

**State of Board of Health  
Agenda  
December 5, 2013 – 11:00 a.m.  
Perimeter Center – Boardroom 2  
9960 Mayland Drive  
Richmond, Virginia 23233**

Call to Order and Welcome	Bruce Edwards, Chair
Pledge of Allegiance	Mr. Edwards
Introductions	Mr. Edwards
Review of Agenda	Joseph Hilbert Director of Governmental and Regulatory Affairs
Approval of September 12, 2013 Minutes	Mr. Edwards
Commissioner's Report	Cynthia C. Romero, MD, FAAFP State Health Commissioner
Abortion Facility Licensure Status Report	Erik Bodin, Director Office of Licensure and Certification
Regulatory Action Update	Mr. Hilbert
Working Lunch	
Lunch Speaker – Chip Decker, CEO, Richmond Ambulance Authority	
Public Comment Period	
<u>Regulatory Action Items</u>	
Rules and Regulations Governing Health Data Reporting 12VAC5-215 (Fast Track Amendments)	Debbie Condrey, Chief Information Officer, and Director, Office of Information Management
Member Reports	
Other Business	
Adjourn	



# COMMONWEALTH of VIRGINIA

*Department of Health*

P O BOX 2448  
RICHMOND, VA 23218

Cynthia C. Romero, MD, FAAFP  
STATE HEALTH COMMISSIONER

TTY 7-1-1 OR  
1-800-828-1120

## MEMORANDUM

DATE: November 19, 2013

TO: Virginia State Board of Health

FROM: Debbie Condrey, Chief Information Officer & Director of the Office of Information Management and Health IT

SUBJECT: Rules and Regulations Governing Health Data Reporting (12VAC5-215).

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Enclosed for your review is a Fast Track Action for the Rules and Regulations Governing Health Data Reporting (12VAC5-215).

To fulfill the statutory mandate to review regulations and protect the citizens of the Commonwealth, the Department conducted a periodic review of the Rules and Regulations Governing Health Data Reporting (12VAC5-215), and the Methodology to Measure Efficiency and Productivity of Health Care Institutions (12VAC5-216). As a result of that review, the Department determined the regulations included reporting requirements that are no longer necessary, and reports which are no longer collected by the Department. Additionally, combining the regulatory chapters created clearer and less burdensome regulatory requirements. The proposed amendments update the regulations to reflect current practice and have been drafted with input from stakeholders. The Department does not expect that this regulatory action will be controversial.

The Board of Health is requested to approve the Fast Track Action. Should the Board of Health approve the Fast Track Action, it shall be published in the Virginia Register of Regulations. After publication, a 30-day public comment period begins and a public comment forum on the Town Hall opens. Fifteen days after the close of the public comment period, the regulation becomes effective unless there is objection to the Fast Track regulation. If an objection is received from any member of the applicable standing committee of the Senate, any member of the applicable standing committee of the House of Delegates, any member of the Joint Commission on Administrative Rules or 10 or more members of the public, the Fast-Track regulation will serve as a Notice of Intended Regulatory Action and the standard rulemaking process shall be followed to promulgate the regulation.



Virginia  
Regulatory  
Town Hall

[townhall.virginia.gov](http://townhall.virginia.gov)

## Fast Track Proposed Regulation Agency Background Document

<b>Agency name</b>	Virginia Department of Health
<b>Virginia Administrative Code (VAC) citation</b>	12VAC5-215 (amendments) & 12VAC5-216 (repeal)
<b>Regulation title</b>	Rules and Regulations Governing Health Data Reporting & Methodology to Measure Efficiency and Productivity of Health Care Institutions
<b>Action title</b>	Combine regulatory chapters 215 and 216 as a result of periodic review for clarity, efficiency and effectiveness.
<b>Date this document prepared</b>	November 13, 2013

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 14 (2010) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual*.

### Brief summary

*Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes.*

The State Board of Health (Board) proposes to amend 12VAC5-215 *et seq.* "The Rules and Regulations Governing Health Data Reporting" and repeal 12VAC5-216 *et. seq.* "Methodology to Measure Efficiency and Productivity of Health Care Institutions." The purpose of this regulatory action is to combine both chapters to promote clarity, efficiency, effectiveness and ensure the regulations conform to current practice.

### Acronyms and Definitions

*Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.*

No acronyms are utilized within this Agency Background Document.

### Statement of final agency action

*Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.*

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These amendments to the Rules and Regulations Governing Health Data Reporting (12VAC5-215) and Methodology to Measure Efficiency and Productivity of Health Care Institutions (12VAC5-216) were approved by the State Board of Health, on \_\_\_\_\_.

