 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.

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C. Operating costs.

1. Direct patient care operating costs shall be defined in 12VAC30-90-271.

2. Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and non-legend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with 12VAC30-80-10 et seq.

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in 12VAC30-90-270 et seq., which are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

D. Allowances/goodwill. Bad debts, goodwill, charity, courtesy, and all other contractual allowances shall not be recognized as allowable costs.

12VAC30-90-51. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of 12 VAC 30-90-34-B1.

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See 12VAC30-90-290.)

B. "Related to the provider" shall mean that the provider is related by reasons of common ownership or control by the organization furnishing the services, facilities, or supplies.

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C. Common ownership exists when an individual or individuals or entity or entities possess significant ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction. Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control," as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

1. Effective with cost reports having fiscal years beginning on or after July 1, 1986, an exception to the related organization principle shall be allowed. Under this exception, charges by a related organization to a provider for goods or services shall be allowable cost to the provider if all four of the conditions set out below are met.

2. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of DMAS that the following criteria have been met:

    a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

    b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of goods or services furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity.

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For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arms-length bargaining by well informed buyers and sellers.

c. The goods or services shall be those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the good or services from outside sources rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such goods or services. The phrase "open market" takes the same meaning as "open, competitive market" in subdivision b above.

3. Where all of the conditions of this exception are met, the charges by the supplier to the provider for such goods or services shall be allowable as costs.

4. This exception does not apply to the purchase, lease or construction of assets such as property, buildings, fixed equipment or major movable equipment. The terms "goods and services" may not be interpreted or construed to mean capital costs associated with such purchases, leases, or construction.

E. Three competitive bids shall not be required for the building and fixed equipment components of a construction project outlined in 12VAC30-90-31. Reimbursement shall be in accordance with subsection A of this section with the limitations stated in 12VAC30-90-31 B.

12VAC30-90-52. Administrator/owner compensation.

A. Administrators' compensation, whether administrators are owners or non-owners, shall be based on a schedule adopted by DMAS and varied according to facility bed size. The compensation schedule shall be adjusted annually to reflect cost-of-living increases and shall be published and distributed to providers annually. The administrator's compensation schedule covers only the position of administrator and assistants and does not include the compensation of owners employed in capacities other than the nursing facility administrator (see 12VAC30-90-290, Cost reimbursement limitations).

B. Administrator compensation shall mean remuneration paid regardless of the form in which it is paid. This includes, but shall not be limited to, salaries, professional fees, insurance

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premiums (if the benefits accrue to the employee/owner or his beneficiary), director fees, personal use of automobiles, consultant fees, management fees, travel allowances, relocation expenses in excess of IRS guidelines, meal allowances, bonuses, pension plan costs, and deferred compensation plans. Management fees, consulting fees, and other services performed by owners shall be included in the total compensation if they are performing administrative duties regardless of how such services may be classified by the provider.

C. Compensation for all administrators (owner and non-owner) shall be based upon a 40-hour week to determine reasonableness of compensation.

D. Owner/administrator employment documentation.

1. Owners who perform services for a nursing facility as an administrator and also perform additional duties must maintain adequate documentation to show that the additional duties were performed beyond the normal 40-hour week as an administrator. The additional duties must be necessary for the operation of the nursing facility and related to patient care.

2. Services provided by owners, whether in employee capacity, through management contracts, or through home office relationships shall be compared to the cost and services provided in arms-length transactions.

3. Compensation for such services shall be adjusted where such compensation exceeds that paid in such arms-length transactions or where there is a duplication of duties normally rendered by an administrator. No reimbursement shall be allowed for compensation where owner services cannot be documented and audited.

12VAC30-90-53. Depreciation.

A. The allowance for depreciation shall be restricted to the straight line method with a useful life in compliance with AHA guidelines. If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

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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 and effective for dates of service beginning July 1, 2001, through June 30, 2014:

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii) a 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.

2. 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:

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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 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.

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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 sevice 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.

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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, The 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, pp 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.)

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12 VAC 30-90-66 through 12 VAC 30-90-69. Reserved.

Article 7
Cost Reports

12VAC30-90-70. Cost report submission.

A. Cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete for the purpose of cost settlement when DMAS has received all of the following (note that if the audited financial statements required by subdivisions 3 a and 6 b of this subsection are received not later than 120 days after the provider's fiscal year end and all other items listed are received not later than 90 days after the provider's fiscal year end, the cost report shall be considered to have been filed at 90 days):

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);
2. The provider's trial balance showing adjusting journal entries;
3. a. The provider's audited financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of cash flows, the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, footnotes to the financial statements, and the management report. Multi-facility providers shall be governed by subdivision 7 of this subsection;
   b. Schedule of restricted cash funds that identify the purpose of each fund and the amount;
   c. Schedule of investments by type (stock, bond, etc.), amount, and current market value;
4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

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5. Depreciation schedule;
6. Schedule of Assets as defined in Attachment 4.19-D, Supplement 1, page 19 (12 VAC 30-90-38).
7. Nursing facilities which are part of a chain organization must also file:

a. Home office cost report;

b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report and footnotes to the financial statements;

c. The nursing facility's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value; and

8. Such other analytical information or supporting documentation that may be required by DMAS.

B. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. For example, for a September 30 fiscal year end, payments will be reduced starting with the payment on and after March 1.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

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12 VAC 30-90-71 through 12 VAC 30-90-74. Reserved.

12VAC30-90-75. Reporting form; accounting method; cost report extensions; fiscal year changes.

A. All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

B. The accrual method of accounting and cost reporting is mandated for all providers.

C. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;
2. Financial statements not completed;
3. Office or building renovations;
4. Home office cost report not completed;
5. Change of stock ownership;
6. Change of intermediary;
7. Conversion to computer; or
8. Use of reimbursement specialist.

D. All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year.

12 VAC 30-90-76 through 12 VAC 30-90-79. Reserved.

Article 8
Prospective Rates

12VAC30-90-80. Time frames.

A. For cost reports filed on or after August 1, 1992, a prospective rate shall be determined by DMAS within 180 days of the receipt of a complete cost report. (See 12VAC30-90-70 A.) Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, the DMAS shall have an additional 120 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. The DMAS

will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

12 VAC 30-90-81 through 12 VAC 30-90-89. Reserved.

Article 9
Retrospective Rates

12VAC30-90-90. Retrospective rates.

The retrospective method of reimbursement shall be used for mental health/mental retardation facilities.

12VAC30-90-91 to 90-109. Reserved.

Article 10
Record Retention

12VAC30-90-110. Record retention.

A. Time frames. All of the NF's accounting and related records, including the general ledger, books of original entry, and statistical data must be maintained for a minimum of five years, or until all affected cost reports are final settled.
Certain information must be maintained for the duration of the provider's participation in the Medicaid program and until such time as all cost reports are settled. Examples of such information are set forth in subsection B of this section.

B. Types of records to be maintained. Information which must be maintained for the duration of the provider's participation in the Medicaid program includes, but is not limited to:

1. Real and tangible property records, including leases and the underlying cost of ownership;
2. Itemized depreciation schedules; and
3. Mortgage documents, loan agreements, and amortization schedules;
4. Copies of all cost reports filed with the DMAS together with supporting financial statements.

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C. Record availability. The records must be available for audits by DMAS staff. Where such records are not available, costs shall be disallowed.

12 VAC 30-90-111 through 12 VAC 30-90-119. Reserved.

Article 11
Audits

12VAC30-90-120. Audit overview; scope of audit.

A. Desk audits shall be performed to verify the completeness and accuracy of the cost report, and reasonableness of costs claimed for reimbursement. Field audits, as determined necessary by the DMAS, shall be performed on the records of each participating provider to determine that costs included for reimbursement were accurately determined and reasonable, and do not exceed the ceilings or other reimbursement limitations established by the DMAS.

B. The scope of the audit includes, but shall not be limited to: trial balance verification, analysis of fixed assets, schedule of assets, indebtedness, selected revenues, leases and the underlying cost of ownership, rentals and other contractual obligations, and costs to related organizations. The audit scope may also include various other analyses and studies relating to issues and questions unique to the NF and identified by the DMAS. Census and related statistics, patient trust funds, and billing procedures are also subject to audit.

12VAC30-90-121. Field audit requirements.

