COMMONWEALTH of VIRGINIA
Office of the Governor

Janet Vestal Kelly
Secretary of Health and Human Resources

December 11, 2025

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Dear Mr. McMillion:

Attached for your review and approval is amendment 25-019, entitled "Nursing Facility Reimbursement Methodology" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve this change as quickly as possible.

Sincerely,

Janet V. Kelly

Janet V. Kelly

Attachment

cc: Cheryl J. Roberts, Director, Department of Medical Assistance Services
CMS, Region III

Transmittal Summary

SPA 25-019

I. IDENTIFICATION INFORMATION

Title of Amendment: Nursing Facility Reimbursement Methodology

II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

Purpose: In accordance with the 2025 Appropriations Act, Item 288.IIIII, this SPA modifies the nursing facility reimbursement methodology to the Patient-Driven Payment Model (PDPM) instead of Resource Utilization Groups (RUG). This change shall be implemented in a budget neutral manner and will be effective October 1, 2025.

RUGs was developed and used by CMS to classify nursing facility residents into payment groups based on their resource utilization. CMS will no longer support RUGs after October 1, 2025. The shift to PDPM aims to modernize payment systems and align reimbursement more closely with resident care needs.

Substance and Analysis: The sections of the State Plan that are affected by this amendment is "Methods and Standards for Establishing Payment Rates for Long-Term Care, Nursing Home Payment System, and Methods and Standards for Establishing Payment Rates for Specialized Care"

Impact: None.

Tribal Notice: Please see attached.

Prior Public Notice: See Attached.

Public Comments and Agency Analysis: Please see attached.

Outlook

Tribal Notice –Nursing Facility Reimbursement Methodology

From Lee, Meredith (DMAS) <Meredith.Lee@dmas.virginia.gov>

Date Thu 11/20/2025 7:12 AM

To TribalOffice@MonacanNation.com <tribaloffice@monacannation.com>; Ann Richardson <chiefannerich@aol.com>; pamelathompson4@yahoo.com <pamelathompson4@yahoo.com>; rappahannocktrib@aol.com <rappahannocktrib@aol.com>; regstew007@gmail.com <regstew007@gmail.com>; Richard.matens@pamunkey.org <richard.matens@pamunkey.org>; Chief Diane Shields <chief@monacannation.gov>; chiefstephenadkins@gmail.com <chiefstephenadkins@gmail.com>; bradbybrown@gmail.com <bradbybrown@gmail.com>; tabitha.garrett@ihs.gov <tabitha.garrett@ihs.gov>; kara.kearns@ihs.gov <kara.kearns@ihs.gov>; administrator@nansemond.gov <administrator@nansemond.gov>; Information <info@afwellness.com>; info@fishingpointhc.com <info@fishingpointhc.com>; contact@Nansemond.gov <contact@nansemond.gov>; brandon.custalow@mattaponination.com <brandon.custalow@mattaponination.com>; admin@umitribe.org <admin@umitribe.org>; Reels-Pearson, Lorraine (IHS/NAS/AO) <lorraine.reels-pearson@ihs.gov>; Holmes, Remedios (IHS/NAS/RIC) <remedios.holmes@ihs.gov>; Lindsey.Taylor@ihs.gov <lindsey.taylor@ihs.gov>

1 attachment (215 KB)

Tribal Notice Letter, signed.pdf;

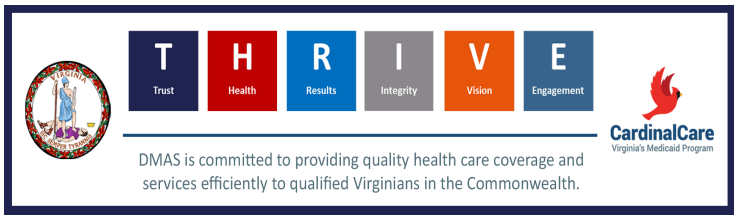
Dear Tribal Leaders and Indian Health Programs:

Attached is a Tribal Notice letter from Virginia Medicaid Director Cheryl Roberts indicating that the Department of Medical Assistance Services (DMAS) plans to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services. This SPA modifies the nursing facility reimbursement methodology to use the Patient-Driven Payment Model (PDPM) instead of Resource Utilization Groups (RUG).

If you would like a copy of the SPA documents or proposed text changes, or if you have any questions, please let us know.

Thank you! -- Meredith Lee

Meredith Lee
Policy, Regulations, and Manuals Supervisor
Policy Division
Department of Medical Assistance Services
meredith.lee@dmas.virginia.gov, (804) 371-0552
Hours: 7:00 am - 3:30 pm (Monday-Friday)
www.dmas.virginia.gov


T
Trust
H
Health
R
Results
I
Integrity
V
Vision
E
Engagement
CardinalCare
Virginia's Medicaid Program
DMAS is committed to providing quality health care coverage and services efficiently to qualified Virginians in the Commonwealth.

