

**4.19 Payments for Medical and Remedial Care and Services**

**Methods and Standards for Determining Payment Rates for non-State-Owned Nursing Facilities - Excludes State-Owned Facilities**

I. Cost Finding and Reporting

All nursing facilities certified to participate in the program are required to maintain cost data and submit cost reports according to the methods and procedures prescribed by the State agency.

A. Chart of Accounts

The Department adopted the Chart of Accounts for Long Term Care Facilities published by the American Nursing Home Association as the basic document for the LTC system July 1, 1975. The basic chart of accounts is updated and modified periodically and has been converted to a mandated computerized format. This standard computerized cost reporting mechanism must be used by all participating facilities to maintain facility cost data for cost reporting and auditing purposes.

B. Financial and Statistical Report

Facility costs for nursing facilities must be reported on the computerized format of the Financial and Statistical Report for Nursing Homes. These reports must be completed in accordance with generally accepted accounting principles using the accrual method of accounting and must be complete and accurate. Facilities are also required to submit a trial balance of the reporting entity as of the closing date of the reporting period. Incomplete reports or reports containing inconsistent data will be returned to the facility for correction.

C. Cost Reporting Periods

All participating facility costs are reported semi-annually. The six-month reporting periods are January 1<sup>st</sup> through June 30<sup>th</sup>, and July 1<sup>st</sup> through December 31<sup>st</sup>.

D. Filing Periods

Cost reports must be filed with the State agency and postmarked within sixty (60) days following the end of the reporting period. The due dates are March 1<sup>st</sup> for the December 31<sup>st</sup> closing date and August 29<sup>th</sup> for the June 30<sup>th</sup> closing date.

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An extension of time for filing cost reports may be granted by the State agency for extenuating circumstances where requested and justified by the facility in writing by the close of business on the due date. Requests for an extension of the filing period are to be addressed in writing to the Director, Financial Analysis and Rate Setting, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3706.

E. Penalty - Delinquent Reporting

Failure to submit cost reports within the mandated (sixty [60] days) filing period, where no extension has been granted to the facility or within the time constraints of an extension, will result in a ten percent (10%) reduction in reimbursement to that facility. The penalty will be assessed on payments for services delivered on the day(s) the report is late.

Incomplete cost reports returned to the facility for correction which are not promptly completed and resubmitted within specified time constraints, may be subject to the following penalty provision: Facilities submitting cost reports after the beginning of the rate period; i.e., April 1<sup>st</sup> or October 1<sup>st</sup>, will receive rate adjustment effective the month following the month the cost report was received.

F. Correction of Errors

Errors in cost report data identified by the facility may be corrected if resubmitted with thirty (30) days after original rate notification. Only those corrections received by the Department within the thirty (30) day period will be considered for rate revision. The Department will make rate revisions resultant from computational errors in the rate determination process.

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## ATTACHMENT 4.19-D-1

Methods and Standards for Determining Payment Rates for Non-State-Owned Nursing Facilities - (Excludes State-Owned Facilities)G. New Facilities - Projected Rates

A projected rate will be established for new facilities with no previous operating experience. A change of location with the same ownership does not constitute a new facility. Each such facility on a projected rate must submit the calendar semi-annual cost reports during the projected rate period beginning with the first full six months operating experience in a reporting period.

H. Change of Ownership - Projected Rates

A projected rate may be established where there has been a change of ownership and control of the operating entity and the new owners have no previous management experience in the facility.

Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by the State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control. Where the immediate former administrator and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting projected rates.

Each such facility on a projected rate must submit the required semi-annual cost reports during the projected rate period beginning with the first 3 months operating experience in a reporting period.

I. Maintenance of Records

Financial and statistical records must be maintained by the facility to support and verify the information submitted on cost reports. Such records must be maintained for a minimum of five (5) years from the date of the report, and will be furnished upon request to the Department or Federal officials.

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The State agency will maintain cost reports for a minimum of seven (7) years from date of receipt.

II. Allowable Costs

Reimbursement for nursing facility services is limited to those costs required to deliver care to patients. These are facility operating costs, patient direct service costs, and costs for the physical setting.

