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

A. Effective on and after July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group-III (RUG-III) System as defined in Appendix IV (12 VAC 30-90-305 through 307)." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 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.

2. Direct and indirect group ceilings and rates.

a. In accordance with 12VAC30-90-20 C, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in 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) (formerly HCFA) 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 NFs peer group direct patient care ceiling and the NFs normalized facility average Medicaid CMI. A NFs direct patient care operating cost prospective ceiling will be calculated semiannually.

b. A CMI rate adjustment for each semiannual period of a nursing facility's prospective fiscal year shall be applied by multiplying the nursing

facility's normalized facility average Medicaid CMI applicable to each prospective semiannual period by the nursing facility's case-mix neutralized direct patient care operating cost base rate for the preceding cost reporting period (see 12 VAC 30-90-307).

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

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

a. The direct patient care operating ceiling shall be set at 112% 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 ~~106.9%~~ 103.9 per cent 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.

B. Adjustment of ceilings and costs for inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, published by Standard & Poor's DRI. For State

Fiscal Year 2003 peer group ceilings and rates for indirect costs will not be adjusted for inflation.

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

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

3. Ceilings shall be adjusted from the common point established in the most recent 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 average(s) for each applicable second quarter, taken from the DRI table published for the fourth quarter of the year immediately preceding the calendar year in which the prospective rate years begin. Rebased ceilings shall be effective on July 1 of each 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

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.

E. The prospective rate for each NF shall be based upon operating cost and plant/capital cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of 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.

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.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

11/09/2002
Date

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

12 VAC 30-90-257. Credit Balance Reporting.

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

"Claim" means a bill submitted by a provider, consistent with 12VAC 30-20-180, to the Department 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.

"Interest at the maximum rate" means the interest rate specified in the Code of Virginia, § 32.1-312 or §32.1-313, depending on the facts of the excess payment."

"Negative balance transaction" means the reduction of a payment or payments otherwise due to a provider by amounts or portions of amounts owed the Department from previous overpayments to the provider.

"Overpayment" means payments to a provider in excess of the amount that was or is due to the provider.

"Weekly remittance" means periodic (usually weekly) payment to a provider of amounts due to the provider for claims previously submitted by the provider.

A. NFs shall be required to report Medicaid credit balances on a quarterly basis no later than 30 calendar days after the close of each quarter. For a credit balance arising on a Medicaid claim within three years of the date paid by the Department, the NF shall submit an adjustment claim. If the NF does not want the claim retracted from future DMAS payments, a check in the amount of the credit balance or the adjustment claim or claims shall be submitted with the report. For credit balances arising on claims over three years old, the NF shall submit a check for the balance due and a copy of the original DMAS payment. Interest at the maximum rate allowed shall be assessed for those credit balances (overpayments) which are identified on the quarterly report but not reimbursed with the submission of the quarterly report. Interest will begin to accrue 30 days after the end of the quarter and will continue to accrue until the overpayment has been refunded or adjusted.

B. A penalty shall be imposed for failure to submit the quarterly credit balance report timely as follows:

1. NFs which have not submitted their Medicaid credit balance data within the required 30 days after the end of a quarter shall be notified in writing by the Department. If the required report is not submitted within the next 30 days, there will be a 20 percent reduction in the Medicaid per diem payment.

2. If the required report is not submitted within the next 30 days (60 days after the due date), the per diem payments shall be reduced to zero until the report is received.

3. If the credit balance has not been refunded within 90 days of the end of a quarter, it shall be recovered, with interest, from the due date through the use of a negative balance transaction on the weekly remittance.

4. A periodic audit shall be conducted of the NFs' quarterly submission of Medicaid credit balance data. NFs shall maintain an audit trail back to the underlying accounts receivable records supporting each quarterly report.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

_11/09/2002_____ _/s/ Patrick W. Finnerty_____
Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services