COMMONWEALTH of VIRGINIA

CHERYL J. ROBERTS
DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

November 20, 2025

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to Nursing Facility Reimbursement Methodology.

Dear Tribal Leader and Indian Health Programs:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to amend the Virginia State Plan for Medical Assistance with the Centers for Medicare and Medicaid Services (CMS). Specifically, DMAS is providing you notice about a State Plan Amendment (SPA) that the Agency will file with CMS in order to modify the nursing facility reimbursement methodology.

In accordance with the 2025 Appropriations Act, Item 288.IIIII, this SPA modifies the nursing facility reimbursement methodology to use the Patient-Driven Payment Model (PDPM) instead of Resource Utilization Groups (RUG). This change shall be implemented in a budget neutral manner.

We realize that the changes in this SPA may impact Medicaid members and providers, including tribal members and providers. Therefore, we encourage you to let us know if you have any comments or questions. The tribal comment period for this SPA is open through December 20, 2025. You may submit your comments directly to Meredith Lee, DMAS Policy Division, by phone (804) 371-0552, or via email: Meredith.Lee@dmas.virginia.gov. Finally, if you prefer regular mail you may send your comments or questions to:

Virginia Department of Medical Assistance Services
Attn: Meredith Lee
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,

Cheryl J. Roberts, JD
Director

Agency **Department of Medical Assistance Services**

Board **Board of Medical Assistance Services**

Edit Notice

General Notice

Public Notice - Intent to Amend State Plan - Nursing Facility Reimbursement Methodology

Date Posted: 8/29/2025

Expiration Date: 2/28/2026

Submitted to Registrar for publication: YES

30 Day Comment Forum closed. Began on 8/29/2025 and ended 9/28/2025

LEGAL NOTICE
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
NOTICE OF INTENT TO AMEND

(Pursuant to §1902(a)(13) of the *Act (U.S.C. 1396a(a)(13)*)

THE VIRGINIA STATE PLAN FOR MEDICAL ASSISTANCE

This Notice was posted on August 29, 2025

The Virginia Department of Medical Assistance Services (DMAS) hereby affords the public notice of its intention to amend the Virginia State Plan for Medical Assistance to provide for changes to the *Methods and Standards for Establishing Payment Rates – Long-Term Care (12 VAC 30-90)*.

This notice is intended to satisfy the requirements of 42 C.F.R. § 447.205 and of § 1902(a)(13) of the *Social Security Act*, 42 U.S.C. § 1396a(a)(13). A copy of this notice is available for public review from Meredith Lee, DMAS, 600 Broad Street, Suite 1300, Richmond, VA 23219, or via e-mail at: Meredith.Lee@dmas.virginia.gov.

DMAS is specifically soliciting input from stakeholders, providers and beneficiaries, on the potential impact of the proposed changes discussed in this notice. Comments or inquiries may be submitted, in writing, within 30 days of this notice publication to Meredith Lee and such comments are available for review at the same address. Comments may also be submitted, in writing, on the Town Hall public comment forum attached to this notice.

This notice is available for public review on the Regulatory Town Hall (**https://townhall.virginia.gov**) on the General Notices page, found at: **https://townhall.virginia.gov/L/generalnotice.cfm**

In accordance with the 2025 Appropriations Act, Item 288.IIIII, DMAS will be making the following changes:

Methods & Standards for Establishing Payment Rates-Long-Term Care (12 VAC 30-90

The state plan is being revised to modify the nursing facility reimbursement methodology to use the Patient-Driven Payment Model (PDPM) instead of Resource Utilization Groups (RUG). This change to reimbursement methodology

shall be implemented in a budget neutral manner.

There are no expected increases or decreases in annual fee-for-service aggregate expenditures in federal fiscal year 2026 or federal fiscal year 2027.

Contact Information

Name / Title:	Meredith Lee / *Policy, Regulations, and Manuals Supervisor*
Address:	600 E. Broad St Richmond, 23219
Email Address:	**Meredith.Lee@dmas.virginia.gov**
Telephone:	(804)371-0552 FAX: (804)786-1680 TDD: (800)343-0634

This general notice was created by Meredith Lee on 08/29/2025 at 7:38am

Public comment forums

Make your voice heard! Public comment forums allow all Virginia's citizens to participate in making and changing our state regulations.

See our Public Comment Policy

Currently showing **4** comment forums closed within the last 45 days for the Department of Medical Assistance Services.