Allowable Costs for Cost Centers

Cost center areas are standard services, mandated services, nursing services, and capital. A cost upper limit is developed for each cost center area and becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

1. Standard Services

Standard services are Dietary, Laundry/Housekeeping, Medical Records, and Administration. Cost standards for these services are computed from the current cost report; i.e., salaries, supplies and services as submitted by the facilities. Total allowable costs for all patients are arrayed assuming 100% occupancy; i.e., licensed beds times days, to establish a per patient day cost. The costs are then arrayed by bed range; i.e., 0-90 and 91 plus. Extremes are eliminated by including only those values falling within plus or minus one standard deviation. This establishes a cost average point (CAP), i.e., average cost per bed range. The CAP is then adjusted by a 90% occupancy level to establish the cost standard for each standard service department. These standard service departments' cost standards are then summed to obtain a cost ceiling that establishes the maximum allowable cost by bed range for the standard services.

2. Mandated Services

Mandated services are defined as Maintenance, Utilities, Taxes and Insurance, and Activities. Reported allowable cost for these services is fully recognized to the extent that it does not exceed the percentile of allowable reported costs

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by facility classification as determined from the current cost report.

**3. Nursing Services**

Allowable costs and reimbursement for nursing services will be determined by the kind and amount of services needed by and being delivered to the residents, the staffing required to deliver the care and the restorative and rehabilitative programs offered by the facility. Such determination will be based on the application of a minimum staffing pattern and adjustments to reflect needs determined by case mix characteristics.

Monthly billing forms for services rendered to nursing home residents will include data directly derived from the computerized MDS for each resident, which will be used to determine composite case mix scores for each resident and for the facility. These case mix scores will measure the relative intensity of service needs of the facility residents and will comprise the basis for determining allowable adjustments to per diem staffing and costs required to deliver the kind and amount of services needed.

**4. Cost of Capital**

Reimbursement for cost of capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). The value includes the necessary real property and equipment associated with the actual use of the property as a long term care facility. The Standard Appraised Value (SAV) uses the cost approach to value modified by the Model Nursing Home Standard, where appropriate. This valuation is the basis for capitalization to determine a per patient day cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest, and return on equity in the traditional approach to capital cost allowance.

**a. Cost Approach to Value**

The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting them from the estimated accrued depreciation, and adding the market value of the land (actually used or required for use as if vacant and available for

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development of such use). Established sources of cost information are used to supply costs to reproduce the structure. Construction indexes used are Marshall Valuation Services and Boeckle Building Valuation Manual.

b. Accrued Depreciation

Accrued depreciation in a cost approach is the difference between the value of a building or other improvement at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the "breakdown" method which involves an analysis of loss in value from the following sources:

- (1) Physical deterioration; curable and incurable.
- (2) Functional obsolescence; curable and incurable.
- (3) Economic obsolescence.

The modified appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plant valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciation, curable and incurable, as well as functional obsolescence, curable and incurable. The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

c. Model Facility Standard

The Model Facility Standard is a composite of current regulations and criteria derived from several sources which include "Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities"--HHS Publication No. (HRS) 81-14500, and West Virginia Rules and Regulations, where appropriate. These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes which foster improved patient

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care or cost effective measures which do not compromise patient care.

d. Appraisal Technique

A complete appraisal of each new facility may be performed as required by the Department after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the Department. Updates of the initial appraisal may be performed annually prior to the October rate setting period. Updates may be performed at any time during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate purposes. Prior to rate setting, the updated appraisals will be indexed to June 30, as a common point valuation, based on the Consumer Price Index.

A copy of the facility appraisal report is furnished to the facility for its records.

5. Compensation

Compensation to be allowed must be reasonable for services' that are necessary, related to patient care and pertinent to the operation of the facility. The services must actually be performed and paid in full less any withholding required by law. The hours worked and compensation must be documented and reported to all appropriate State and Federal authorities for income tax, Social Security, and unemployment compensation purposes.

Reasonable means that the compensation must be comparable for the same services provided by facilities in the bed ranges. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 2,080 hours per year worked in patient-related duties.

Compensation must include the total benefit paid for the services rendered; i.e., fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to or for the benefit of those providing the services.

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6. Administrators

Compensation for administrators who do not work full time will be proportionate to the total number of hours worked. This includes persons who hold administrative positions in more than one facility, as well as those who hold various other positions in the same or alternate facility.

7. Owners

Administrators/owners will be compensated for administrative duties performed. Where the costs of administrative services are allowed, additional services performed by the administrator and/or owner are considered rendered primarily to protect their investment and are not allowable.

Compensation will not be allowed for owners, operators, or their relatives who claim to provide some administrative functions required to operate the facility where the facility has a full-time administrator and/or assistant administrator or where other full-time or part-time staff positions are filled. Owner includes any individual or organization with an equity interest in the facility operation and any member of such individual's family including spouse's family. Owner also includes all partners and all stockholders in the facility operation and partners and stockholders of organizations which have an equity interest in the facility.

