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

I. Minimum Data Set (MDS)

A. Minimum Data Set (MDS)

The most recent version of the Minimum Data Set (MDS) resident assessment instrument (RAI) and the West Virginia-specific Section S are to be used by NFs for each federally required assessment. Effective for assessments with assessment reference dates on or after October 1, 2023 until September 30, 2024, the State mandates the use of the optional state assessment (OSA) item set. The OSA item set is required to be completed in conjunction with each assessment and at each assessment interval detailed within this Section. The OSA item set must have an assessment reference date that is identical to that of the federally required assessment it was performed in conjunction with. Failure to do so may result in the assessment being assigned the lowest possible case mix score.

These forms may be found in the RAI Manual as published and periodically updated by CMS; please refer to OHFLAC website for Section S instructions specifications.

The CMS requires that a comprehensive MDS assessment be completed on every resident admitted into a nursing facility by day 14 of the admission and reassessed on at least a quarterly basis and annually thereafter. Reference should be made to the RAI manual for the complete Omnibus Budget Reconciliation Act (OBRA) assessment schedule.

B. MDS Submission Criteria for Reimbursement

Effective for reimbursement through September 30, 2024, the State utilizes the MDS assessments to determine (through the West Virginia specific 29 – case mix grouper), the acuity level of each individual residing in the nursing facility. West Virginia has case mix classes 01-29, (when billed on the UB claim form or 837I format, the scores are depicted as AAA01- AAA29).

Effective October 1, 2024, the State utilizes the MDS assessments to determine (through the Patient Driven Payment Model grouper) the acuity level of each individual residing in the nursing facility. West Virginia uses the nursing component of PDPM, (when billed on the UB claim form or 837I format, the scores are determined from the applicable Health Insurance Prospective Payment System [HIPPS] code).

The case mix workbook may be found on the State's website. The billing schedule is published annually, which may also be found on the State's website with the nursing facility billing deadline dates, aswell as the MDS extraction date.

II. Cost Finding and Reporting

A. Chart of Accounts

The Medicaid Chart of Accounts (MCOA) is mandated by the State for nursing facility service providers who are required to complete the Financial and Statistical Report for Nursing Homes (Medicaid Cost Report) as part of their participation in the Medicaid program. The MCOA details the account number, account name, file/field specification (FIELD), page and line reference (MAP), and description of items applicable for each account. The file/field specification (FIELD) column contains the file and field layout for submission of the Medicaid Cost Report.

It is not mandatory for providers to use the MCOA for internal reporting purposes; however, the provider's internal chart of accounts MUST contain a sufficient number of accounts to capture data in the level of detail necessary to correlate to the MCOA. Individual accounts must be used to report separate types of costs, even if the accounts aggregate to one cost report cost center.

The provider must submit a trial balance using the MCOA as part of the automated cost reporting process. This is accomplished in the cost reporting software by assigning the appropriate MCOA number to the provider's internal account number. It is the provider's responsibility to secure and maintain acceptable cost report software. The MCOA is maintained by Rate Setting Unit of the Office of Accountability and Management Reporting (OAMR) and is periodically updated. Cost reports must be submitted in accordance with the MCOA.

The Grouping Report (a trial balance submitted with the cost report through which each provider's internal account has been mapped to the appropriate MCOA number) must reflect the actual balance in each provider's internal account for the semi-annual, or annual, period reported, and the "Per Books" column must agree directly to the balance for each account in the provider's general ledger for that six months or year of activity. All adjustments are to be posted through the "Net Adjustments" column of the Grouping Report.

B. Financial and Statistical Report

Facility costs must be reported on the Financial and Statistical Report for Nursing Homes, which must be completed in accordance with Generally Accepted Accounting Principles (GAAP) and the accrual method of accounting. The reports must be submitted to the OAMR; Attention: Division of Audit and Rate Setting, as an electronic submission in a format as required by the State.

The report must also be accompanied by the Medicaid Grouping Report trial balance that matches the costs on the report. These reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be rejected and returned to the facility for correction.

C. Cost Reporting and Filing Periods

For cost report periods ending through December 30, 2023, facility costs are reported semi-annually with the two reporting periods being January 1 through June 30 with a deadline of August 29, and July 1 through December 31 with a deadline of March 1 (February 29 on leap years). Cost reports must be filed with the State within 60 days following the end of the reporting period. The December 31, 2023 cost report period ended will be the last semi-annual filing period.

For cost report periods ending on or after January 1, 2024, facility costs are to be reported annually with the reporting period being January 1 through December 31 with a submission deadline of the following March 31. Cost reports must be filed with the State within 90 days following the end of the reporting period, or as required by the State. The January 1, 2024 through December 31, 2024 cost report period will represent the first required annual filing period.

For new providers, providers with changes of ownership, or those who have undergone a temporary closure, a cost report must be filed for any fiscal period as determined necessary by the State, with a minimum filing period of 6 months.

D. Extension Requests

An extension of time for filing cost reports may be granted by the OAMR for extenuating circumstances where requested and justified by the facility in writing by the close of business on the due date. For cost report periods ending through December 31, 2023, extension requests will be limited to a maximum of 30 calendar days. For cost report periods beginning January 1, 2024, extension requests may be approved by the Department for extenuating circumstances. The procedure for requesting extensions shall be communicated by the State in advance of the filing deadline.

E. Penalty for Delinquent Reporting

Failure to submit cost reports by the due date, where no extension has been granted to the facility or within the time constraints of an extension, will result in penalties to that facility in accordance with the State Plan. If incomplete cost reports are not corrected and resubmitted within 10 calendar days, the facility may be subject to these penalty provisions at the discretion of the State.