### Legal basis

*Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority.*

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The regulation is promulgated under the authority of §32.1-12, and §32.1-276.2 through 32.1-276.11 of Chapter 7.2 of Title 32.1 of the Code of Virginia (Code). Section 32.1-12 of the Code grants the Board the legal authority "to make, adopt, promulgate, and enforce such regulations necessary to carry out the provisions of Title 32.1 of the Code." Section 32.1-276.2 of the Code requires the Board to administer the health care data reporting initiatives established by Chapter 7.2 of Title 32.1. The Board, pursuant to §§32.1-276.2 through 32.1-276.11 of the Code, is required to collect, analyze and make public certain financial data and findings relating to hospitals which operate within the Commonwealth of Virginia.

### Purpose

*Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.*

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The regulations are mandated by Chapter 7.2 of Title 32.1 of the Code. Section 32.1-276.5 of the Code elaborates which providers must submit data, Section 32.1-276.6 of the Code establishes reporting requirements, Section 32.1-276.7 of the Code establishes the methodology to review and measure the efficiency and productivity of health care providers, and Section 32.1-276.8 of the Code establishes the fees for processing, verification and dissemination of data. Each of these Code Sections requires that the Board promulgate regulations to carry out the mandate of the General Assembly. The regulations are essential to improve the quality and efficiency of health care, fostering competition among health care providers and increasing consumer choice, thus protecting the health and welfare of citizens (Code Section 32.1-276.2)

To fulfill the statutory mandate to review regulations and to protect the citizens of the Commonwealth, the Virginia Department of Health (Department) conducted a periodic review of 12VAC5-215 and 12VAC5-216 pursuant to Executive Order (EO) 14 (2010). As a result of this review, the Department plans to begin the regulatory process to amend these regulations.

During the review it was noted the regulations included reporting requirements that are no longer necessary and reports which are no longer collected by the Department. It was further noted that if the regulatory chapters were to be combined the regulatory requirements would be clearer, more effective and less burdensome. The goal and purpose of this regulatory action is to remove unnecessary regulations and create clearer, more effective and less burdensome regulations.

### Rationale for using fast track process

*Please explain the rationale for using the fast track process in promulgating this regulation. Why do you expect this rulemaking to be noncontroversial?*

*Please note: If an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall (i) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.*

These amendments update the regulations to reflect current practice and have been drafted with input from stakeholders. The Department does not expect that this regulatory action will be controversial.

### Substance

*Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (Provide more detail about these changes in the "Detail of changes" section.) Please be sure to define any acronyms.*

12VAC5-215-10. Definitions. Amend this section to update outdated definitions. Add missing definitions. Clarifying language.

12VAC5-215-20. Limitations. The substantive elements of this section were previously located in 12VAC5-216-10. Unnecessary language was removed from the previous 12VAC5-216-10.

12VAC5-215-30 Eliminating duplication in reporting. The substantive elements of this section were previously located in 12VAC5-216-30. An improper Code citation has been removed.

12VAC5-215-40 Categories of information. The substantive elements of this section were previously located in 12VAC5-216-40. The language of that section was amended to provide clarifying language.

12VAC5-215-50 Efficiency and productivity indicator. The substantive elements of this section were previously located in 12VAC5-216-50. The language of that section was amended to update references to classification systems.

12VAC5-215-60. Public access to data. The substantive elements of this section were previously located in 12VAC5-216-70 and 12VAC5-215-190. The language of those sections were amended to provide clarifying information regarding what information is available to the public on the electronic database.

12VAC5-215-70. Annual historical performance filing. The substantive elements of this section were previously located in 12VAC5-215-50 and 12VAC5-216-20. The language of those sections were amended to provide clarifying language, remove inaccurate Code citations and remove unnecessary and confusing language.

12VAC5-215-80. Electronic submission of data. The substantive elements of this section were previously located in 12VAC5-216-60 and 12VAC5-215-130. The language of those sections were amended due to a necessary stylistic change.

12VAC5-215-90. Fees. The substantive elements of this section were previously located in 12VAC5-215-140.

12VAC5-215-100. Schedule. The substantive elements of this section were previously located in 12VAC5-215-150.

12VAC5-215-110. Late Charges. The substantive elements of this section were previously located in 12VAC5-215-160. The language of this section was amended to remove references to sections the agency proposes repealing.

12VAC5-215-120. Ranking other peer groupings. The substantive elements of this section were previously located in 12VAC5-216-90.

12VAC5-215-130. Exemptions from the ranking procedure. The substantive elements of this section were previously located in 12VAC5-216-100.

12VAC5-215-140. Statistical data. The substantive elements of this section were previously located in 12VAC5-215-210. The language of this section was amended to update a Code reference.

