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MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **ELIZABETH M. GUGGENHEIM** EMG
Assistant Attorney General

DATE: **July 5, 2016**

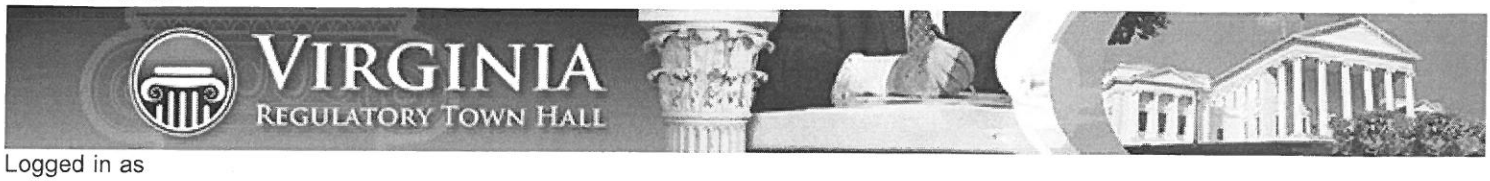
SUBJECT: **Fast Track Regulations regarding Institutional Provider Reimbursement Changes**

I have reviewed the attached fast track regulations, which would eliminate inflation for nursing facilities and implement the "hold harmless provision" for those that meet the bed capacity and occupancy requirements, reimbursing with the price-based operating rate rather that the transition operating rate for those facilities. Based on that review, it is my view that the Director, acting on behalf of the Board pursuant to Virginia Code § 32.1-324 and with the authority provided for by Item 301.IIII of Chapter 665 of the *2015 Acts of the Assembly,* Item 301.KKK(6) of the *2015 Acts of the Assembly* and Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Please be aware that this review is based solely upon whether DMAS has the legal authority to promulgate these regulations, not the appropriateness of whether it should be promulgated pursuant to the fast track process. Pursuant to Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either House of the General Assembly or of the Joint Commission on Administrative Rules, the Department of Medical Assistance Services shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the fast-track regulations serving as the Notice of Intended Regulatory Action.

If you have any questions or need any additional information, please feel free to call me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General



Proposed Text

Action: Institutional Provider Reimbursement Changes
Stage: Fast-Track 4/21/16 9:43 AM

12VAC30-90-44. Nursing facility price-based reimbursement methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates in 12VAC30-90-41 to a price-based methodology. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

1. 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.

2. The initial base year for calculating the cost per day shall be cost reports ending in calendar year 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent, reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1. No adjustments will be made to the base year data for purposes of rate setting after that date.

3. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost per day by the raw Medicaid facility case-mix that corresponds to the base year by facility.

4. 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. Effective July 1, 2015, through June 30, 2016, the inflation adjustment for nursing facility operating rates shall be zero (0) percent.

5. 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.

6. 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. Direct peer groups are:

a. Northern Virginia,

b. Other MSAs,

c. Northern Rural, and

d. Southern Rural.

7. The following definitions shall apply to indirect peer groups. The indirect peer group for Northern Virginia is the same as the direct peer group for Northern Virginia. Rest of State peer groups shall be defined as any localities other than localities in the Northern Virginia peer group for nursing facilities with greater than 60 beds or 60 beds or less. Rest of State - Greater than 60 Beds shall be further subdivided into Other MSA, Northern Rural and Southern Rural peer groups using the locality definitions for direct peer groups. Indirect 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.

Rest of State - 60 Beds or Less.

8. Any changes to peer group assignment based on changes in bed size or MSA will be implemented for reimbursement purposes the July 1 following the effective date of the change.

9. 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.

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

10. 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.

11. 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.

12. 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 12VAC30-90-306 in determining the direct costs used 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.

B. Transition. The department shall transition to the price-based methodology over a period of four years, blending the adjusted price-based rate with the facility-specific case-mix neutral cost-based rate calculated according to 12VAC30-90-41 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 12VAC30-90-41 and adjusted to state fiscal year 2015. In subsequent years of the transition, the cost-based rates shall be increased by inflation described in this section.

1. Based on a four-year transition, the rate will be based on the following blend:

a. Fiscal year 2015 - 25% of the adjusted price-based rate and 75% of the cost-based rate.

b. Fiscal year 2016 - 50% of the adjusted price-based rate and 50% of the cost-based rate.

c. Fiscal year 2017 - 75% of the adjusted price-based rate and 25% of the cost-based rate.

d. Fiscal year 2018 - 100% of the adjusted price-based (fully implemented).

2. During the first transition year for the period July 1, 2014, through October 31, 2014, DMAS shall case-mix adjust each facility's direct cost component of the rates using the average facility case-mix from the two most recent finalized quarters (September and December 2013) instead of adjusting this component claim by claim.

3. Cost-based rates to be used in the transition for facilities without cost data in the base year but placed in service prior to July 1, 2013, shall be determined based on the most recently settled cost data. If there is no settled cost report at the beginning of a fiscal year, then 100% 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.

4. 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.

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 12VAC30-90-36. There will be no separate calculation for beds subject to or not subject to transition.

2. Nursing facilities that put into service a major renovation or new beds may request a mid-year fair rental value per diem rate change.

a. A major renovation shall be defined as an increase in capital of $3,000 per bed. The nursing facility shall submit complete pro forma documentation at least 60 days prior to the effective date, and the new rate shall be effective at the beginning

of the month following the end of the 60 days.

b. The provider shall submit final documentation within 60 days of the new rate effective date, and the department shall review final documentation and modify the rate if necessary effective 90 days after the implementation of the new rate. No mid-year rate changes shall be made for an effective date after April 30 of the fiscal year.

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

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