F. Correction of Errors

Errors in cost report or rate setting data identified by the facility must be corrected and resubmitted to the state. If submitted within 30 days after the original rate notification, those corrections will be considered for rate revision. The State will make rate revisions resulting from computational errors in the rate determination process.

An instance where a rate is revised for correction of an error, whether identified by the facility or the State for computational or other errors, shall not prohibit the State from making additional rate revisions as needed upon subsequent discovery of additional errors.

G. Maintenance of Records

A desk review of the cost report may be done prior to rate setting and an on-site audit of facility records will be conducted periodically. Financial and statistical records must be maintained by the facility to support and verify the information submitted on the cost reports. Such records must be maintained for a minimum of five years from the ending date of the report. Upon request by the State, all records will be made available within 10 working days. If not produced within that time frame, the records will be considered non-existent. The State reserves the right to determine the site where the records are to be made available. Cost or census data reported that is found to be unsubstantiated or related to records requested but not produced will be disallowed.

H. Census Data

A Provider shall include with the cost report a detail of census data and bed reservations billed to Medicaid for the cost reporting period.

Upon request for desk review or audit, source documentation for census as reported on the cost report must include at a minimum a midnight census (by payer class with bed reservations specifically identified) that agrees in aggregate to a monthly census (by payer class with bed reservations specifically identified), which agrees (or has an accompanying reconciliation) to each month as reported on the cost report, with bed reservations specifically identified.

III. Projected Rates and Rates After Change of Ownership

For changes of ownership occurring through September 30, 2024, 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. When a stock purchase occurs, a projected rate is not established. If a change of ownership and control has occurred because there has been a complete purchase of assets, a projected rate is established.

A projected rate will be established for new facilities with no previous operating experience for rate periods through September 30, 2024. A change of location with the same ownership does not constitute a new facility. A projected rate will last no longer than 18 months from the opening date of the facility. The facility may choose to go off the projected rate at any time after a full twelve months of operating experience in a cost reporting period. Each facility on a projected rate must submit the calendar year cost reports during the projected rate period even if the first report is a partial report (less than twelve months).

At the end of the projected rate period, the audited cost report of the facility will be reconciled with the projected cost reimbursement using actual occupancy and tested for reasonableness against the cost standard established for the bed groups (0-90 beds and 91+ beds). Overpayment identified in the reconciliation process will be recovered by the State.

A projected rate for a new facility or a facility with a recognized change of ownership and control will be established as follows:

a. Standard Services: The cost standard Cost Average Point (CAP) established for the bed group.

b. Mandated Services: The cost standard CAP established for the bed group.

c. Nursing Services: The average of the cost established for the bed group.

d. Cost of Capital: The Standard Appraised Value (SAV) methodology is applied to a new facility or the SAV established for the facility if a change of ownership occurs.

For changes of ownership on or after October 1, 2024, a change of ownership shall result in the new operator of a facility receiving the previous operator's reimbursement rate until such a time that the new operators costs are fully incorporated into a rate calculation period. New operator costs will be considered for rate setting beginning with the July 1 rate period following the filing of the new operator's first cost report, which is 6 months or greater, and has been reviewed by the State.

For new providers operating on or after October 1, 2024, the reimbursement rate shall be the statewide average reimbursement rate per component for their bed group except for cost of capital and quality.

For the quality per diem, the provider will receive the points for new providers as described in the Quality Scoring Metrics and Special Population Determination file published to the State website. Any days utilized in determining the Quality Per Diem shall utilize the minimum occupancy standard for the quality per diem calculation.

As a condition of the change of ownership, the new operator agrees to assume the liabilities owed to the State by any predecessor provider, whether the provider is purchased through an asset purchase, stock purchase, or another arrangement.

IV. Allowable Costs and Rate Determination

A. Rate Determination for Rate Periods Through September 30, 2024

1. Initial Rate Establishment
For rate periods through September 30, 2024, reimbursement rates shall be calculated as follows:

Reimbursement for nursing facility services is limited to those costs required to deliver care to residents. These are costs related to inpatient care; i.e., facility operating costs and the cost of direct services to residents, which are considered for reimbursement. Allowed costs are subject to the regulations prescribing the treatment of specific items.

A cost standard is developed for each of four cost centers, which becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

a) **Standard Services**: The cost standard for standard services is comprised of four departmental cost centers:
   (1) Dietary;
   (2) Laundry and housekeeping;
   (3) Medical records; and
   (4) Administration.

A separate cost standard is calculated for each of these cost centers by bed group based on bed size (0- 90 beds and 91+ beds). Within each cost center, the Per Patient Day (PPD) allowable costs are arrayed assuming 100% occupancy on a facility specific basis. Extremes are eliminated by including only those values falling within plus or minus one standard deviation; this is then adjusted to a 90% occupancy level. The cost standard for standard services is the sum of the cost center CAP for dietary, laundry and housekeeping, medical records and administration. The cost standard establishes the maximum allowable cost by bed group for standard services.

b) **Mandated Services**: The mandated services component comprised of four departmental cost centers:
   (1) Activities;
   (2) Maintenance;
   (3) Utilities; and
   (4) Taxes and insurance.

A separate cost standard is calculated for each of these cost centers by bed group. Within each cost center the PPD allowable costs are arrayed from highest to lowest. The 90th percentile value of each cost center is then selected as the CAP. The mandated services cost standard is the sum of the cost center CAP for activities, maintenance, utilities, and taxes and insurance. The cost standard then establishes the maximum allowable cost by bed group for mandated services.

3. **Nursing Services**

The cost standard for nursing services is shown as the Resident Assessment calculation on the rate sheet. This calculation provides for professional staffing levels and supply costs that are recognized as representative of those necessary for delivery of the core level of resident needs. It incorporates all minimum federal and state mandates for licensure and certification of nursing facilities.