8. Nonallowable Costs

Bad debt, charity, and courtesy allowances are not included as allowable costs. Other items of expense may be specified in the State agency regulations as nonallowable costs.

9. Purchase from Related Companies or Organizations

All related companies or organizations involved in any business transactions with the facility must be identified on the cost report. Detailed data must be available in the facility records which describe the nature and extent of such business transactions.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Cost for purchases of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable services purchased elsewhere, whichever is less.

**III. Rate Determination**

Individual facility rates are established on a prospective basis, based on licensed beds, considering cost to be expected and allowable during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors or omissions of data, reconciliation of audit findings related to falsification or misreporting costs, or incorrect reporting of census or costs. The basic vehicle for arriving at each facility's rate is the uniform Financial and Statistical Report.

The reported costs are subject to desk audit and then converted to rates per patient day. Rates will be in effect for six-month (6) periods beginning April 1 and October 1 based on each facility's reported costs and adjustments for the applicable reporting period.

Effective October 1, 2015, the Bureau will reduce the October 2015 rates by \$2.75 per patient day as a cost savings measure. The \$2.75 per patient day rate reduction will be in effect for the period October 1, 2015 thru June 30, 2016. The facility appraisal process was waived for the October 2015 rate setting methodology. The April 2016 rates will become effective July 1, 2016. All other long term care nursing facility regulations, policies and procedures will remain in effect throughout the freeze period unless otherwise modified through general updating practices.

**A. Cost Adjustment**

Reported facility costs are subject to review and analysis through desk audit. Adjustments are made to exclude non-allowable costs and by application of the agency's established cost standards using the following methodologies:

**1. Standard Services**

Reported allowable costs in the standard services area are compared against the cost ceiling for standard services using the appropriate bed range for the facility or facility class. If the allowable reported cost exceeds the cost ceiling then the facility rate is limited to the ceiling.

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Mandated services are defined as Maintenance, Utilities, Taxes and Insurance, and Activities. Reported allowable cost for these services is fully recognized to the extent that it does not exceed the 90<sup>th</sup> percentile of allowable reported costs by facility classification as determined from the current cost report.

3. Cost of Capital

Capital costs will be determined on a facility-by-facility basis applying the Standard Appraised Value (SAV) methodology.

a. Capitalization Rate

A capitalization rate is established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, and an allowance for return on equity investment in the land, building and equipment.

The Band of Investment approach is used to blend the allowable cost of mortgage money (fixed income capital) and the allowable cost of equity money (venture or equity capital) which produces a rate which may be changed semi-annually to reflect current money values in the mortgage market. This band of investment sets a 75:25 debt-service to equity ratio.

The yield on equity allowance is based on the average Medicare Trust Fund return on equity allowable during the cost reporting period.

The interest rate for the mortgage component will be based upon an average of the Prime Rate of interest as published by the Federal Reserve Board. A ten (10) year running average of the Prime Rates will be calculated by the Bureau, with an additional three (3) percentage point added to the calculated interest rate average in order to establish, as needed, the allowable interest rate to be used for rate setting purposes. A floor and ceiling with a maximum of twelve (12) percent and a minimum of ten (10) percent, respectively, will be used in the interest rate calculation.

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b. Capital Allowance

All facilities per patient day capital allowance shall be determined by applying the capitalization rate for the mortgage and equity component to the valuation of the facility determined by the Standard Appraised Value methodology. As facility valuations under SAV methodology are updated annually over a period of several months, all derived facility valuations will be standardized to June 30 of each year using the Consumer Price Index.

The proposed change in capital cost will be phased in over four (4) rate setting periods as follows:

- October 1, 2006, 25%
- April 1, 2007, 50%
- October 1, 2007, 75%
- April 1, 2008, 100%

4. Nursing Service and Restorative Services

Nursing and related service costs, including restorative services, will be determined on a facility-by-facility basis by applying the allowable cost formula and case mix adjustments. Nursing service reimbursement will consist of an adjusted base component and allowable case mix add-on.