The agency proposes repealing all other sections in Chapter 215 and 216.

**Issues**

*Please identify the issues associated with the proposed regulatory action, including:*

- 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;*
- 2) the primary advantages and disadvantages to the agency or the Commonwealth; and*
- 3) other pertinent matters of interest to the regulated community, government officials, and the public.*

*If there are no disadvantages to the public or the Commonwealth, please indicate.*

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The primary advantages of the regulatory action to the public, the agency, the regulated entities and the Commonwealth is clearer and less burdensome regulations. There are no known disadvantages related to the regulatory action.

**Requirements more restrictive than federal**

*Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.*

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There are no requirements in this proposal that exceed federal requirements.

**Localities particularly affected**

*Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.*

No locality will be particularly affected by the proposed regulation.

**Regulatory flexibility analysis**

*Pursuant to §2.2-4007.1B of the Code of Virginia, please describe the agency’s analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.*

The alternative regulatory methods are not applicable. The regulations are mandated by Chapter 7.2 of Title 32.1 of the Code. Section 32.1-276.5 of the Code elaborates which providers must submit data, Section 32.1-276.6 of the Code establishes reporting requirements, Section 32.1-276.7 of the Code establishes the methodology to review and measure the efficiency and productivity of health care providers, and Section 32.1-276.8 of the Code establishes the fees for processing, verification and dissemination of data. Each of these Code Sections requires that the Board promulgate regulations to carry out the mandate of the General Assembly. These statutory requirements provide little regulatory flexibility.

As a result of a periodic review the Department found that 12VAC5-215 and 12VAC5-216 included reporting requirements that are no longer necessary and reports which are no longer collected by the Department. It was further noted that if the regulatory chapters were to be combined the regulatory requirements would be clearer, more effective and less burdensome. The goal of this regulatory action is to create clearer, more effective and less burdensome regulations.

**Economic impact**

*Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact. Please keep in mind that we are looking at the impact of the proposed changes to the status quo.*

<p><b>Description of the individuals, businesses or other entities likely to be affected (positively or negatively) by this regulatory proposal.</b> Think broadly, e.g., these entities may or may not be regulated by this board</p>	<p>Virginia Health Information, and health care institutions across the Commonwealth</p>
<p><b>Agency’s best estimate of the number of (1) entities that will be affected, including (2) small businesses affected.</b> Small business means a</p>	<p>The Virginia Department of Health licenses 105 hospitals across the Commonwealth. The Department of Behavioral Health and</p>

business, including affiliates, that is independently owned and operated, employs fewer than 500 full-time employees, or has gross annual sales of less than \$6 million.	Developmental Services operates 16 state hospital facilities across the Commonwealth.
<b>Benefits expected as a result of this regulatory proposal.</b>	Clearer, more effective and less burdensome regulations
<b>Projected cost to the <u>state</u> to implement and enforce this regulatory proposal.</b>	Projected cost to the state is negligible.
<b>Projected cost to <u>localities</u> to implement and enforce this regulatory proposal.</b>	No projected cost is foreseen to implement and enforce this regulatory proposal.
<b>All projected costs of this regulatory proposal for <u>affected individuals, businesses, or other entities</u>.</b> Please be specific and include all costs, including projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses, and costs related to real estate development.	None. The regulatory amendments simply combine the two chapters and conform the regulations to current practice.

**Alternatives**

*Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.*

There are no other viable alternatives other than the proposed amendments to simplify the current regulations to be less burdensome, while also continuing to fulfill the Board’s statutory mandate to establish effective health care data analysis and reporting initiatives to improve the quality and efficiency of health care, foster competition among health care providers and increase consumer choice with regard to health care services in the Commonwealth (Section 32.1-276.2 of the Code). The regulations are mandated by Chapter 7.2 of Title 32.1 of the Code. Section 32.1-276.5 of the Code elaborates which providers must submit data, Section 32.1-276.6 of the Code establishes reporting requirements, Section 32.1-276.7 of the Code establishes the methodology to review and measure the efficiency and productivity of health care providers, and Section 32.1-276.8 of the Code establishes the fees for processing, verification and dissemination of data. Each of these Code Sections requires that the Board promulgate regulations to carry out the mandate of the General Assembly. These statutory requirements provide little regulatory flexibility.

**Periodic review and small business impact review report of findings**

***If this fast-track regulation is not the result of a periodic review and/or small business impact review report of the regulation, please delete this entire section.***

*If this fast-track regulation is the result of a periodic review, please (1) summarize all comments received during the public comment period following the publication of the Notice of Periodic Review, and (2) indicate whether the regulation meets the criteria set out in Executive Order 14 (2010), e.g., is necessary for the protection of public health, safety, and welfare, and is clearly written and easily understandable.*

*If this fast-track regulation is also a small business impact review report of the regulation, pursuant to § 2.2-4007.1 E and F, a discussion of the agency’s consideration of: (1) the continued need for the*

regulation; (2) the nature of complaints or comments received concerning the regulation from the public; (3) the complexity of the regulation; (4) the extent to which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation is required.