The professional staffing hours on the Resident Assessment calculation serve as a benchmark and are held constant over time. A factor of 0.35 hours PPD is included in the licensed practical nurse (LPN) hours for 0-90 beds and 0.30 hours PPD for 91+ beds to account for restorative services. Additionally, 0.05 hours PPD is included in the standard Aides hours for restorative services.

The standard hours PPD, by bed group, for each of the professional levels of nursing staff are as follows:

Staff	1-90 Beds	91+ Beds
Registered Nurse (RN)	0.20	0.20
LPN	0.85	0.80
Aides	1.85	1.85
Total Hours PPD	2.90	2.85

The cost standard for nursing wage rates uses total compensation and is calculated by bed group. Hourly wage rates, by professional level, are derived from the cost reports of each facility and arrayed from highest to lowest in each bed group. The 70th percentile value is then selected as the bed group CAP. The CAP is multiplied by the hour benchmark to yield the salary component of the nursing services cost standard. Nursing and restorative supply costs are summed for each facility and converted to a PPD cost. These PPD costs are then arranged, by bed group, from highest to lowest, and the 70th percentile is selected as the nursing supplies CAP.

The director of nursing (DON) salary is selected at the 70th percentile, by bed group, as derived from the submitted cost reports. An additional factor is added for the DON by dividing the DON salary by each facility's beds at 100% occupancy.

The cost standard for nursing services is derived as the sum of the above factors (RN, LPN, Aide, Supplies, and DON). The CAP is then adjusted to a facility specific CAP based on the facility's average Medicaid MDS score from the six-month reporting period. The average Medicaid MDS score (including the Medicaid Hospice resident) is divided by 2.5 and then multiplied by the base constant to arrive at an adjusted nursing services CAP for each facility. The adjusted nursing services CAP cannot exceed 112% (MDS average of 2.8) or be less than 80% (MDS average of 2.0) of the base constant. The facility actual allowable PPD nursing costs are reimbursed up to the level of the nursing services CAP.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the rate 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 specific resident. 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.

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 title 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 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:

(a) Physical deterioration; curable and incurable.
(b) Functional obsolescence; curable and incurable.
(c) Economic obsolescence.

The nursing facility 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 and WV Legislative Rule 64 CSR 13 (Nursing Home Licensure Rule).

These criteria form a living document drawn from Federal and State regulation and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes which foster improved resident care or cost effective measures which do not compromise resident care.

The model nursing facility standard also sets an upper reasonable cost limit for constructing a nursing facility. This effectively discourages the creation of unnecessarily costly facilities. Currently, land is being appraised at its "highest and best" use. This occasionally results in land values in excess of the building and equipment appraisal.

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 and used in the October 1st rate setting period, in addition to the following April 1st 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. Initial and annual appraisals must include on-site inspections. Prior to rate setting, the updated appraisals will be indexed to June 30, as a common point valuation, based on the Consumer Price Index. All appraisals will include an on-site evaluation.

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

B. Allowable Costs

1. Capitalized Assets

Reported capitalized assets shall align with Medicare cost reporting principles, as described in CMS publication 15-1 §108, Guidelines for Capitalization of Historical Costs and Improvement Costs of Depreciable Assets.

2. Working Capital Interest

Working Capital Interest (WCI) is limited to short-term loans (term of one year or less) taken out to meet immediate needs of daily operations. To be allowable, there must be a genuine effort by the provider to repay these notes. If no evidence of repayment is apparent and if no justification can be made for nonpayment of the note and these notes are merely renewed throughout the year, the program will not consider these to be bona fide working capital notes and the interest incurred will not be allowed.

3. Vehicle Expenses

Allowable vehicles include the cost of ownership, as well as reimbursement for use of personal vehicles. Providers must maintain appropriate records and invoices related to vehicle-related expenditures.

4. Allocated Costs

Hospital-based nursing facilities and nursing facilities associated with assisted living facilities or other related parties that use allocated costs must maintain detailed documentation to support any costs allocated on the cost report (either allocated to the facility or allocated among individual cost centers) andthe allocation calculation(s) must be made available upon request for desk review or audit. All costs mustshow reasonableness and be comparable to other facilities in the industry.

5. Home Office Costs

Certain home office costs may be included in the provider's cost report and considered for reimbursementas part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain. The administrator or designee must prove the home office costs are related to patient care. The administrator or designee must maintain documentation to establishthe benefit to patient care realized as a result of any home office costs included in the cost report. Please reference Allowable Costs for Cost Centers for additional guidance. Management fees charged between related organizations are not allowable costs, and such fees must be reported as non-allowable on the provider's cost report. Any cost report received with related party management fees and home office costs will be rejected and returned to the facility for correction. Home office costs must be appropriately reported by individual line item on the home office schedules of the cost report, and should not be aggregated as management fees. Thus, allowable cost is limited to the lesser of:

a) Allowable costs properly allocated to the provider, and
b) The price for comparable services, facilities, or supplies that could be purchased elsewhere,taking into account the benefits of effective purchasing that would accrue to each member orprovider because of aggregate purchasing on a chain wide basis.

Home office costs must be reported at cost and net of any inter-company profit, and the home office must be disclosed as a related party on the cost report. Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable, as home office costs to be allocated to providers. Costs related to nonmedical enterprises are not considered allowable home office costs. All allocated central office costs are considered administrative in nature and, therefore, must comply with regulations governing allowable costs at individual facility locations.

Starting with its total costs, including those costs paid on behalf of providers (or components in the chain),the home office must delete all costs which are not specifically allowable in accordance with the provider manual.