Field audits shall be required as follows:

1. For the first cost report on all new NF's.
2. For the first cost report in which costs for bed additions or other expansions are included.
3. When a NF is sold, purchased, or leased.
4. As determined by DMAS desk audit.

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12VAC30-90-122. Provider notification.

The provider shall be notified in writing of all adjustments to be made to a cost report resulting from desk or field audit with stated reasons and references to the appropriate principles of reimbursement or other appropriate regulatory cites.

12VAC30-90-123. Field audit exit conference.

A. The provider shall be offered an exit conference to be executed within 15 days following completion of the on-site audit activities, unless other time frames are mutually agreed to by the DMAS and provider. Where two or more providers are part of a chain organization or under common ownership, DMAS shall have up to 90 days after completion of all related on-site audit activities to offer an exit conference for all such NFs. The exit conference shall be conducted at the site of the audit or at a location mutually agreeable to the DMAS and the provider.

B. The purpose of the exit conference shall be to enable the DMAS auditor to discuss such matters as the auditor deems necessary, to review the proposed field audit adjustments, and to present supportive references. The provider will be given an opportunity during the exit conference to present additional documentation and agreement or disagreement with the audit adjustments.

C. All remaining adjustments, including those for which additional documentation is insufficient or not accepted by the DMAS, shall be applied to the applicable cost report or reports regardless of the provider's approval or disapproval.

D. The provider shall sign an exit conference form that acknowledges the review of proposed adjustments.

E. After the exit conference the DMAS shall perform a review of all remaining field audit adjustments. Within a reasonable time and after all documents have been submitted by the provider, the DMAS shall transmit in writing to the provider a final field audit adjustment report (FAAR), if revised, which will include all remaining adjustments not resolved during the exit-conference. The provider shall have 15 days from the date of the letter which transmits the FAAR, to submit any additional documentation which may affect adjustments in the FAAR.

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12VAC30-90-124. Audit delay.

In the event the provider delays or refuses to permit an audit to occur or to continue or otherwise interferes with the audit process, payments to the provider shall be reduced as stated in 12VAC30-90-70

12VAC30-90-125. Field audit time frames.

A. If a field audit is necessary after receipt of a complete cost report, such audit shall be initiated within three years following the date of the last notification of program reimbursement and the on site activities, including exit conferences, shall be concluded within 180 days from the date the field audit begins. Where audits are performed on cost reports for multiple years or providers, the time frames shall be reasonably extended for the benefit of the DMAS and subject to the provisions of 12VAC30-90-123.

B. Documented delays on the part of the provider will automatically extend the above time frames to the extent of the time delayed.

C. Extensions of the time frames shall be granted to the department for good cause shown.

D. Disputes relating to the timeliness established in 12VAC30-90-123 and 12VAC30-90-124, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the DMAS or his designee.

12VAC30-90-126 TO 12VAC30-90-129. RESERVED.

Subpart III
Appeals

12VAC30-90-130. Dispute resolution for nonstate operated nursing facilities. Repealed.

12VAC30-90-131. Conditions for appeal. Repealed.

12VAC30-90-132. Appeal procedure. Repealed.

12VAC30-90-133. Appeals time frames. Repealed.

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12VAC30-90-134. Dispute resolution for state-operated NFs.

A. Definitions.

"DMAS" means the Department of Medical Assistance Services.

"Division director" means the director of a division of DMAS.

"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

1. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

2. The appropriate DMAS division must receive the reconsideration request within 30 business days after the date of a DMAS Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

C. Informal review. The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

D. Division director action. The division director shall consider any recommendation of his designee and shall render a decision.

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E. DMAS director review. A state-operated provider may, within 30 business days after the date of the informal review decision of the division director, request that the DMAS Director or his designee review the decision of the division director. The DMAS Director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 business days after the date of the decision of the DMAS Director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other cabinet secretary as appropriate. Any determination by such secretary or secretaries shall be final.

12VAC30-90-135. Reimbursement of legal fees associated with appeals having substantial merit. Repealed.