The base nursing services component will reflect minimum staffing patterns for nursing personnel, plus a factor to account for restorative services, and amounts reflecting Director of Nursing costs and the costs of supplies and services. Basic nursing staffing is established at a case mix score of 2.5, which reflects nursing and restorative staffing hours per patient day as follows:

<u># of Beds</u>	<u>Position</u>	<u>Nursing</u>	<u>Restorative</u>	<u>Total</u>
1-90	R.N.	.20	.00	.20
	L.P.N.	.50	.35	.85
	Aides	<u>1.80</u>	<u>.05</u>	<u>1.85</u>
<b>TOTAL</b>		<b>2.50</b>	<b>.40</b>	<b>2.90</b>
<hr/>				
91+	R.N.	.20	.00	.20
	L.P.N.	.50	.30	.80
	Aides	<u>1.80</u>	<u>.05</u>	<u>1.85</u>
<b>TOTAL</b>		<b>2.50</b>	<b>.35</b>	<b>2.85</b>

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Multiplying these PPD staffing patterns by the 70<sup>th</sup> percentile value of hourly wages, based on total compensation for the peer group yields the nursing services CAP, or ceiling, for each facility in the peer group.

A factor is added for supplies equal to the PPD supply costs at the 70<sup>th</sup> percentile for the bed groups determined from the submitted cost reports. An additional factor is added for the Director of Nursing (DON) by dividing the DON salary at the 70<sup>th</sup> percentile from the bed range, as derived from the submitted cost reports, by each facility's beds at 100% occupancy. Adding these factors together yields the base constant through the six-month reimbursement period.

The peer group CAP is then adjusted to a facility specific CAP based on that facility's average MDS score from the six month reporting period. The average MDS is divided by 2.5 and then multiplied by the base constant to arrive at an adjusted nursing CAP for each facility. The adjusted nursing CAP cannot exceed 112% (MDS average of 2.8), or be less than 80% (MDS average of 2.0), of the base constant.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the reimbursement period when the case mix score derived from the MDS, as determined at the time of monthly billing, indicates a higher level of need and care delivered to a resident in a given facility. A base case mix score of 2.9 is established as a threshold. For residents with a monthly case mix score of 2.9 or less, there is no add-on factor. If the monthly case mix score exceeds 2.9, then an add-on factor is determined by dividing the excess of the case mix score over 2.9 by the threshold factor of 2.25. The resulting factor is then multiplied by the Nursing Rate to derive a PPD nursing services add-on.

**5. Minimum Occupancy Standard**

Cost adjustments will be made by applying a minimum occupancy standard of 90% of all cost centers. Actual facility occupancy is used to determine allowable cost per patient day if equal to or greater than 90%. When the actual occupancy level is less than 90%, the actual allowable per patient day cost will be adjusted to assume a 90% occupancy level.

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B. Efficiency Incentive

An efficiency incentive will be allowed where the standard services area allowable costs are less than the total of the cost ceilings. Fifty percent (50%) of the difference between the allowable costs and the cost ceiling will be applied to the prospective rate for the standard services area. The total of the calculated efficiency incentive may not exceed \$2.00 per patient day.

Quality Assurance

A facility qualifying for efficiency incentive shall not have any deficiencies related to standard services or substandard care, quality of life, and/or quality of care as defined by the surveying agency during the reporting period. Survey and licensure agency reports are reviewed to determine compliance with licensure, certification and agency standards. If it has been determined that a facility has significant deficiencies, the facility will be denied efficiency incentive for that period.

C. Inflation Factor

After combining the various components, a factor is assigned to costs as a projection of inflation during the next rate-setting cycle. In setting an inflation factor, changes in industry wage rates and supply costs compared with CPI are observed and the lesser amount of change is expressed as a percentage and applied to the allowable reimbursable costs for the six-month rate setting period. The amount of change experienced during the six-month reporting period or the CPI becomes the inflation factor applied to the next six-month rate setting period. The inflation factor, once set for a given rate period, is not adjusted as it represents a reasonable expectation for cost increases.

Indicators used for tracking economic changes and trends include:

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- I. Semi-Annual Cost Reporting - The average per patient day cost of service is compared to the cost incurred in providing the same services in the prior cost reporting period. The percentage of change is then expressed as an increase or decrease in the cost from the prior period.
- II. Regulatory Costs - Regulatory costs, such as minimum wage increase, FICA increase, and Worker's Compensation changes may be considered as a component of the inflation factor.
- III. National Data - The Consumer Price Index (CPI) for the most current cost reporting period is analyzed and compared with state experience.

D. Change in Bed Size

A cost adjustment may be made during a rate period where there has been a change in the facility bed size if it affects the appraisal value of the facility. In this instance, an appraisal of the facility will be completed after the change in bed size has been certified. Any revision of the per diem rate as a result of the change in bed size will become effective with the month the facility changes were certified by the state survey agency.