Recently closed
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Regulatory Activity Forums (4) | Guidance Document Forums (0)

Actions () | Periodic Reviews () | Petitions for Rulemaking () | General Notices (4)

Board of Medical Assistance Services

View Comments	Public Notice - Intent to Amend State Plan - Nursing Facility Reimbursement Methodology	**General Notice** Public Notice - Intent to Amend State Plan - Nursing Facility Reimbursement Methodology Closed: 9/28/25 0 comments
View Comments	DMAS FORM #460: Virginia Informed Choice Form	**General Notice** DMAS FORM #460: Virginia Informed Choice Form Closed: 10/22/25 — 13 comments Last comment: 10/22/25 7:26 pm
View Comments	Notice of Public Comment Period: Mental Health Case Management	**General Notice** Notice of Public Comment Period: Mental Health Case Management Closed: 10/13/25 — 22 comments Last comment: 10/13/25 7:58 pm
View Comments	Notice of Public Comment Period: Community Psychiatric Support and Treatment (CPST) - School Setting	**General Notice** Notice of Public Comment Period: Community Psychiatric Support and Treatment (CPST) - School Setting Closed: 10/22/25 — 52 comments Last comment: 10/22/25 10:29 pm

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

Article 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)~~ on page 45 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 on page 56, 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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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~~ Subpart VII on page 45.

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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 Price-Based Rates at least ~~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 per day by the raw non-specialized care Medicaid nursing facility case-mix that corresponds to the base year by facility.

1. DMAS shall use Patient Driven Payment Model (PDPM) weights effective for dates of service on and after October 1, 2025. The case mix indices shall use completed OBRA assessments for Virginia Medicaid nursing facility residents with assessment effective dates within the quarter's picture dates. The member's case mix index for each unique PDPM code shall be determined using all five components of PDPM codes, Physical Therapy, Occupational Therapy, Speech/Language Therapy, Nursing, and Non-Therapy Ancillary. The case mix index for each component will be Medicare's current values as of September 1st prior to the rebasing effective date, and each component will be weighted based on Medicare weighting identified from Medicare per diems for each component.

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

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2. Unique to the rates effective October 1, 2025, PDPM case mix will be calculated using MDS records from July 1, 2023 through June 30, 2024. Future nursing facility rebasing will return to the standard process.

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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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. Claim Payment

a. Individual claim payment for direct costs shall be based on each resident's ~~Resource Utilization Group (RUG)~~ billing code during the service period times the facility direct price.

b. For dates of services provided on or after October 1, 2025, individual claim payment for direct costs shall be based on each resident's PDPM case mix times the facility's direct care rate times the number of days.

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~~1. 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.~~

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APPENDIX IV

~~RESOURCE UTILIZATION GROUPS (RUGs)~~ PATIENT-DRIVEN PAYMENT MODEL (PDPM)

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~~12VAC 30-90-300 through 12 VAC 30-90-304. Repealed. 12 VAC 30-90-305.~~

~~Resource Utilization Groups (RUGs)~~ Patient-Driven Payment Model (PDPM).

~~A. The Resource Utilization Groups III (RUG-III), Version 5.12, 34-group, index maximizing model shall be used as the resident classification system to determine the RUG-III group for each resident assessment. RUG-III classifies resident assessments according to the intensity of each resident's needs.~~ ~~Data~~ Medicaid Resident Patient-Driven Payment Model (PDPM) case mix data from the minimum data set (MDS) submitted by each facility to the Centers for Medicare and Medicaid Services (CMS) shall be used to classify the resident assessments into ~~RUG- III~~ PDPM groups.

~~B.~~ Definitions. The following words and terms when used in this appendix shall have the following meanings unless the context clearly indicates otherwise.

"Base year" means the calendar year for which the most recent reliable nursing facility cost settled cost reports are available in the DMAS database as of September 1 of the year prior to the year in which the rebased rates will be used. (See also definition of rebasing.)

"Case-mix index (CMI)" means a numeric score that identifies the relative resources used by similar residents and represents the average resource consumption of those residents.

"Case-mix neutralization" means the process of removing cost variations for direct patient care costs associated with different levels of resident case mix.

"Day-weighted median" means a weighted median where the weight is Medicaid days.

"Medicaid average case-mix index" means a simple average, carried to four decimal places, of all resident case mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

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

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

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

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

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

~~A. Effective for dates of service beginning July 1, 2001, through June 30, 2014, nursing facility case- mix indices shall be applied as described in this subsection. Each resident in a Virginia Medicaid certified nursing facility on the last day of the calendar quarter with an effective assessment date during the respective quarter shall be assigned to one of the RUG-III 34-groups.~~

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~~B.~~ A. Effective for dates of service on or after ~~July 1, 2014~~ October 1, 2025, nursing facility reimbursement described in 4.19-D, Supp. 1, p. ~~26.2~~ 26.1-26.7 ~~(12 VAC 30-90-44)~~ shall be based on ~~the~~ PDPM case-mix ~~or RUG weights as described in this subsection. Standard case-mix indices, developed by CMS for the Medicaid population (B01), shall be assigned to each of the RUG-III 34 groups as indicated in Table III~~ and weights.