12VAC30-90-136. Elements of the capital payment methodology that shall not be subject to appeal shall be:

1. The definitions provided in Article 3, and the application of those definitions to the FRV rate calculation.
2. The transition policy described in Article 1.
3. The formula for determining the FRV per diem rate described in Article 3.
4. The calculation of the FRV rental amount described in Article 3.
5. The exclusion of certain beds from the transition policy, as provided in Article 3.

12VAC30-90-137 to 12VAC30-90-139. Reserved.

Subpart IV
Individual Expense Limitation

12VAC30-90-140. Individual expense limitation.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in 12VAC30-90-290, Cost Reimbursement Limitations.

12 VAC 30-90-141 to 12 VAC 30-90-149. Reserved.

Subpart V
Cost Report Preparation Instructions

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12VAC30-90-150. Cost report preparation instructions.
Instructions for preparing NF cost reports will be provided by the DMAS.

12 VAC 30-90-151 to 12 VAC 30-90-159. Reserved.

Subpart VI
Stock Transactions
Article 1.
Plant Cost Applicable.

12VAC30-90-160. Stock acquisition; merger of unrelated and related parties.

A. The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets. Any cost associated with an acquisition of capital stock shall not be an allowable cost. The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.

B. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation. The non-surviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

C. The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

12 VAC 30-90-161 through 90-164. Reserved.

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Article 2.
Capital Cost Applicable.

12 VAC 30-90-165. Stock acquisition; merger of unrelated and related parties.

A. The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets. Any cost associated with an acquisition of capital stock shall not be an allowable cost. The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.

B. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation. The non-surviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

C. The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

12 VAC 30-90-166 through 90-169. Reserved.

Subpart VII
Nurse Aide Training and Competency Evaluation Program and Competency Evaluation Programs (NATCEPs)

12VAC30-90-170. NATCEPs costs.

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

B. NATCEPs costs shall be as defined in 12VAC30-90-270.

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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 that is 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 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 (12 VAC 30-90-44). To calculate the NATCEPs per diem rate, NATCEPs costs in the base year shall be converted to a per diem amount by dividing allowable NATCEPs 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).

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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.

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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 calcualted. In a rebasing year, the calculation shall be based on the base yaer described in 4.19-D, Supp. 1, p. 26.2 (12 VAC 30-90-44). 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.

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Subpart IX
Use of MMR-240

12VAC30-90-190. Use of MMR-240.

All providers must use the data from computer printout MMR-240 based upon a 60-day accrual period.

Subpart X
Commingled Investment Income

12VAC30-90-200. Commingled investment income.

DMAS shall treat funds commingled for investment purposes in accordance with PRM-15, § 202.6.

Subpart XI
Provider Notification

12VAC30-90-210. Provider notification.

DMAS shall notify providers of State Plan changes affecting reimbursement 30 days prior to the enactment of such changes.

Subpart XII
Start-up Costs and Organizational Costs

12VAC30-90-220. Start-up costs.

A. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they shall be capitalized as deferred charges and amortized over a 60-month time frame.

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B. Start-up costs may include, but are not limited to, administrative and nursing salaries; heat, gas, and electricity; taxes, insurance; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as operating costs must be appropriately classified as such and excluded from start-up costs.

C. Start-up costs that are incurred immediately before a provider enters the Program and that are determined by the provider, subject to the DMAS approval, to be immaterial need not be capitalized but rather may be charged to operations in the first cost reporting period.

D. Where a provider incurs start-up costs while in the Program and these costs are determined by the provider, subject to the DMAS approval, to be immaterial, these costs shall not be capitalized but shall be charged to operations in the periods incurred.

12VAC30-90-221. Time frames.

A. Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient (whether Medicaid or non-Medicaid) is admitted for treatment, or where the start-up costs apply only to nonrevenue producing patient care functions or non-allowable functions, to the time the areas are used for their intended purposes.

B. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred charge account and shall be amortized when the first patient is admitted for treatment.

C. If a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs shall be capitalized and amortized separately for the portion or portions of the provider's facility prepared during different time periods.

D. Moreover, if a provider expands its NF by constructing or purchasing additional buildings or wings, start-up costs shall be capitalized and amortized separately for these areas.

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E. Depreciation time frames.

1. Costs of the provider's facility and building equipment shall be depreciated using the straight line method over the lives of these assets starting with the month the first patient is admitted for treatment.