No comments were received from the public during the recent periodic review. There is a continued need for the regulation as it is mandated by law. The Department has not received any complaints or comments concerning the regulation from the public. With the proposed amendments the regulation is clearly written and easily understandable and the Department is confident based on this most recent review that the regulation does not overlap, duplicate or conflict with federal state law or regulation.

**Family impact**

*Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.*

The Board has assessed the impact the proposed amendments will have on the institution of the family and family stability. The Board anticipates no impact to the family or family stability.

**Detail of changes**

*Please list all changes that are being proposed and the consequences of the proposed changes. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action.*

*If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all differences between the **pre-emergency** regulation and this proposed regulation, and (2) only changes made since the publication of the emergency regulation.*

For changes to existing regulation(s) or regulations that are being repealed and replaced, use this chart:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
215-10 Definitions.		The following words and terms, when used in this chapter, shall have the following meanings:  "Adjusted patient days" means inpatient days divided by the percentage of	The following words and terms, when used in this chapter, shall have the following meanings:  "Adjusted patient days" means inpatient days divided by the percentage of inpatient revenues to total patient

		<p>inpatient revenues to total patient revenues.</p> <p>"Board" means the Board of Health.</p> <p>"Certified nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare or Medicaid provider, or both, pursuant to § 32.1-137 of the Code of Virginia.</p> <p>"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.</p> <p>"Health care institution" means (i) a general hospital, ordinary hospital, or outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, (ii) a mental or psychiatric hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1 of the Code of Virginia or (iii) a hospital operated by the University of Virginia or Virginia Commonwealth</p>	<p>revenues.</p> <p><u>"Annual historical performance filing" means facility specific financial indicators that include revenue, deductions from revenue, expenses, assets, liabilities and patient days by payor.</u></p> <p>"Board" means the Board of Health.</p> <p>"Certified nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare or Medicaid provider, or both, pursuant to § 32.1-137 of the Code of Virginia.</p> <p><del>"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.</del></p> <p>"Health care institution" means (i) a general hospital, ordinary hospital, or outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, (ii) a mental or psychiatric hospital licensed pursuant to Chapter <del>48</del> (§ <del>37.1-179</del>§ <u>37.2-403</u> et seq.) of <del>Title 37.1</del><u>Title 37.2</u> of the Code of Virginia or (iii) a hospital operated by <u>the Department of Behavioral Health and Developmental Services</u> <del>the University of Virginia or Virginia Commonwealth University</del>. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia, any physician's office, nursing</p>
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		<p>University. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia, any physician's office, nursing care facility of a religious body which depends upon prayer alone for healing, independent laboratory or outpatient clinic.</p> <p>"Hospital" means any facility licensed pursuant to § 32.1-123 et seq. or § 37.1-179 et seq. of the Code of Virginia.</p> <p>"Late charge" means a fee that is assessed a health care institution that submits any of the board's filings past the due date.</p> <p>"Nursing home" means any facility or any identifiable component of any facility licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.</p> <p>"Patient day" means a unit of measure denoting lodging</p>	<p>care facility of a religious body which depends upon prayer alone for healing, independent laboratory or outpatient clinic.</p> <p>"Hospital" means any facility licensed pursuant to § 32.1-123 et seq. or <del>§ 37.1-179</del> <u>§ 37.2-403</u> et seq. of the Code of Virginia <u>or a hospital operated by the Department of Behavioral Health and Developmental Services for the care and treatment of individuals with mental illness.</u></p> <p><del>"Late charge" means a fee that is assessed a health care institution that submits any of the board's filings past the due date.</del></p> <p><u>"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise and capacity to execute the powers and duties set forth for such entity in Chapter 7.2 (§ 32.1-276.2 et seq.) of Title 32.1 of the Code of Virginia and with which the Commissioner of Health has entered into a contract as required by the Code of Virginia.</u></p> <p>"Nursing home" means any facility or any identifiable component of any facility licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.</p> <p>"Patient day" means a unit of measure denoting lodging facilities provided and services rendered to one inpatient, between census-taking-hour on two successive days. The day of admission but not the day of discharge or death is counted a patient day. If both admission and discharge or death occur on the</p>
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		<p>facilities provided and services rendered to one inpatient, between census-taking-hour on two successive days. The day of admission but not the day of discharge or death is counted a patient day. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day. For purposes of filing fees to the board, newborn patient days would be added. For a medical facility, such as an ambulatory surgery center, which does not provide inpatient services, each patient undergoing surgery during any one 24-hour period will be equivalent to one patient day.</p>	<p>same day, the day is considered a day of admission and counts as one patient day. For purposes of filing fees to the board, newborn patient days would be added. For a medical facility, such as an ambulatory surgery center, which does not provide inpatient services, each patient undergoing surgery <del>during any one</del> <u>which occurs in less than a 24-hour period</u> <del>will</del> <u>shall</u> be equivalent to one patient day.</p> <p>Intent: Provide the definition for annual historical performance filing and nonprofit organization, remove the unnecessary definition of consumer and late charge, correct the definitions of health care institution, hospital and patient day.</p> <p>Likely impact: Greater clarity and efficacy of the regulations.</p>
<p>215-20 Authority for regulations- Limitations</p>		<p>The board, by §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia, is required to collect, analyze and make public certain financial data and findings relating to hospitals which operate within the Commonwealth of Virginia. Sections 32.1-276.7 and 32.1-276.8 of the Code of Virginia direct the board from time to time to make such rules and regulations as may be necessary to carry out its responsibilities as prescribed in the Code of Virginia.</p>	<p><del>The board, by §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia, is required to collect, analyze and make public certain financial data and findings relating to hospitals which operate within the Commonwealth of Virginia. Sections 32.1-276.7 and 32.1-276.8 of the Code of Virginia direct the board from time to time to make such rules and regulations as may be necessary to carry out its responsibilities as prescribed in the Code of Virginia. Nothing in this chapter or the actions taken by the board pursuant to any of its provisions shall be construed as constituting approval by the Commonwealth or any of its agencies or officers of the reasonableness of any charges made or costs incurred by any health care institution.</del></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-216-10. Unnecessary language was removed from this section.</p> <p>Likely impact: Greater clarity and efficacy of the regulations.</p>
<p>215-30-</p>		<p>A. The board has</p>	<p>A. The board has promulgated these</p>