E. Projected Rates

Projected rates will be established for new facilities with no previous operating experience for a period of eighteen (18) months. The facility may choose to go off the projected rate at any time after a full six (6) months of operating experience in a cost reporting period. Projected rates may be established for a maximum period of eighteen (18) months where there has been a change of ownership and control of the operating entity, and the new owners have no management experience in the facility. Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control.

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Where the immediate former administrator and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting a projected rate.

At the end of the projected rate period, actual cost experience of the facility will be reconciled with the projected cost reimbursement and tested for reasonableness against the standards established for the bed range for the appropriate rate periods.

For facilities constructed after April 1, 1981 and financed by public bonded indebtedness, the actual cost experience of the facility will be based on the actual occupancy experience of the facility during the projected rate period, rather than the minimum occupancy standard. However, these actual costs will be compared with the same standards, as detailed above, and therefore subject to the same test of reasonableness.

Resulting overpayments from overprojection will be recovered by the State agency in accordance with provisions of Chapter 700, Long Term Care Regulations.

Rates based on projected costs do not include management incentives or occupancy allowance.

1. New Facilities

A projected rate for new facilities with no previous operating experience will be established as follows:

- a. Standard Services - The cost standard established for the appropriate bed range peer group.
- b. Mandated Services - The established CAP for the appropriate bed range peer group.
- c. Nursing Services - The average of the costs established for the appropriate bed range peer group.

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- d. Cost of Capital - The Standard Appraised Value (SAV) methodology applied to the facility. The facility will be appraised following certification for participation in the program.

2. Change of Ownership

A projected rate established for facilities where there has been a recognized change of ownership and control will be established as follows:

- a. Standard Services - The cost standard established for the appropriate bed range peer group.
- b. Mandated Services - The CAP of the costs established for the appropriate bed range peer group.
- c. Nursing Services - The average of the cost established for the appropriate bed range peer group.
- d. Cost of Capital - The Standard Appraised Value (SAV) established for the facility.

IV. Administrative Review

Procedures to be followed for administrative review and evidentiary hearings related to the per diem rate established for facility reimbursement are found in Chapter 700, Long Term Care Regulations.

V. Audits

Department audit staff will perform a desk audit of cost statements prior to rate setting, and will conduct on-site audits of facility records periodically.



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A. Desk Audit

Financial and statistical reports submitted by the participating facilities will be subjected to desk review and analysis for rate setting within sixty (60) days of receipt. Incomplete and inaccurate cost reports are not accepted.

B. Field Audit

Periodic on-site audits of the financial and statistical record of each participating facility will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report, and all data to support payroll and census reports. These records must be maintained at the facility or be made available at the facility for review by Department staff for audit purposes upon notice. Records found to be incomplete or missing at the time of the scheduled on-site review, must be delivered to the Department within forty-eight (48) hours or an amount of time agreed upon by audit staff at the exit conference. Costs found to be unsubstantiated will be disallowed and considered as an overpayment.

C. Record Retention

Audit reports will be maintained by the agency for five (5) years following date of completion.

D. Credits and Adjustments

The State will account for and return the Federal Portion of all overpayments to CMS in accordance with the applicable Federal laws and regulations.

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VI. Bed Reservation Policy

Reimbursement will be made to reserve a bed during a resident's temporary absence from the facility at the established per diem rate provided the facility is fully (95% or greater) occupied and has a waiting list for admissions. A day of absence is defined as a twenty-four (24) hour period.

Medical Leave of Absence

A bed may be reserved for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, and whose stay is more than twenty-four (24) hours.

The maximum number of days of medical leave for a resident is twelve (12) days in a calendar year.

Therapeutic Leave of Absence

A bed may be reserved for a therapeutic leave which is included in the resident's plan of care.

The maximum number of days of therapeutic leave for a resident is six (6) days in a calendar year.

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The prospective payment rates established for these four rate periods will include projected wage increases for certified nurse aides.

- 2. Other OBRA Costs - 1919(b)(1)(2)(3)(4)(6)(7); 1919(c)(1)(2)(3)(4)(5)(6)(7)(8) and 1919(d)

Based on the attached Supplement 1, a per patient day additional payment of \$0.82 will be made to the rates established for the periods 10-1-92 and 9-30-93, which is broken down as follows:

Quality Assurance Committee	.13
Updating Plan of Care	.18
Annual Resident Assessment	.25
Quarterly Resident Assessment	.15
Admission and Discharge	.07
Management of Resident Funds	.04

C. Final Implementation

Effective with nursing facility rates established for the rate period October 1, 1993, all costs necessary to meet Federal and State requirements for nursing facility services, excluding costs for NATCEP, will have been reported by the facilities on the semi-annual cost reports, therefore, the previous OBRA add-on is no longer necessary. Prospective rates will be established according to the methodology in the approved plan, ATTACHMENT 4.19-D-1, and will recognize all costs associated with the requirements in Section 1902 of the Act.