2. Where portions of the provider's NF are prepared for patient care services after the initial start-up period, those asset costs applicable to each portion shall be depreciated over the remaining lives of the applicable assets. If the portion of the NF is a non-revenue-producing patient care area or non-allowable area, depreciation shall begin when the area is opened for its intended purpose. Costs of major movable equipment, however, shall be depreciated over the useful life of each item starting with the month the item is placed into operation.

12VAC30-90-222. Organizational costs.

A. Organizational costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organizational costs extend over more than one accounting period and thus affect the costs of future periods of operations.

B. Allowable organizational costs shall include, but not be limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders and fees paid to states for incorporation.

C. The following types of costs shall not be considered allowable organizational costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate state or federal authorities, stamp taxes, etc.

D. Allowable organization costs shall generally be capitalized by the organization. However, if DMAS concludes that these costs are not material when compared to total allowable costs, they may be included in allowable indirect operating costs for the initial cost reporting period. In all other circumstances, allowable organization costs shall be amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

12VAC30-90-223 to 12VAC30-90-229. Reserved.

Subpart XIII
DMAS Authorization

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12VAC30-90-230. Access to records.

A. DMAS shall be authorized to request and review, either through a desk or field audit, all information related to the provider's cost report that is necessary to ascertain the propriety and allocation of costs (in accordance with Medicare and Medicaid rules, regulations, and limitations) to patient care and non-patient care activities.

B. Examples of such information shall include, but not be limited to, all accounting records, mortgages, deeds, contracts, meeting minutes, salary schedules, home office services, cost reports, and financial statements.

C. This access also applies to related organizations as defined in 12VAC30-90-51 who provide assets and other goods and services to the provider.

Subpart XIV
Home Office Costs

12VAC30-90-240. Home office operating costs.

A. Home office operating costs shall be allowable to the extent they are reasonable, relate to patient care, and provide cost savings to the provider.

B. Provider purchases from related organizations, whether for services, or supplies, shall be limited to the lower of the related organizations actual cost or the price of comparable purchases made elsewhere.

C. Home office operating costs shall be allocated in accordance with § 2150.3, PRM-15.

D. Home office costs associated with providing management services to nonrelated entities shall not be recognized as allowable reimbursable cost.

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E. Allowable and non-allowable home office costs shall be recognized in accordance with § 2150.2, PRM-15.

F. Item 398 D Chapter 723 of 1987 Acts of Assembly (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

Subpart XV
Refund of Overpayments

12VAC30-90-250. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk audit, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund.

12VAC30-90-251. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall be used to reduce the balance of the overpayment.

12VAC30-90-252. Payment schedule.

A. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request in writing an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request in writing an extended repayment schedule.

B. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of DMAS may approve a repayment schedule of up to 36 months.

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C. A provider shall have no more than one extended repayment schedule in place at one time. If subsequent audits identify additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amounts.

D. If, during the time an extended repayment schedule is in effect, the provider ceases to be a participating provider or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

E. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered from interim payments to the provider or by lump sum payments.

12VAC30-90-253. Extension request documentation.

In the written request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. The provider must make payments in accordance with the proposed schedule while the schedule is pending approval. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

12VAC30-90-254. Interest charge on extended repayment.

A. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

B. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

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C. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

12VAC30-90-255 Reserved.
12 VAC30-90-256 Reserved.

12 VAC 30-90-257 Credit balance reporting.

A. Definitions. The following words or terms when used in this regulaiton shall have the following meanings unless the context clearly indicates otherwise:

"Claim" means a bill consistent with Attachment 4.19-E, page 1 (12 VAC 30-20-180) submitted by a provider to the departmetn for services furnished to a recipient.

"Credit balance" means an excess or overpayment made to a provider by Medicaid as a result of patient billings.

B. Credit balances may occur when a provider's reimbursement for sevices it provides exceeds the allowable amount or when the reimbursement has been for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid or another third party payer for the same services.

C. For a credit balance arisign on a Medicaid claim within three years of the date paid by the department, the NF shall submit an adjustment claim. For credit balances arisign on claims over three years old, the NF shall submit a check for the balance due and a copy of the original DMAS payment.