<p><del>Purpose, administration, application, and effective date of rules and regulations. <u>Eliminating duplication in reporting</u></del></p>		<p>promulgated these rules and regulations to set forth an orderly administrative process by which the board may govern its own affairs and require compliance with the provisions of §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia.</p> <p>B. These rules and regulations are administered by the board.</p> <p>C. These rules and regulations have general applicability throughout the Commonwealth. The requirements of the Virginia Administrative Process Act, codified as § 9-6.14:1 et seq. of the Code of Virginia, apply to their promulgation.</p> <p>D. These rules and regulations or any subsequent amendment, modification, or deletion in connection with these rules and regulations shall become effective 30 days after the final regulation is published in The Virginia Register.</p>	<p><del>rules and regulations to set forth an orderly administrative process by which the board may govern its own affairs and require compliance with the provisions of §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia.</del></p> <p><del>B. These rules and regulations are administered by the board.</del></p> <p><del>C. These rules and regulations have general applicability throughout the Commonwealth. The requirements of the Virginia Administrative Process Act, codified as § 9-6.14:1 et seq. of the Code of Virginia, apply to their promulgation.</del></p> <p><del>D. These rules and regulations or any subsequent amendment, modification, or deletion in connection with these rules and regulations shall become effective 30 days after the final regulation is published in The Virginia Register. The board shall direct the nonprofit to obtain information that is collected by other public and private entities that is used by the board in its evaluation of efficiency and productivity directly from the appropriate agency or entity. Data shall also be drawn from the Virginia Patient Level Data System and from other available data bases.</del></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-216-30. An improper Code citation was removed from that section and clarifying language was added.</p> <p>Likely impact: Greater clarity and efficacy of the regulations.</p>
<p><del>215-40- Powers and procedures of regulations not exclusive. <u>Categories of information</u></del></p>		<p>The board reserves the right to authorize any procedure for the enforcement of these regulations that is not inconsistent with the provision set forth herein and the provisions of §§ 32.1-27 and 32.1-276.11 of the Code of Virginia.</p>	<p><del>The board reserves the right to authorize any procedure for the enforcement of these regulations that is not inconsistent with the provision set forth herein and the provisions of §§ 32.1-27 and 32.1-276.11 of the Code of Virginia. The board shall direct the nonprofit to assemble information concerning charges, costs, elements of costs, efficiency, productivity, resource utilization, financial viability, and</del></p>