~~Table III~~

~~Case Mix Indices (CMI)~~

~~RUG CATEGORY~~	~~RUG Description~~	~~CMS "Standard" B01 CMI Set~~
~~RAD~~	~~Rehabilitation All Levels / ADL 17-18~~	~~1.66~~
~~RAC~~	~~Rehabilitation All Levels / ADL 14-16~~	~~1.31~~
~~RAB~~	~~Rehabilitation All Levels / ADL 10-13~~	~~1.24~~
~~RAA~~	~~Rehabilitation All Levels / ADL 4-9~~	~~1.07~~
~~SE3~~	~~Extensive Special Care 3 / ADL >6~~	~~2.10~~
~~SE2~~	~~Extensive Special Care 2 / ADL >6~~	~~1.79~~
~~SE1~~	~~Extensive Special Care 1 / ADL >6~~	~~1.54~~
~~SSC~~	~~Special Care / ADL 17-18~~	~~1.44~~
~~SSB~~	~~Special Care / ADL 15-16~~	~~1.33~~
~~SSA~~	~~Special Care / ADL 4-14~~	~~1.28~~
~~CC2~~	~~Clinically Complex with Depression / ADL 17-18~~	~~1.42~~
~~CC1~~	~~Clinically Complex / ADL 17-18~~	~~1.25~~
~~CB2~~	~~Clinically Complex with Depression / ADL 12-16~~	~~1.15~~
~~CB1~~	~~Clinically Complex / ADL 12-16~~	~~1.07~~
~~CA2~~	~~Clinically Complex with Depression / ADL 4-11~~	~~1.06~~
~~CA1~~	~~Clinically Complex / ADL 4-11~~	~~0.95~~
~~IB2~~	~~Cognitive Impairment with Nursing Rehab / ADL 6-10~~	~~0.88~~
~~IB1~~	~~Cognitive Impairment / ADL 6-10~~	~~0.85~~
~~IA2~~	~~Cognitive Impairment with Nursing Rehab / ADL 4-5~~	~~0.72~~
~~IA1~~	~~Cognitive Impairment / ADL 4-5~~	~~0.67~~

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~~BB2~~	~~Behavior Problem with Nursing Rehab / ADL 6-10~~	~~0.86~~
~~BB1~~	~~Behavior Problem / ADL 6-10~~	~~0.82~~
~~BA2~~	~~Behavior Problem with Nursing Rehab / ADL 4-5~~	~~0.71~~
~~BA1~~	~~Behavior Problem / ADL 4-5~~	~~0.60~~
~~PE2~~	~~Physical Function with Nursing Rehab / ADL 16-18~~	~~1.00~~
~~PE1~~	~~Physical Function / ADL 16-18~~	~~0.97~~
~~PD2~~	~~Physical Function with Nursing Rehab / ADL 11-15~~	~~0.91~~
~~PD1~~	~~Physical Function / ADL 11-15~~	~~0.89~~
~~PC2~~	~~Physical Function with Nursing Rehab / ADL 9-10~~	~~0.83~~
~~PC1~~	~~Physical Function / ADL 9-10~~	~~0.81~~
~~PB2~~	~~Physical Function with Nursing Rehab / ADL 6-8~~	~~0.65~~
~~PB1~~	~~Physical Function / ADL 6-8~~	~~0.63~~
~~PA2~~	~~Physical Function with Nursing Rehab / ADL 4-5~~	~~0.62~~
~~PA1~~	~~Physical Function / ADL 4-5~~	~~0.59~~

~~C.~~ B. There shall be four "picture dates" for each calendar year: March 31, June 30, September 30 and December 31. Each resident in each Medicaid-certified nursing facility on the picture date with a completed assessment that has an effective assessment date within the quarter shall be assigned a case-mix index based on the resident's most recent assessment for the picture date as available in the DMAS MDS database.

~~D.~~ C. Using the individual Medicaid resident case-mix indices, a facility average Medicaid case-mix index shall be calculated four times per year for each facility. The facility average Medicaid case-mix indices shall be used for case-mix neutralization of resident care costs and for case-mix adjustment.

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1. ~~During the time period beginning with the implementation of RUG-III up to the~~ For ~~ceiling~~ ceilings and ~~rate~~ rates ~~setting effective July 1, 2004~~, the case-mix index calculations shall be based on assessments for residents for whom Medicaid is the principal payer. The statewide average Medicaid case-mix index shall be a simple average, carried to four decimal places, of all case-mix indices for nursing facility residents in Virginia Medicaid certified nursing facilities for whom Medicaid is the principal payer on the last day of the calendar quarter. The facility average Medicaid case-mix index shall be a simple average, carried to four decimal places, of all case-mix indices for nursing facility residents in the Virginia Medicaid-certified nursing facility for whom Medicaid is the principal payer on the last day of the calendar quarter.

2. The facility average Medicaid case-mix index shall be normalized across all of Virginia's Medicaid-certified nursing facilities for each picture date. To normalize the facility average Medicaid case-mix index, the facility average Medicaid case-mix index is divided by the statewide average Medicaid case-mix index for the same picture date.