D. A periodic audit shall be conducted of the NFs' claim adjustments of Medicaid credit balance data. NFs shall maintain an audit trail back to the underlying accounts receivable records supporting each claim adjusted for credit balances.

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12 VAC 30-90-258 Reserved
12VAC30-90-259. Reserved.

Subpart XVI
Revaluation of Assets

12VAC30-90-260. Repealed.

12 VAC 30-90-261 through 12 VAC 30-90-263. Reserved.

12VAC30-90-264. Specialized care services.

Specialized care services provided in conformance with Attachment 3.1-C, page 6 (12VAC30-60-40 E and H), Attachment 3.1-C, Supplement 1, page 16 (12VAC30-60-320) and Attachment 3.1-C, Supplement 1, page 17 (12VAC30-60-340) shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the category of Ventilator Dependent Care will be placed in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in Appendix 1 of the NHPS, page 2, section 2.1 (12VAC30-90-271) and Appendix 1 of the NHPS, page 4, section 3.1 (12VAC30-90-272). To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days. Effective July 1, 2016, the base year for routine operating cost shall be the most recently settled cost reports with a fiscal year ending in a calendar year for all specialized care facilities as of the end of the calendar year prior to the prospective rate year.

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article 5 of Part II of this chapter (Attachment 4.19-D, Supplement 1, page 26.8, 12VAC30-90-50 et seq.) and of Appendix III of Part II of this chapter (Nursing Home Payment System, Appendix III, page 2, 12VAC30-90-290) shall apply to specialized care cost and reimbursement.

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine

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operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 4.19-D, Supp 1, page 21 (12 VAC 30-90-41).

4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:

   a. Statewide ceiling. The statewide routine operating ceiling shall be $415 as of July 1, 2002. This routine operating ceiling amount shall be adjusted for inflation based on 4.19-D, Supp 1, page 21 (12VAC 30-90-41). Effective July 1, 2016, the routine operating ceilign shall be $573.09 as of SFY 15 and shall be adjusted for inflation bawed on 4.19-D, supp 1, page 26.2 (12 VAC 30-90-44) to the upcoming state fiscal year, the prospecitve rate year.

   b. The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after the January 1 for which the normalization is calculated. Effective July 1, 2016, the normalized wage index for the FFY following the base year shall be applied to the SFY ceiling.

5. Facility-specific prospective routine operating base cost per day: The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted for inflation based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). Effective July 1, 2016, the routine operating base cost per day in subdivision 1 shall be adjusted for inflation based on 4.19-D, Supp 1, page 26.2 (12 VAC 30-90-44) to the upcoming state fiscal year, the prospective rate year.

6. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report available at the time the interim rates must be set, except that failure to submit a cost report timely may result in adjustment to interim rates as provided elsewhere. Effective July 1, 2016, this section is no longer applicable.

7. Ancillary costs. Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:

   a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. Effective for specialized care days on or after January 15, 2007, reimbursement for reasonable costs shall be subject to a ceiling. The ceiling shall be $238.81 per day for calendar year 2004 (150% of average costs) and shall be inflated to the appropriate provider fiscal year. For cost report years beginning in each calendar year, ancillary ceilings will be inflated based on 4.19-D, Supp 1, page 21 (12 VAC 30-90-41). See NHPS, Appendix III, page 2 (12VAC30-90-290) for the cost reimbursement limitations. Effective July 1, 2016, the ancillary ceiling of $300.38 in SFY 15, inclusive of kinetic therapy devices, shall be adjusted for inflation to the prospective rate year based on 4.19-D, Supp 1, page 26.2 (12 VAC 30-90-44).

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b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See NHPS, Appendix III, page 2 (12VAC30-90-290) for the cost reimbursement limitations.

c. Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet the following wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that cannot be closed, or second to third degree burns covering more than 10% of the body.

8. Covered ancillary services are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services, psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care nursing facility cost reporting period.