Where the home office incurs costs for activities not related to patient care in the chain's participating providers, the allocation basis used must provide for the appropriate allocation of costs such as rent, administrative salaries, organization costs, and other general overhead costs which are attributable to nonresident care activities, as well as to patient care activities. All activities and functions in the homeoffice must bear their allocable share of home office overhead and general administrative costs.

The basis for allocation of allowed costs among long-term care facilities should be patient days. However,another basis may be considered appropriate and more accurate. The home office must make a written request, with its

justification, to the State for approval of the change.

The written request must be received no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The State's approval of a home office request will be furnished to the home office in writing. Where the Medicare intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approved a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

6. Non-Reimbursed Prescription Costs

Prescription drugs are not allowable on the cost report and are not included in the per diem rate. See Pharmacy Services and Non-Prescription Items of this state plan and state regulation for information regarding covered prescription drug services.

7. Transportation Service Costs

The cost of emergency and non-emergency ambulance services is not allowed on the cost report. However, the cost of the transportation contract between the nursing facility and the NEMT provider and the transportation provided by a vehicle owned by the facility, is included in the all-inclusive Medicaid rate and is allowable on the cost report.

8. Compensation

Allowable compensation is compensation that is reasonable for services that are necessary, related to patient care, and pertinent to the operation of the facility. The services must be performed and paid in full less any withholding required by law. The hours worked must be documented as well as the compensation received. This information must be 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 group. The method used to calculate "reasonable" will be as follows: The ninetieth (90^{th}) percentile of the hourly wage of the employee classification for each bed group. No owners, operators, and relatives will be included in the calculation. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 2,080 hours per annual cost report period worked (1,040 hours for semi-annual cost report periods) in resident related duties and includes documented vacation and sick time.

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.

A bonus plan must be clearly established in writing and given to employees prior to the beginning of the cost reporting period. To be considered allowable, any bonuses (including performance-based bonuses) must be paid in accordance with the plan, accrued in the period earned, and be nondiscretionary (i.e., payable to all eligible employee classifications as set forth in the written plan, including owners and related parties of owners) so as not to be misconstrued as a discretionary distribution of excess earnings exclusively to owners and related parties of owners.

9. Administrators

No owners, operators, or relatives will be included in the calculation. Full time is considered at least 2,080 documented hours, which includes vacation and sick time, per annual cost reporting period (1,040 hours for semi-annual cost report periods) for resident related duties. If the services are provided less than full time, the compensation must reflect this fact. The administrator cannot act as director of nursing.

10. 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 allowed.

Owners that do not serve as administrators will be compensated for duties performed, excluding services rendered primarily to protect their investment. To be included on the cost report, the facility must be able to document that the services provided by the owner are not duplicated by other positions.

Compensation is not allowed for owners, operators, or their relatives who claim to provide some administrative or other function required to operate the facility, but who do not actually provide said service. Where functions claimed to be provided by owners, operators, or their relatives are merely a duplication of services already provided by other employees or are functions which should reasonably be expected to be performed by other emplyees, such services are not reimbursable. For example: if a facility has a full-time administrator or other full-time or part-time staff position filled and compensated, the facility's owner, operator, or their relative claiming compensation for the same or similar functions are not allowed by the program.

11. Nonallowable Costs, Fines and Penalties, Damage Awards and Negotiated Settlements, and Reorganization/Refinancing Costs.

Details around these specific costs, and their allowability and treatment for cost reporting, are listed in the West Virginia Nursing Facility provider manual.

12. Purchases 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.

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. The facility must maintain and make available, upon request for desk review or audit, detailed documentation that the related party purchase has been included in the cost report at the related party's cost and any calculations to demonstrate that any inter-company profit that would have passed to the related party from the transaction has been eliminated in the cost report preparation.

13. Filing Reports – Requests for Assistance

Financial and statistical reports and questions regarding cost reporting are to be addressed to OAMR as communicated prior to the filing deadline.

14. Cost Adjustment

Reported facility costs are subject to review and analysis through document/desk review process. Adjustments are made to exclude non-allowable costs.

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

15. Authoritative Guidance

West Virginia nursing facility costs are reported on the Financial and Statistical Report for Long-Term Care Facilities, which should be completed in accordance with generally accepted accounting principles (GAAP) and the accrual basis of accounting. The rules and regulations governing cost allowability for WV Medicaid Nursing Provider rate methodology are determined by the West Virginia Medicaid State Plan and the West Virginia Bureau for Medical Services (or BMS) Provider Manual, Chapter 514; where these are silent as to a situation, the Federal Medicare rules and regulations provide guidance. If all are silent as to a situation, then the GAAP rules should be followed.

2. Prospective Rate Determination
For rate period begin dates through October 1, 2023, individual facility rates are established on a prospective basis, considering costs to be expected during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors of omissions of data or reconciliation of audit findings related to falsification or misreporting of costs or census. The basic vehicle for arriving at each facility's rate is the uniform financial and statistical report for nursing homes. The reported costs are subject to desk review and then converted to cost per patient day. Rates will be issued for six-month periods beginning April 1 and October 1 based on each facility's reported costs and adjustments for the applicable reporting period. The October 1, 2023 rate period will be in effect through September 30, 2024.

a) Cost Adjustment: Reported facility costs are subject to review and analysis through document/desk review process. Adjustments are made to exclude non-allowable costs and by application of the agency's established cost standards using the following methodologies: Standard services, mandated services, and nursing services (described below):

(1) Standard Services
Total reported allowable costs in the standard services area are compared against the total cost standard for these cost centers using the appropriate bed group for the facility. If the total reported allowable exceeds the total cost standard, then the facility rate is limited to the standard services CAP.