3. ~~The department shall monitor the case-mix, including the case mix normalization and the neutralization processes, indices during the first two years following implementation of the RUG- III system. Effective July 1, 2004, the~~ The statewide average case-mix index may be changed to recognize the fact that the costs of all residents are related to the case mix of all residents. The statewide average case-mix index of all residents, regardless of principal payer on the effective date of the assessment, in a Virginia Medicaid certified nursing facility may be used for case-mix neutralization. The use of the facility average Medicaid case-mix index to adjust the prospective rate would not change.

4. There shall be a correction period for Medicaid-certified nursing facilities to submit correction assessments to the CMS MDS database following each picture date. A report that details the picture date ~~RUG category~~ and CMI score for each resident in each nursing facility shall be mailed to the facility for review. The nursing facility shall have a 30-day time period to submit any correction assessments to the MDS database or to contact the Department of Medical Assistance Services regarding other corrections. Corrections submitted in the 30-day timeframe shall be included in the final report of the CMI scores that shall be used in the calculation of the nursing facility ceilings and rates. Any corrections submitted after the 30-day timeframe shall not be included in the final report of the CMI scores that shall be used in the calculation of the nursing facility ceilings and rates.

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5. Assessments that cannot be classified to a ~~RUG-III~~ PDPM group due to errors shall be assigned the lowest case-mix index score.

6. Assessments shall not be used for any out-of-state nursing facility provider that is enrolled in the Virginia Medical Assistance Program and is required to submit cost reports to the Medicaid program.

~~12 VAC 30-90-307.~~ Applicability of case-mix indices (CMI).

A. The CMI shall be used to adjust the direct patient care cost ceilings and rates for application to individual nursing facilities. Indirect patient care cost ceilings and rates shall not be case-mix adjusted. The CMI shall be calculated using MDS data taken from picture dates as specified in this section.

B. When a facility's direct patient care cost ceiling is compared to its facility specific direct patient care cost rate to determine the direct patient care prospective rate, both the ceiling and the rate shall be case-mix neutral. The direct patient care cost ceiling shall be case-mix neutral because it shall be calculated using base year facility direct patient care cost data that have been case-mix neutralized. To accomplish this neutralization, each facility's base year direct patient care operating cost shall be divided by the facility's average normalized Medicaid CMI developed for the two semiannual periods of assessment data that most closely match the provider's cost reporting year that ends in the base year (see Table IV below). This shall be the facility's case-mix neutral direct patient care per diem for the base year and shall be used in the calculation of the peer group direct patient care cost ceilings. Table IV shows an example of the picture dates used to case-mix neutralize facility specific direct costs for the ceiling calculation. For the first few provider fiscal years for which cost neutralization will be done, a data limitation affects the picture dates that can be used. Accurate case-mix data are available starting with the fourth quarter of calendar year (CY) ~~1999~~. For providers with cost reporting periods ending during the first, second, and third quarters of CY ~~2000~~, the picture dates used in cost neutralization shall be modified to reflect only accurate case-mix data. For provider cost reporting periods ending in the fourth quarter ~~of 2000 and afterward~~, this limitation no longer exists and assessment data shall be used that most closely match the cost reporting period.

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Table IV

Quarter of Provider Cost Report Year End	Picture Dates Used to Neutralize Costs for Ceiling Calculation	
	Preferred Picture Dates if No Data Limitation Applied	Picture Dates That Shall be Used Due to Data Limitation
First Quarter of CY 2000	3/31~~/99~~, 6/30~~/99~~, 9/30~~/99~~, 12/31~~/99~~	12/31~~/99~~
Second Quarter of CY 2000	6/30~~/99~~, 9/30~~/99~~, 12/31~~/99~~, 3/31~~/00~~	12/31~~/99~~, 3/31~~/00~~
Third Quarter of CY 2000	9/30~~/99~~, 12/31~~/99~~, 3/31~~/00~~, 6/30~~/00~~	12/31~~/99~~, 3/31~~/00~~, 6/30~~/00~~
Fourth Quarter of CY 2000	12/31~~/99~~, 3/31~~/00~~, 6/30~~/00~~, 9/30~~/00~~	12/31~~/99~~, 3/31~~/00~~, 6/30~~/00~~, 9/30~~/00~~

C. When direct patient care prospective rates are set, the direct patient care ceilings used in the calculation shall be the case-mix neutralized ceiling described in subsection B of this section, adjusted for inflation to the midpoint of the prospective period. However, the facility-specific direct patient care cost rates used in the calculation shall not be from the base year, but shall be from the provider fiscal year prior to the period for which a prospective rate is being calculated. Therefore, the provider's direct patient care rate from the previous cost reporting period shall be case-mix neutralized using the facility average normalized Medicaid CMI developed for the two semiannual

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periods of assessment data that most closely match the cost reporting period prior to the prospective period for which a rate is being calculated. Each year when a new prospective rate is developed, the provider specific direct patient care rate shall be case-mix neutralized using CMI data that uses picture dates that correspond to the cost reporting period used to develop the rate. The relationship between provider cost reporting period and picture dates shall be that illustrated in Table IV, except that in the time period when rates will first be set, the data limitation that affected the picture dates shown in Table IV, will not apply. Therefore, for all provider cost reporting periods, picture dates that correspond to the cost reporting period shall be used.