			<p><u>community support services from the filings made pursuant to this chapter.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-216-40. Clarifying language was added to the language from that previous section.</p> <p>Likely impact: Greater clarity and efficacy of the regulations.</p>
<p>215-50- Annual historical filing- Efficiency and Productivity Indicator.</p>		<p>Each individual health care institution shall submit an annual historical filing of revenues, expenses, other income, other outlays, assets and liabilities, units of service, and related statistics as prescribed in § 9-158 (Repealed) of the Code of Virginia on forms provided by the board together with unconsolidated certified audited financial statements. If the health care institution is part of a publicly held company, the individual institution may submit unconsolidated unaudited financial statements. Investor-owned institutions organized as proprietorships, partnerships, or S-corporations that impute income tax on the annual historical filing report an imputed income tax based on the maximum tax rates for federal and state income. The combined rate for 1989 is equal to 34% for individuals and 40% for corporations. Operating losses may be carried forward no more than five years but may not be carried back to prior years. The schedule of imputed income taxes shall be reported as a note to the financial statements or as a supplemental schedule of the certified audited financial</p>	<p><del>Each individual health care institution shall submit an annual historical filing of revenues, expenses, other income, other outlays, assets and liabilities, units of service, and related statistics as prescribed in § 9-158 (Repealed) of the Code of Virginia on forms provided by the board together with unconsolidated certified audited financial statements. If the health care institution is part of a publicly held company, the individual institution may submit unconsolidated unaudited financial statements. Investor-owned institutions organized as proprietorships, partnerships, or S-corporations that impute income tax on the annual historical filing report an imputed income tax based on the maximum tax rates for federal and state income. The combined rate for 1989 is equal to 34% for individuals and 40% for corporations. Operating losses may be carried forward no more than five years but may not be carried back to prior years. The schedule of imputed income taxes shall be reported as a note to the financial statements or as a supplemental schedule of the certified audited financial statements submitted to the board by the institution. The annual historical filing and the unconsolidated certified audited financial statement shall be received by the board no later than 120 days after the end of the respective applicable health care institution's fiscal year. The requirement for the submission of an annual historical filing and an unconsolidated certified audited financial statement may be waived if a health care institution can show that an extenuating circumstance exists. Requests for a waiver must be submitted in writing prior to the due</del></p>

		<p>statements submitted to the board by the institution. The annual historical filing and the unconsolidated certified audited financial statement shall be received by the board no later than 120 days after the end of the respective applicable health care institution's fiscal year. The requirement for the submission of an annual historical filing and an unconsolidated certified audited financial statement may be waived if a health care institution can show that an extenuating circumstance exists. Requests for a waiver must be submitted in writing prior to the due date. Examples of an extenuating circumstance include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.</p> <p>Each health care institution with licensed nursing home beds or certified nursing facility beds shall exclude all revenues, expenses, other income, other outlays, assets and liabilities, units of service and related statistics directly associated with a hospital, continuing care retirement community, or with adult care residence beds in the annual report filed with the board. For those health care institutions that participate in either the Medicare or Medicaid program, the cost allocation methodology required by the Virginia Department of Medical Assistance Services and Medicare for cost</p>	<p><del>date. Examples of an extenuating circumstance include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.</del></p> <p><del>Each health care institution with licensed nursing home beds or certified nursing facility beds shall exclude all revenues, expenses, other income, other outlays, assets and liabilities, units of service and related statistics directly associated with a hospital, continuing care retirement community, or with adult care residence beds in the annual report filed with the board. For those health care institutions that participate in either the Medicare or Medicaid program, the cost allocation methodology required by the Virginia Department of Medical Assistance Services and Medicare for cost reports submitted to it shall be utilized for filings submitted to the board. Any health care institution that does not participate in the Medicare or Medicaid program may develop and utilize an alternative methodology to determine the nursing home portion of its costs if it chooses not to utilize the cost allocation methodology used by the Department of Medical Assistance Services and Medicare. That methodology shall then be approved by the board and the health care institution must continue to utilize that methodology for all subsequent filings unless a subsequent change is approved by the board.</del></p> <p><u>Individual data elements from the general categories identified in 12VAC5-215-40 shall be used to form ratio indicators. These indicators shall be used to evaluate health care institutions and rank health care institutions in relation to their peers. These indicators shall include:</u></p> <p><u>1. Case mix index. Using the 3M APR DRG Classification system, the non-profit shall calculate a case-mix index utilizing Virginia patient level data for each licensed hospital.</u></p>
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		<p>reports submitted to it shall be utilized for filings submitted to the board. Any health care institution that does not participate in the Medicare or Medicaid program may develop and utilize an alternative methodology to determine the nursing home portion of its costs if it chooses not to utilize the cost allocation methodology used by the Department of Medical Assistance Services and Medicare. That methodology shall then be approved by the board and the health care institution must continue to utilize that methodology for all subsequent filings unless a subsequent change is approved by the board.</p>	<p><u>2. Each nursing home that has received a Resource Utilization Groups Systems (RUGS) Service Intensity Index (SII) number from the Virginia Department of Medical Assistance Services shall report the four quarterly final RUGS SSI scores associated with its fiscal year. These scores are to be reported on the institution's annual historical performance filing.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-216-50. Clarifying language was added to the language from that previous section to update the references to the classification systems.</p> <p>Likely impact: Greater clarity and efficacy of the regulations.</p>
<p>12VAC5-215-60 <u>Schedule of charges. Public access to data</u></p>		<p>Each health care institution shall file annually a schedule of charges to be in effect on the first day of such fiscal year, as prescribed in § 9-159 A 3 (Repealed) of the Code of Virginia. The institution's schedule of charges shall be received by the board within 10 days after the beginning of its respective applicable fiscal year.</p> <p>Any subsequent amendment or modification to the annually filed schedule of charges shall be filed within 10 days of the effective date of the revised annual projection. In addition to the requirement above, a new schedule of charges must be submitted if any of the following conditions exist: (i) the creation or revision of a markup or pricing methodology, or (ii) the</p>	<p><del>Each health care institution shall file annually a schedule of charges to be in effect on the first day of such fiscal year, as prescribed in § 9-159 A 3 (Repealed) of the Code of Virginia. The institution's schedule of charges shall be received by the board within 10 days after the beginning of its respective applicable fiscal year.</del></p> <p><del>Any subsequent amendment or modification to the annually filed schedule of charges shall be filed within 10 days of the effective date of the revised annual projection. In addition to the requirement above, a new schedule of charges must be submitted if any of the following conditions exist: (i) the creation or revision of a markup or pricing methodology, or (ii) the creation or revision of charges for new services or products. Amendments or modifications to a schedule of charges that are due only to cost adjustments resulting from the pass through of a markup or pricing methodology that had been implemented since the beginning of the fiscal year are considered minimal and need not be reported. The board</del></p>