(2) Mandated Services

Total reported allowable costs in the mandated services area are fully recognized for these cost centers, providing they do not exceed the 90th percentile of total reported costs by bed group.

(3) Nursing Services

Allowable costs and reimbursement for nursing services will be determined on a facility-by-facility basis by the kind and amount of services needed and being delivered to the resident. The staffing required to deliver the care and the restorative and rehabilitative programs offered by the facility will be based on the application of a minimum staffing pattern and adjustments to reflect needs determined by the case mix characteristics. Monthly billing information for services rendered to nursing facility residents will include data derived directly from the computerized assessment instrument for each resident, which may be used to determine case mix scores for each resident and a composite score for the facility. These case mix scores will measure the relative intensity and service needs of the facility's residents and will comprise the basis for determining allowable adjustments to per diem staffing and nursing costs required to deliver the kind and amount of services needed.

(4) Minimum Occupancy Standard

For rate periods through September 30, 2024, cost adjustments will be made by applying a minimum occupancy standard of 90% to all cost centers. Actual facility occupancy is used to determine allowable costs per patient day if equal to or greater than 90%. However, if the actual occupancy level is less than 90%, the per patient day, allowable cost will be adjusted to assume a 90% occupancy level.

Beginning October 1, 2024, minimum occupancy shall be applied as described in the Rate Determination for Rate Periods Effective October 1, 2024 section of this State Plan.

(5) Efficiency Incentive

For rate periods through September 30, 2024, an efficiency incentive will be allowed where the standard services area allowable costs are less than the total of the cost standard. The 50% of the difference between the total allowable costs and the total cost standard 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.

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, during the reporting period. Statements of deficiencies generated by OHFLAC for non-compliance found during licensure inspections and/or certification surveys are reviewed to determine compliance with licensure, certification and agency standards.

If it has been determined that a facility has significant deficiencies (defined as one or more deficiencies cited at a severity level of actual harm or immediate jeopardy and/or constituting substandard quality of care on the survey and licensure agency reports), the facility may be denied efficiency incentive for that period. When an audit adjustment results in a change in the allowable costs in the standard services component, no increase or decrease in the efficiency incentive will be made.

Effective October 1, 2024, this section shall no longer be applicable to provider reimbursement.

(6) Inflation Factor

For rate periods through September 30, 2024, after combining the various components, a factor is assigned to costs as a projection of inflation during the next rate-setting cycle. The amount of change in the Consumer Price Index (CPI) experienced during the six-month reporting period becomes the inflation factor applied to the next six-month period. The inflation factor, once set for a given rate period, is not adjusted as it represents a reasonable expectation for cost increases.

Regulatory costs, such as minimum wage increases, tax changes, Federal Insurance Contributions Act (FICA) increase, Worker's Compensation changes, etc., will be considered an inclusive component of the inflation

factor.

For rate periods beginning on or after July 1, 2025, the allowable rate component costs have an inflation factor applied for the forthcoming rate setting period. The annual inflation factor is applied each July 1 and shall be established for the most recently published (or as otherwise noted) Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit or a comparable index, if this index ceases to be produced. The inflation factor, once set for a given rate period, is not adjusted as it represents what is a reasonable expectation for cost increases. The inflation factor will be applied as described in each rate component methodology section.

(7) 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. When a bed change occurs it is recognized effectively in the month in which the change occurs. In this instance, an appraisal of the facility will be completed after the change in bed size has been certified. If the annual appraisal has been completed, the facility will be responsible for the cost of the additional appraisal.

C. Rate Determination for Rate Periods Effective October 1, 2024

Effective for rate periods beginning October 1, 2024 and after, reimbursement for nursing facility services is limited to those costs required to deliver care to residents. These are costs related to inpatient care, i.e., facility operating costs and the cost of direct services to residents, which are considered for reimbursement. Allowed costs are subject to the regulations prescribing the treatment of specific items in this manual.

Effective October 1, 2024, a rate is comprised of the following rate components which are updated annually, save for the Quality component which is updated semi-annually. The base year used for the October 1, 2024 rates will be the desk reviewed July 1, 2022 to December 31, 2022 cost reports.

After October 1, 2024, these rate components will be rebased at a minimum of every two years. The State, at their discretion, may choose to rebase more frequently than every two years. An inflationary index factor as discussed in this section below will be applied each July 1 for a non-rebase year.

1. Direct Care: The direct care component is comprised of the following departmental cost centers:
   a) Registered Nurses;
   b) Licensed Practical Nurses;
   c) Nurse Aides;
   d) Restorative and;
   e) Contracted Nurses.

The per diem direct care cost for each NF is determined by dividing the facility's direct care cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period or 70% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed within this section below.

The per diem normalized direct care cost is calculated by dividing each NF provider's inflated direct care cost per diem by the NF provider's NF cost report period case mix index.

The price for the direct care component is established by peer group. The direct care normalized per patient day allowable costs are arrayed from highest to lowest. The statewide direct care prices are established at one hundred and twelve and a half percent (112.50%) of the 90th percentile for each peer group. This price is then reduced for each facility by the direct care spending floor adjustment, to set the final direct care per diem.

The direct care spending floor adjustment is calculated as follows:

a) The sum of the NF provider's direct care cost component calculated above is multiplied by the spending floor percentage to determine the direct care spending floor threshold.

b) The direct care spending floor percentage is 80% of the direct care price for the facility.

c) The direct care spending floor adjustment is calculated as the lesser of the normalized direct care cost per diem minus the direct care spending floor threshold, or zero.