D. After the case-mix neutral direct patient are ceiling (adjusted for inflation from the base year to the prospective period) is compared to the case-mix neutralized facility-specific direct patient care rate (adjusted for inflation from the previous cost reporting period to the prospective period), the lower of the two shall be chosen. This lower amount shall be the case-mix neutral prospective rate per diem for the prospective period. It shall then be adjusted for the CMI intended to correspond as closely as possible to the prospective period. Because of the manner in which the necessary data are reported, there shall be a lag between the picture dates used to develop the CMI information and the prospective period to which the CMI shall apply. The relationship between picture dates and prospective rate periods is illustrated in Table V.

Table V
Example of Picture Dates Used in Case-Mix Adjustment of Prospective Rate

Quarter of Provider Cost Report Year End	Picture Dates Used to Adjust First Prospective Semiannual Period	Picture Dates Used to Adjust Second Prospective Semiannual Period
First Quarter CY 2002	9/30/~~01~~, 12/31/~~01~~	3/31/~~02~~, 6/30/~~02~~
Second Quarter CY 2002	12/31/~~01~~, 3/31/~~02~~	6/30/~~02~~, 9/30/~~02~~
Third Quarter CY 2002	3/31/~~02~~, 6/30/~~02~~	9/30/~~02~~, 12/31/~~02~~
Fourth Quarter CY 2002	6/30/~~02~~, 9/30/~~02~~	12/31/~~02~~, 3/31/~~03~~

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR SPECIALIZED CARE

~~12VAC 30-90-320] National RUG-III Categories and Weights~~

~~**RUG III Group Name**~~	~~**RUG Group Code**~~	~~**Nursing Only Weight**~~
~~Rehabilitation~~	~~RVC~~	~~1.79~~
	~~RVB~~	~~1.18~~
	~~RVA~~	~~0.82~~
	~~RHD~~	~~1.93~~
	~~RHC~~	~~1.50~~
	~~RHB~~	~~1.31~~
	~~RHA~~	~~1.06~~
	~~RMC~~	~~2.09~~
	~~RMB~~	~~1.38~~
	~~RMA~~	~~1.25~~
	~~RLB~~	~~1.36~~
	~~RLA~~	~~1.14~~
~~Extensive Services~~	~~SE3~~	~~3.97~~
	~~SE2~~	~~2.65~~
	~~SE1~~	~~1.78~~
~~Special Care~~	~~SSC~~	~~1.61~~
	~~SSB~~	~~1.47~~
	~~SSA~~	~~1.28~~
~~Clinically Complex~~	~~CD2~~	~~1.46~~
	~~CD1~~	~~1.37~~
	~~CC2~~	~~1.19~~
	~~CC1~~	~~1.16~~
	~~CB2~~	~~1.08~~
	~~CB1~~	~~0.94~~
	~~CA2~~	~~0.76~~
	~~CA1~~	~~0.67~~
~~Impaired Cognition~~	~~IB2~~	~~0.88~~
	~~IB1~~	~~0.80~~

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR SPECIALIZED CARE

	~~IA2~~	~~0.60~~
	~~IA1~~	~~0.49~~
~~Behavior Problems~~	~~BB2~~	~~0.87~~
	~~BB1~~	~~0.78~~
	~~BA2~~	~~0.58~~
	~~BA1~~	~~0.41~~
~~Physical Functions~~	~~PE2~~	~~1.19~~
	~~PE1~~	~~1.13~~
	~~PD2~~	~~1.01~~
	~~PD1~~	~~1.00~~
	~~PC2~~	~~0.86~~
	~~PC1~~	~~0.77~~
	~~PB2~~	~~0.68~~
	~~PB1~~	~~0.66~~
	~~PA2~~	~~0.52~~
	~~PA1~~	~~0.39~~

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0019

2. STATE: VA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/1/2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Supplement 1, revised pages 21, 25, 26.1, 26.2, 26.5, and 26.5.1
Nursing Home Payment System, Appendix IV, revised pages 1-9
Nursing Home Payment System, Appendix VI, revised pages 1-2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, Supplement 1, revised pages 21, 25, 26.1, 26.2, and 26.5
Nursing Home Payment System, Appendix IV, revised pages 1-9

9. SUBJECT OF AMENDMENT
Nursing Facility Reimbursement Methodology

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Secretary of Health and Human Resources

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Cheryl J. Roberts

13. TITLE
Director

14. DATE SUBMITTED
11/14/2025

15. RETURN TO
Department of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Policy, Regulations, and Manuals Supervisor

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

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

Article 4
Operating Cost Component

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 on page 45 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. 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). 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 section 10 on page 56, for special procedures for computing the number of patient days required to meet the occupancy percentage requirement.

Nursing facility reimbursement formula.

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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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 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 Subpart VII on page 45.