		<p>creation or revision of charges for new services or products. Amendments or modifications to a schedule of charges that are due only to cost adjustments resulting from the pass through of a markup or pricing methodology that had been implemented since the beginning of the fiscal year are considered minimal and need not be reported.</p>	<p><u>shall direct the nonprofit to publish an annual report which incorporates the data collected and analysis of the data including, but not limited to an evaluation of the relative efficiency, productivity of health care institutions, cost per admission comparison, cost per patient day comparison, percentage increase in cost per patient day, operating profits and losses, deductions from revenue (contractuals, bad debts, and charity care) and utilization. An electronic database open to the public shall contain information drawn from audited financial statements and detailed operational information provided by facilities required by law to report. The topics included in the database include but are not limited to: cardiac care, hospital patient satisfaction, outpatient procedures, obstetrics, and health care prices. Patient, physician and employer identifying information shall not be included in the database. Information from mental or psychiatric hospital licensed pursuant to Chapter 4 Title 37.2 of the Code of Virginia or hospitals operated by the Department of Behavioral Health and Developmental Services shall not be included in the database.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-216-70 and 12VAC5-215-190. Language was added to the language from that previous section to clarify the information available to the public on the electronic database.</p> <p>Likely impact: Greater clarity and efficacy of the regulations.</p>
<p>12VAC5-215-70 - <u>Survey of rates. Annual historical performance filing.</u></p>		<p>Each health care institution shall file annually a survey of rates charged. For hospitals, the survey shall consist of up to 30 select charges, including semi-private and private room rates. The survey shall also consist of charges of the most frequently occurring diagnoses or procedures for inpatient and outpatient</p>	<p><del>Each health care institution shall file annually a survey of rates charged. For hospitals, the survey shall consist of up to 30 select charges, including semi-private and private room rates. The survey shall also consist of charges of the most frequently occurring diagnoses or procedures for inpatient and outpatient treatment. The charges shall be calculated by taking an average for one month of all patient bills where the requested CPT or ICD-9 code numbers</del></p>