2. Care Related: The care related component is comprised of the following departmental cost centers:
    a) Director of Nursing;
    b) Supplies;
    c) Non-Prescription Drugs;
    d) Oxygen;
    e) Other Nursing;
    f) Therapy;
    g) Medical Records and;
    h) Activities

The per diem care related cost for each NF is determined by dividing the facility's care related cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period, or 75% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed in this section below.

The price for the care related component is established by peer group. The care related per patient day allowable costs are arrayed from highest to lowest. The statewide care related prices are established at one hundred and twelve and a half percent (112.50%) of the 80th percentile for each peer group. This price is then reduced for each facility by the care related spending floor adjustment, to set the final care related per diem.

The care related spending floor adjustment is calculated as follows:

a) The sum of the NF provider's care related cost component calculated above is multiplied by the spending floor percentage to determine the care related spending floor threshold.

b) The care related spending floor percentage is 75% of the care related price for the facility.

c) The care related spending floor adjustment is calculated as the lesser of the care related cost per diem minus the care related spending floor threshold, or zero.

3. Operational: The operational component is comprised of the following departmental cost centers:
   a) Dietary;
   b) Laundry and Housekeeping;
   c) Administration; and
   d) Maintenance

The per diem operational cost for each NF is determined by dividing the facility's operational cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period, or 85% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the index factor as discussed in this section below.

The price for the operational component is established by peer group. The operational per patient day allowable costs are arrayed from highest to lowest. The statewide operational prices are established at one hundred and five percent (105.00%) of the 75th percentile for each peer group. This price is then reduced for each facility by the operational spending floor adjustment, to set the final operational per diem.

The operational spending floor adjustment is calculated as follows:

a) The sum of the NF provider's operational cost component calculated above is multiplied by the spending floor percentage to determine the operational spending floor threshold.

b) The operational spending floor percentage is 75% of the operational price for the facility.

c) The operational spending floor adjustment is calculated as the lesser of the operational cost per diem minus the operational spending floor threshold, or zero.

4. Pass-Through: The pass-through services component is comprised of the following departmental cost centers:
   a) Utilities; and
   b) Taxes and insurance.

The per diem pass-through cost for each NF is determined by dividing the facility's pass-through cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting

period, or 85% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed in this section below.

From October 1, 2024 until the next rebase which incorporates cost reports from calendar year 2025 or later, an additional $4.21 will be included in the pass-through per diem for each provider.

5. Liability Insurance: The per diem for liability insurance is determined for each NF by dividing the facility's liability insurance cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period, or 80% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed in this section below.

   The cost standard CAP for the liability insurance component is established by bed group. The liability insurance per patient day allowable costs are arrayed from highest to lowest. One hundred and five percent (105.00%) of the 75th percentile for each bed group is then selected as the CAP or maximum rate. The cost standard then establishes the maximum allowable cost by bed group for the liability insurance component. For each facility the lesser of the facility-specific cost per diem or the CAP will be utilized for their final per diem.

6. Cost of Capital: At October 1, 2024, the SAV will be frozen from the values established at October 1, 2022. Inflation will be applied thereafter at each July 1 rate setting period, trended from midpoint of state-fiscal year 2025 to the midpoint of the current state fiscal year using the inflation factor as discussed in the section below. The SAV determination from October 1, 2022 will follow the methodology as described in this state plan.

   Implementation of a new Cost of Capital methodology is not to occur prior to October 1, 2025.

7. Quality: Facilities are eligible for quality based reimbursement via a per diem in the reimbursement rate. The total combined projected pool of dollars for quality is a total pool of $60,000,000 as of October 1, 2024. In subsequent years on an annual basis, this pool shall be inflated using the most recently published Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit or a comparable index, if this index ceases to be produced. The inflation factor, once set for a given rate period, is not adjusted as it represents what is a reasonable expectation for cost increases. The inflation factor will be applied from the mid-point of the prior state fiscal year rate period, to the mid-point of the state fiscal year rate period. This annual pool of dollars will then be split between the Quality Scoring Metrics and the Special Populations as shown below, with scores and related per-diems updated semi-annually:

Component	Percent of Quality/Special Populations Budget
Quality Scoring Metrics	90.00%
Special Populations	10.00%

a) Quality Measure Reimbursement: Quality outcome measures and associated measure cut points shall be established and contained in the policy document, "Quality Scoring Metrics and Special Population Determination." These measures shall be weighted out of 100 total available points per facility per semi-annual rate period. Changes to the "Quality Scoring Metrics and Special Population Determination" document shall be determined by the State based on the needs of the program or to align with any future changes to CMS scoring information. These changes shall be published to the State website. As of October 1, 2024, this information can be found at: https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

Quality scores shall be calculated each semi-annual rate period using the most recently available source data information available for the quality measures calculated in accordance with the published policy document "Quality Scoring Metrics and Special Population Determination."

b) Special Populations Reimbursement: The rate component is meant to offset additional costs associated with certain members with behavioral conditions as established and contained in the policy document, "Quality Scoring Metrics and Special Population Determination". Changes to the "Quality Scoring Metrics and Special Population Determination" document shall be determined by the State based on the needs of the program or to align with any future changes to CMS scoring information. These changes shall be published to the State's website. As of October 1, 2024, this information can be found at:
https://dhhr.wv.gov/bms/Provider/LTC/Pages/default.aspx

The rate component will based on the most recently available semiannual MDS assessment data prior to each semi-annual rate calculation and paid claims from the same time period.

c) These payments will be calculated as follows:

(1) Quality Measure Reimbursement:

(a) The facility's percentage of the projected annual payment pool

(i) Quality score adjusted Medicaid days / Total statewide quality adjusted Medicaid days

(a) Quality adjusted Medicaid days

(i) Facility's semi-annual quality score / 100 points possible multiplied by Medicaid days
(ii) Medicaid days from the most recently reviewed cost report at the time of payment calculation or Medicaid days from the state MMIS data at the discretion of the State.