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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 except, effective July 1, 2021, for nursing facilities operated by the Department of Veteran Affairs.

Nursing Facility Price Based Payment Methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates 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 department shall rebase Price-Based Rates at least every three years 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 September 1.

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

1. DMAS shall use Patient Driven Payment Model (PDPM) weights effective for dates of service on and after October 1, 2025. The case mix indices shall use completed OBRA assessments for Virginia Medicaid nursing facility residents with assessment effective dates within the quarter's picture dates. The member's case mix index for each unique PDPM code shall be determined using all five components of PDPM codes, Physical Therapy, Occupational Therapy, Speech/Language Therapy, Nursing, and Non-Therapy Ancillary. The case mix index for each component will be Medicare's current values as of September 1st prior to the rebasing effective date, and each component will be weighted based on Medicare weighting identified from Medicare per diems for each component.

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2. Unique to the rates effective October 1, 2025, PDPM case mix will be calculated using MDS records from July 1, 2023 through June 30, 2024. Future nursing facility rebasing will return to the standard process.

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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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. Claim Payment

a. Individual claim payment for direct costs shall be based on each resident's billing code during the service period times the facility direct price.

b. For dates of services provided on or after October 1, 2025, individual claim payment for direct costs shall be based on each resident's PDPM case mix times the facility's direct care rate times the number of days.

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

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APPENDIX IV

PATIENT-DRIVEN PAYMENT MODEL (PDPM)

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Patient-Driven Payment Model (PDPM).

A. Medicaid Resident Patient-Driven Payment Model (PDPM) case mix data from the minimum data set (MDS) submitted by each facility to the Centers for Medicare and Medicaid Services (CMS) shall be used to classify the resident assessments into PDPM groups.

B. Definitions. The following words and terms when used in this appendix shall have the following meanings unless the context clearly indicates otherwise.

"Base year" means the calendar year for which the most recent reliable nursing facility cost settled cost reports are available in the DMAS database as of September 1 of the year prior to the year in which the rebased rates will be used. (See also definition of rebasing.)

"Case-mix index (CMI)" means a numeric score that identifies the relative resources used by similar residents and represents the average resource consumption of those residents.

"Case-mix neutralization" means the process of removing cost variations for direct patient care costs associated with different levels of resident case mix.

"Day-weighted median" means a weighted median where the weight is Medicaid days.

"Medicaid average case-mix index" means a simple average, carried to four decimal places, of all resident case mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

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

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

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

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

Case-mix index (CMI).

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A. Effective for dates of service on or after October 1, 2025, nursing facility reimbursement described in 4.19-D, Supp. 1, p. 26.1-26.7 shall be based on PDPM case-mix and weights.

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B. There shall be four "picture dates" for each calendar year: March 31, June 30, September 30 and December 31. Each resident in each Medicaid-certified nursing facility on the picture date with a completed assessment that has an effective assessment date within the quarter shall be assigned a case-mix index based on the resident's most recent assessment for the picture date as available in the DMAS MDS database.

C. Using the individual Medicaid resident case-mix indices, a facility average Medicaid case-mix index shall be calculated four times per year for each facility. The facility average Medicaid case-mix indices shall be used for case-mix neutralization of resident care costs and for case-mix adjustment.

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1. For ceilings and rates, the case-mix index calculations shall be based on assessments for residents for whom Medicaid is the principal payer. The statewide average Medicaid case-mix index shall be a simple average, carried to four decimal places, of all case-mix indices for nursing facility residents in Virginia Medicaid certified nursing facilities for whom Medicaid is the principal payer on the last day of the calendar quarter. The facility average Medicaid case-mix index shall be a simple average, carried to four decimal places, of all case-mix indices for nursing facility residents in the Virginia Medicaid-certified nursing facility for whom Medicaid is the principal payer on the last day of the calendar quarter.

2. The facility average Medicaid case-mix index shall be normalized across all of Virginia's Medicaid-certified nursing facilities for each picture date. To normalize the facility average Medicaid case-mix index, the facility average Medicaid case-mix index is divided by the statewide average Medicaid case-mix index for the same picture date.

3. The statewide average case-mix index may be changed to recognize the fact that the costs of all residents are related to the case mix of all residents. The statewide average case-mix index of all residents, regardless of principal payer on the effective date of the assessment, in a Virginia Medicaid certified nursing facility may be used for case-mix neutralization. The use of the facility average Medicaid case-mix index to adjust the prospective rate would not change.

4. There shall be a correction period for Medicaid-certified nursing facilities to submit correction assessments to the CMS MDS database following each picture date. A report that details the picture date and CMI score for each resident in each nursing facility shall be mailed to the facility for review. The nursing facility shall have a 30-day time period to submit any correction assessments to the MDS database or to contact the Department of Medical Assistance Services regarding other corrections. Corrections submitted in the 30-day timeframe shall be included in the final report of the CMI scores that shall be used in the calculation of the nursing facility ceilings and rates. Any corrections submitted after the 30-day timeframe shall not be included in the final report of the CMI scores that shall be used in the calculation of the nursing facility ceilings and rates.