All allowable costs incurred by nursing facilities in providing care and services to Medicaid residents, whether or not they are resultant from the additional requirements of the Act, are subject to the test for reasonableness as required under the Boren amendment.

D. OBRA '90 Amendment

Section 4801(e)(1)(A) of OBRA '90 amended section 1920(a)(13)(A) of the Act to require that States account for the cost of providing services required

97-03 April 1, 1997

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TN No. 96-15 Approval Date JUL 01 1997 Effective Date APR 01 1996

Supersedes TN No. 93-01 96-15

4.19 Payments for Medical and Remedial Care and Services

ATTACHMENT 4.19-D-1

Methods and Standards for Determining Payment Rates for Non-State-Owned Nursing Facilities - (Excludes State-Owned Facilities)

to attain or maintain the highest practical physical, mental, and psycho-social well-being of each resident eligible for benefits under title XIX. The State of West Virginia will not incur any additional costs related to the aforementioned sections of OBRA '90 since service required to attain or maintain the highest practical mental, physical and psycho-social well-being have been accounted for in our nursing assessment methodology originally implemented in 1981. Also, the State of West Virginia licensure requirements for nursing facilities provide that nursing facilities must include services that are required to attain or maintain the highest practical physical, mental, and psycho-social well-being for each resident. The licensure inspection of each facility documents that these requirements are met.

VII. Bed Reservation Policy

Reimbursement will be made to reserve a bed during a resident's temporary absence from the facility at the established per diem rate provided the facility is fully occupied and has a waiting list for admissions. A day of absence is defined as a twenty-four hour period.

Medical Leave of Absence

A bed may be reserved for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, and whose stay is more than twenty-four hours.

The maximum medical leave for a resident is twelve days in a calendar year.

Non-medical Leave of Absence

A bed may be reserved for a therapeutic leave which is included in the resident's plan of care.

The maximum non-medical leave for a resident is six days in a calendar year.

**SUMMARY OF  
UPPER LIMITS CALCULATIONS  
APRIL 1, 1995 - SEPTEMBER 30, 1996**

**MEDICARE UPPER LIMITS:**

<b>BED GROUP</b>	<b>MEDICAID PATIENT DAYS</b>	<b>ALLOWABLE MEDICARE REIMB.</b>
0-90	492,192	\$45,193,322
91+	907,181	\$84,522,962
Subtotal:	1,399,373	\$129,716,284
Times: Market Basket Index (5.2%)		\$6,745,247
<b>TOTAL MEDICARE UPPER LIMIT</b>		<b><u>\$136,461,530</u></b>

**MEDICAID REIMBURSEMENT SYSTEM:**

<b>BED GROUP</b>	<b>MEDICAID PATIENT DAYS</b>	<b>ALLOWABLE MEDICAID REIMB.</b>
0-90	492,192	\$43,060,205
91+	907,181	\$81,770,590
	1,399,373	\$124,830,795
<b>TOTAL MEDICAID REIMBURSEMENT</b>		<b><u>\$124,830,795</u></b>

RELATED INFORMATION - AVERAGE PER DIEM RATE

<u>PERIOD</u>	<u>AVERAGE RATE</u>	<u>% CHANGE</u>
10/1/90 - 3/31/91	\$67.73	
4/1/91 - 9/30/91	\$67.80	<b>0.1032%</b>
10/1/91 - 3/31/92	\$68.38	<b>0.8482%</b>
4/1/92 - 9/30/92	\$69.07	<b>0.9990%</b>
10/1/92 - 3/31/93	\$72.03	<b>4.1094%</b>
4/1/93 - 9/30/93	\$78.95	<b>8.7650%</b>
10/1/93 - 3/31/94	\$75.51	<b>-4.5557%</b>
4/1/94 - 9/30/94	\$79.03	<b>4.4540%</b>
10/1/94 - 3/31/95	\$82.17	<b>3.8213%</b>
4/1/95 - 9/30/95	\$84.00	<b>2.1786%</b>
10/1/95 - 3/31/96	\$88.10	<b>4.6538%</b>
4/1/96-9/30/96	\$90.12	<b>2.2415%</b>