(iii) For new providers, should no days be available at the time of calculation, the Medicaid days shall be set at the statewide average occupancy percentage, as of the date of the calculation, of the available bed days for one calendar year.

(b) Multiplied by the total projected annual quality measures payment pool

(2) Special Populations Reimbursement

(a) The facility's allocation of the projected annual payment pool

(i) Semi-Annual Special Population adjusted Medicaid days / Total statewide Semi-Annual Special Population adjusted Medicaid days

(a) Special Population Adjusted Medicaid Days

(b) Number of Qualifying Medicaid Assessments / Total Statewide Number of Qualifying Medicaid Assessments from the same period multiplied by Medicaid days

(i) Medicaid days shall come from the most recently reviewed cost report at the time of payment calculation or Medicaid days from the state MMIS data at the discretion of the State.

(ii) For new providers, should no days be available at the time of calculation, the Medicaid days shall be set at the statewide average occupancy percentage, as of the date of the calculation, of the available bed days for one calendar year.

(b)Multiplied by the total projected annual special populations payment pool

(3) Per Diem Determination: The total semi-annual quality per diem is calculated by summing the quality measure allocation, and the allocation of the special population's reimbursement. This amount will then be divided by total annualized Medicaid days from the most recently reviewed cost report available at the time of rate determination to set the semi-annual quality per diem

8. Phase-in Adjustment: To aid in the transition of rate setting methodologies, a blended rate approach will be utilized to phase-in the new reimbursement rate from the estimated acuity adjusted prior system reimbursement rate. This phase-in will be in effect until June 30, 2027. The phase-in process will be calculated as follows:

(a) A NF provider's base reimbursement rate under RUGs will be established as the October 1, 2023 imputed NF RUG reimbursement rate at the time of rate calculation. Projected provider reimbursement rates will be calculated using all applicable reimbursement provisions specified within this chapter as of October 1, 2023. These base rates will be inflated utilizing trended CPI IHS Market Basket from December 31, 2022 to June 30, 2024. Projected calculated rates will utilize Medicaid billed CMI information from January 1, 2023 through June 30, 2023 to impute an expected CMI adjusted prospective rate.

(1) Beginning with the October 1, 2024 rate period, a phase-in adjustment factor of 100.940% will be applied to each provider's base reimbursement rate. The final adjusted base rate will be the base rate, which will be inflated at the beginning of each current state fiscal year utilizing the inflation factor as discussed in the section below, from the midpoint of state fiscal year 2025 to the midpoint of the current state fiscal year until the phase-in expires.

(b) The providers' current PDPM-based reimbursement rate will be determined according to the rate calculation procedures identified in this chapter as of October 1, 2024. Rate components considered include Direct Care, Care Related, Operational, Pass Through (inclusive of any associated add-on), Liability Insurance, Cost of Capital, and Quality. Projected calculated rates will utilize the most recent semi-annual period, as of the date of each rate calculation, of Medicaid billed CMI information to impute an expected CMI adjusted prospective rate. If Medicaid billed PDPM CMI information is not available, the most recent semi-annual MDS assessment information will be utilized in its place. At January 1, 2025, January 1, 2026, and January 1, 2027 the projected rates for use in blending will utilize all the same components as July 1, 2024, July 1, 2025, and July 1, 2026, respectively, with the exception of the semi-annual update to the quality component.

(c) The blended rate shall be calculated using the following percentages:

Rate Effective Date	Percentage of Base Reimbursement Rate	Percentage of Current PDPM-based Reimbursement Rate
October 1, 2024	75%	25%
January 1, 2025	75%	25%
July 1, 2025	50%	50%
January 1, 2026	50%	50%
July 1, 2026	25%	75%
January 1, 2027	25%	75%
July 1, 2027	0%	100%

(d) Once the blended rate has been determined, the difference between the blended rate and the providers' current PDPM-based reimbursement rate shall be calculated. This difference shall be the phase-in blended adjustment, which shall be its own rate component.

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

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

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 records 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 the State staff (or their representatives) 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 OAMR 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.

VI. Bed Reservation Policy

For rate periods through September 30, 2024, a nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility. This is paid at the facility's established Medicaid base rate.

The facility's occupancy must be 95% or greater as of midnight on the day immediately before the time that the resident leaves and there must be a current waiting list for admission to the nursing facility. The midnight census must be obtained daily and kept either in hard copy or electronic format and must contain, at a minimum, the names and ID numbers for each resident. A waiting list for admission must be maintained either in hard copy or electronic format by day and must contain, at a minimum, the names, addresses and contact numbers of the individuals on the waiting list and must be available immediately upon request by the State.

A day of leave is defined as a continuous 24-hour period. At the time the resident leaves the facility, the primary payer for services must be Medicaid. Bed reservation days may be for acute care hospitalization or a therapeutic leave.

The resident whose bed is reserved is to be accepted by the facility immediately upon discharge from the hospital or return from therapeutic leave. Placement is to be in the same bed and living space occupied by the resident prior to the hospital or therapeutic leave of absence unless the resident's physical condition upon returning to the facility prohibits access to the bed previously occupied. If the nursing facility discharges a resident and return is not anticipated, as indicated on the MDS, the facility cannot charge the State for a Medicaid bed hold.

When all hospital or therapeutic days have been used by a Medicaid resident, a facility may charge a resident to reserve a bed only when there are no vacancies and there is a current waiting list. Families that are willing and able are free to pay these charges, and the amount paid is not considered as a resource or income for Medicaid purposes.