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5. Assessments that cannot be classified to a PDPM group due to errors shall be assigned the lowest case-mix index score.

6. Assessments shall not be used for any out-of-state nursing facility provider that is enrolled in the Virginia Medical Assistance Program and is required to submit cost reports to the Medicaid program.

Applicability of case-mix indices (CMI).

A. The CMI shall be used to adjust the direct patient care cost ceilings and rates for application to individual nursing facilities. Indirect patient care cost ceilings and rates shall not be case-mix adjusted. The CMI shall be calculated using MDS data taken from picture dates as specified in this section.

B. When a facility's direct patient care cost ceiling is compared to its facility specific direct patient care cost rate to determine the direct patient care prospective rate, both the ceiling and the rate shall be case-mix neutral. The direct patient care cost ceiling shall be case-mix neutral because it shall be calculated using base year facility direct patient care cost data that have been case-mix neutralized. To accomplish this neutralization, each facility's base year direct patient care operating cost shall be divided by the facility's average normalized Medicaid CMI developed for the two semiannual periods of assessment data that most closely match the provider's cost reporting year that ends in the base year (see Table IV below). This shall be the facility's case-mix neutral direct patient care per diem for the base year and shall be used in the calculation of the peer group direct patient care cost ceilings. Table IV shows an example of the picture dates used to case-mix neutralize facility specific direct costs for the ceiling calculation. For the first few provider fiscal years for which cost neutralization will be done, a data limitation affects the picture dates that can be used. Accurate case-mix data are available starting with the fourth quarter of calendar year (CY). For providers with cost reporting periods ending during the first, second, and third quarters of CY, the picture dates used in cost neutralization shall be modified to reflect only accurate case-mix data. For provider cost reporting periods ending in the fourth quarter, this limitation no longer exists and assessment data shall be used that most closely match the cost reporting period.

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Table IV

Quarter of Provider Cost Report Year End	Picture Dates Used to Neutralize Costs for Ceiling Calculation	
	Preferred Picture Dates if No Data Limitation Applied	Picture Dates That Shall be Used Due to Data Limitation
First Quarter of CY 2000	3/31, 6/30, 9/30, 12/31	12/31
Second Quarter of CY 2000	6/30, 9/30, 12/31, 3/31	12/31, 3/31
Third Quarter of CY 2000	9/30, 12/31, 3/31, 6/30	12/31, 3/31, 6/30
Fourth Quarter of CY 2000	12/31, 3/31, 6/30, 9/30	12/31, 3/31, 6/30, 9/30

C. When direct patient care prospective rates are set, the direct patient care ceilings used in the calculation shall be the case-mix neutralized ceiling described in subsection B of this section, adjusted for inflation to the midpoint of the prospective period. However, the facility-specific direct patient care cost rates used in the calculation shall not be from the base year, but shall be from the provider fiscal year prior to the period for which a prospective rate is being calculated. Therefore, the provider's direct patient care rate from the previous cost reporting period shall be case-mix neutralized using the facility average normalized Medicaid CMI developed for the two semiannual

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periods of assessment data that most closely match the cost reporting period prior to the prospective period for which a rate is being calculated. Each year when a new prospective rate is developed, the provider specific direct patient care rate shall be case-mix neutralized using CMI data that uses picture dates that correspond to the cost reporting period used to develop the rate. The relationship between provider cost reporting period and picture dates shall be that illustrated in Table IV, except that in the time period when rates will first be set, the data limitation that affected the picture dates shown in Table IV, will not apply. Therefore, for all provider cost reporting periods, picture dates that correspond to the cost reporting period shall be used.

D. After the case-mix neutral direct patient are ceiling (adjusted for inflation from the base year to the prospective period) is compared to the case-mix neutralized facility-specific direct patient care rate (adjusted for inflation from the previous cost reporting period to the prospective period), the lower of the two shall be chosen. This lower amount shall be the case-mix neutral prospective rate per diem for the prospective period. It shall then be adjusted for the CMI intended to correspond as closely as possible to the prospective period. Because of the manner in which the necessary data are reported, there shall be a lag between the picture dates used to develop the CMI information and the prospective period to which the CMI shall apply. The relationship between picture dates and prospective rate periods is illustrated in Table V.

Table V
Example of Picture Dates Used in Case-Mix Adjustment of Prospective Rate

Quarter of Provider Cost Report Year End	Picture Dates Used to Adjust First Prospective Semiannual Period	Picture Dates Used to Adjust Second Prospective Semiannual Period
First Quarter CY 2002	9/30, 12/31	3/31, 6/30
Second Quarter CY 2002	12/31, 3/31	6/30, 9/30
Third Quarter CY 2002	3/31, 6/30	9/30, 12/31
Fourth Quarter CY 2002	6/30, 9/30	12/31, 3/31

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