9. Capital costs. Effective July 1, 2016, capital cost reimbursement rates shall be based on subsection C of 12 VAC 30-90-44 in accordance with 4.19-D, Supp 1, p 14-19 (12 VAC 30-90-35 through 12 VAC 30-90-37) inclusive, except that the required occupancy percentage shall not be separately applied to specialized care. For new nursing homes or major renovations that qualify for mid-year rate adjustments, capital cost reimbursement shall be based on 4.19-D, Supp 1, p 1-3. To determine the capital cost related to specialized care patients, the following calculation shall be applied:

a. Licensed beds, including specialized care beds, multiplied by days in the cost reporting period, shall equal available days.

b. The required occupancy days shall equal the required occupancy percentage multiplied by available days.

c. The required occupancy days minus actual resident days, including specialized care days, shall equal the shortfall of days. If the shortfall of days is negative, the shortfall of days shall be zero.

d. Actual resident days, not including specialized care days, plus the shortfall of days shall equal the minimum number of days to be used to calculate the capital cost per day.

10. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs. NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS. Effective July 1, 2016, NATCEP costs shall be paid on a prospective basis in accordance with 4.19-D, Supp 1, page 45 (12 VAC 300-90-170).

11. Pediatric routine operating cost rate. For pediatric specialized care in a distinct part pediatric specialized care unit, one routine operating cost ceiling will be developed. The routine operating cost ceiling will be $418 as of July 1, 2002. Effective July 1, 2016, the pediatric routine operating cost ceiling shall be $577.24 as of SFY 15.

a. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivisions 4 of this section.

b. The final routine operating cost reimbursement rate shall be computed as described for other than pediatric units in subdivision 3 of this section.

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12. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with subdivision 9 of this section, except that the occupancy requirement shall be 70% rather than the required occupancy percentage.

13. The cost reporting requirements of 4.19-D, Supp 1, page 35 (12 VAC 30-90-70) and 4.19-D, Supp 1, page 37 (12 VAC 30-90-80) shall apply to specialized care providers.

14. Effective July 1, 2020 through June 30, 2023, specialized care operating rates shall be increased by inflating the 2020 rates based on the section of the state plan called the Nursing Facility Price Based Payment Methodology, which starts on page 26.2 of 4.19D, Supplement 1. After state fiscal year 2023, the rates shall revert to the existing prospective methodology.

15. DMAS shall increase nursing facility per diem rates by $15 per day effective July 1, 2021.

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 NHPS, Appendix VII, page 1 (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 accomodations) 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 30-90-269. Reserved.

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Subpart XVII
Value-Based Purchasing Program

A. Nursing Facility Value-Based Purchasing Program

1. The nursing facility (NF) Value-Based Purchasing (VBP) program seeks to improve the quality and outcomes of care furnished to Medicaid members by enhancing performance accountability in specific areas including staffing and avoidance of negative care events.
2. Complete details including technical information regarding program eligibility, performance measures, performance thresholds and payments are available on the Agency's website at the following address: https://www.dmas.virginia.gov/about-us/value-based-purchasing/and are effective beginning July 1, 2022.

B. Payment Structure to Nursing Facilities

1. Virginia Medicaid will distribute performance-based funding based on NF attainment of performance thresholds and improvement on specific performance measures (PM). Per diem values will be established for the performance attainment thresholds of each PM. The size of PM payments will be contingent on NF performance in meeting thresholds and improvements between program years across the measures.
2. Eligible NFs will receive lump sum payments in February and May for PM payments.
3. Funding for the NF VBP program will be distributed to eligible FFS NFs based on Virginia Medicaid's established program methodology available on the Agency's website at the following address: https://www.dmas.virginia.gov/about-us/value-based-purchasing/. No payments will be made that exceed the total available funding for the program

C. Performance Measure Assessment

1. Virginia Medicaid will evaluate performance measures over a twelve (12) month period beginning October 1 of each year and ending September 30 of the next year for each program year.
2. The program methodology will be updated for each program year and will outline the evaluated performance measures, performance and improvement thresholds, per diem values for each threshold and additional information. The methodology can be found on the Agency's website at the following address: https://www.dmas.virginia.gov/about-us/value-based-purchasing/.
3. Virginia Medicaid will select PMs that are standard reporting for Virginia's NFs through the Centers for Medicare & Medicaid Services' (CMS') Minimum Data Set (MDS), Nursing Home (NH) Compare claims-based quality measures and Payroll Based Journal (PBJ) NF staffing measures and data.