Personal needs allowance may be used to reserve a bed only with the resident/member or responsible party's written consent. The resident's contribution to the cost of care (resource) may not be used to pay to reserve a bed. After a hospitalization or a leave of absence for which there was no bed hold, a former resident has the right to be re-admitted to the first available bed in a semi-private room in the nursing facility from which he or she came if the resident requires the services provided by the nursing facility and has not been out of the facility for more than 30 days.

A. Medical Leave of Absence

The medical leave of absence is payable for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, who is expected to return to the facility, and whose stay in the acute care facility is 24 hours or greater. The maximum number of medical leave of absence days which may be reimbursed for an individual for a medical leave of absence is 12 days in a calendar year (i.e., January 1 through December 31).

The resident's medical record must contain the physician's order, the date and time the resident is transferred to the hospital, and the date and time the resident returns to the reserved bed in the nursing facility. The day of transfer from the nursing facility to the hospital is counted as day one of the leave. If the Medicaid member returns to the nursing facility in less than 24 hours, this is not considered a leave day. If the resident expires in the hospital, is transferred to another facility, or goes home, that day must be considered the day of discharge from the nursing facility.

B. Therapeutic Leave of Absence

For a therapeutic leave of absence, such as a home visit, to be eligible for payment, the medical record must contain a physician's order for therapeutic leave and must be a part of the resident's plan of care. The maximum number of therapeutic leave of absence days which may be reimbursed for an individual resident is six days in a calendar year (i.e., January 1 through December 31).

The medical record of the individual requesting therapeutic leave must contain a physician's order, the date and time of the beginning of therapeutic leave, and the date and time the resident returns to the reserved bed in the nursing facility. For therapeutic leave, the date the member leaves the nursing facility is counted as a leave day and the day the resident returns to the facility is not counted as a therapeutic leave day.

VII. Bed Reservation Policy for rate periods beginning October 1, 2024

For rate periods beginning October 1, 2024, a nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility, for a maximum of 18 days during the calendar year. This is paid at the facility's non-acuity adjusted reimbursement rate. West Virginia Chapter 514 addresses details around this billing.

Definitions

A. **Administrator:** A person licensed by the West Virginia Nursing Home Administrators Licensing Board as a "Nursing Home Administrator" who is responsible and accountable for the day-to-day operations of the nursing facility.

B. **Ancillary Service:** A required service necessary to support the primary activities of the nursing facility to meet the resident's needs. However, these services are not included in the per diem rate.

C. **Base Period Cost Report:** A cost report that is six months or longer which is utilized for setting statewide prices and overall reimbursement rates.

D. **Base Reimbursement Rate:** The rate set under reimbursement methodology prior to October 1, 2024.

E. **Case Mix Reimbursement System:** A payment system that measures the intensity of care and services required for each resident. This translates into the amount of reimbursement given to the facility for care provided to each resident.

F. **Change of Ownership:** Any transaction that results in change of control over the capital assets of a nursing facility including, but not limited to, a conditional sale, a sale, a lease, or a transfer of title or controlling stock. The two most common types of change of ownership are asset purchase and stock transfer.

G. **Cost Average Point (CAP):** A calculation used in the reimbursement methodology for establishing rates in nursing facilities.

H. **Cost Report:** The instrument used in the reimbursement system for nursing facilities with rebasing rate adjustments. It is designed to treat all parties fairly and equitably, i.e., the resident, taxpayer, agency and facility. In order to be equitable, complete and accurate, cost data must be maintained by each facility with cost reports accurately prepared and submitted on a timely basis and in an approved format.

I. **Deficiency:** An entry on the federally mandated form provided by the State survey agency, the OHFLAC, which describes the specific requirements of the regulations with which the nursing facility failed to comply, an explicit statement that the requirement was not met, and the evidence to support the determination of noncompliance.

J. **Dually Certified Facility:** A facility which is certified to participate in both the Medicare and Medicaid programs.

K. **Minimum Data Set (MDS):** A core set of screening, clinical, and functional status elements completed by an IDT of which the resident is the principal member. It also includes common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid.

L.

M. **Non-Acuity Adjusted Reimbursement Rate:** All current rate components, including Direct Care, Care Related, Operational, Pass Through, Liability Insurance, Cost of Capital, Quality, and Phase-In Adjustment. No acuity adjustment is applied to this total rate for leave payment purposes.

N. **Nursing Facility Cost Report Period Case Mix Index:** The calendar day weighted average of all applicable all-payer case mix indices, carried to four (4) decimal places. The case mix index periods used in this weighted average will be the calendar day weighted assessments for the active cost reporting year.

O. **Patient Driven Payment Model (PDPM) Resident Classification System:** The resource utilization group used to classify residents. The nursing-only weights PDPM Grouper, or its successor, will be utilized for rate determination purposes beginning October 1, 2024.

P. **Per-diem Normalized Direct Care Cost:** The outcome of removing cost variations associated with case mix. Normalized cost is determined by dividing a provider's inflated per diem direct care case mix adjusted costs by its cost report period average case mix index (CMI).

Q. **RAI Manual:** Long-Term Care Facility Resident Assessment Instrument User's Manual.

R. **Rebase:** The process of reestablishing cost component prices, caps, and reimbursement rates by incorporating the most recently audited or reviewed qualifying cost reports.

S. **Resident:** Any individual residing in a nursing facility, skilled nursing facility, or dually certified skilled nursing facility/nursing facility. For the purpose of Medicaid reimbursement only, the resident may be identified as a member of the Medicaid program.

S. **The State**: The West Virginia Department of Human Services, Bureau for Medical