		<p>treatment. The charges shall be calculated by taking an average for one month of all patient bills where the requested CPT or ICD-9 code numbers are indicated as the principal diagnosis or procedure. For hospitals this information shall be received by the board no later than April 30 of each year.</p> <p>The annual charge survey for nursing homes shall include up to 30 select charges, including semi-private and private room rates. The select charges shall reflect the rates in effect as of the first day of a sample month to be chosen by the board. For nursing homes this information shall be received by the board no later than March 31 of each year.</p>	<p><del>are indicated as the principal diagnosis or procedure. For hospitals this information shall be received by the board no later than April 30 of each year.</del></p> <p><del>The annual charge survey for nursing homes shall include up to 30 select charges, including semi-private and private room rates. The select charges shall reflect the rates in effect as of the first day of a sample month to be chosen by the board. For nursing homes this information shall be received by the board no later than March 31 of each year.</del></p> <p><u>Each individual health care institution shall submit an annual historical performance filing on forms provided by the board together with unconsolidated certified audited financial statements. If the health care institution is part of a publicly held company, the individual institution may submit unconsolidated unaudited financial statements with the annual historical performance filing. Investor-owned institutions organized as proprietorships, partnerships, or S-corporations that impute income tax on the annual historical performance filing shall report an imputed income tax based on the maximum tax rates for federal and state income. Operating losses may be carried forward no more than five years but shall not be carried back to prior years. The schedule of imputed income taxes shall be reported as a note to the financial statements or as a supplemental schedule of the certified audited financial statements submitted to the board by the health care institution. The annual historical performance filing and the unconsolidated certified audited financial statement, or unconsolidated unaudited financial statements submitted by publicly held companies shall be received by the board no later than 120 days after the end of the health care institution's fiscal year. The requirement for the submission of an annual historical performance filing and an unconsolidated certified audited financial statement or unconsolidated</u></p>
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			<p><u>unaudited financial statements submitted by publicly held companies may be waived if a health care institution can show that an extenuating circumstance exists. Requests for a waiver shall be submitted to the board in writing prior to the due date. Examples of an extenuating circumstance include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.</u></p> <p><u>Each health care institution with licensed nursing home beds or certified nursing facility beds shall exclude all revenues, expenses, other income, other outlays, assets and liabilities, units of service and related statistics directly associated with a hospital, continuing care retirement community, or with adult care residence beds in the annual historical performance filing submitted to the board. For those health care institutions that participate in either the Medicare or Medicaid program, the cost allocation methodology required by the Virginia Department of Medical Assistance Services and Medicare for cost reports submitted to it shall be utilized for filings submitted to the board. Any health care institution that does not participate in the Medicare or Medicaid program may develop and utilize an alternative methodology to determine the nursing home portion of its costs if it chooses not to utilize the cost allocation methodology used by the Department of Medical Assistance Services and Medicare. That methodology shall then be approved by the board and the health care institution must continue to utilize that methodology for all subsequent filing unless a subsequent change is approved by the board.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-215-50 and 12VAC5-216-20. Language was added to the language from that previous section to remove a reference to a repealed Code section and remove some unnecessary</p>
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			<p>language.</p> <p>Likely Impact: Greater clarity and efficacy of the regulations.</p>
<p>12VAC5-215-80  <del>Commercial diversification survey.</del>  <u>Electronic submission of data.</u></p>		<p>Each hospital or any corporation that controls a hospital shall respond to a survey conducted by the board to determine the extent of commercial diversification by such hospitals in the Commonwealth. The survey shall be in a form and manner prescribed by the board and shall request the information specified in subdivisions a through j below for each affiliate of such hospital or corporation, if any:</p> <p>a. The name and principal activity;</p> <p>b. The date of the affiliation;</p> <p>c. The nature of the affiliation;</p> <p>d. The method by which each affiliate was acquired or created;</p> <p>e. The tax status of each affiliate and, if tax-exempt, its Internal Revenue tax exemption code number;</p> <p>f. The total assets;</p> <p>g. The total revenues;</p> <p>h. The net profit after taxes, or if not-for-profit, its excess revenues;</p> <p>i. The net equity or, if not-for-profit, its fund balance; and</p> <p>j. Information regarding related party transactions.</p>	<p><del>Each hospital or any corporation that controls a hospital shall respond to a survey conducted by the board to determine the extent of commercial diversification by such hospitals in the Commonwealth. The survey shall be in a form and manner prescribed by the board and shall request the information specified in subdivisions a through j below for each affiliate of such hospital or corporation, if any:</del></p> <p><del>a. The name and principal activity;</del></p> <p><del>b. The date of the affiliation;</del></p> <p><del>c. The nature of the affiliation;</del></p> <p><del>d. The method by which each affiliate was acquired or created;</del></p> <p><del>e. The tax status of each affiliate and, if tax-exempt, its Internal Revenue tax exemption code number;</del></p> <p><del>f. The total assets;</del></p> <p><del>g. The total revenues;</del></p> <p><del>h. The net profit after taxes, or if not-for-profit, its excess revenues;</del></p> <p><del>i. The net equity or, if not-for-profit, its fund balance; and</del></p> <p><del>j. Information regarding related party transactions.</del></p> <p><u>All filings required by this chapter shall be made to the board, and must meet the following requirements:</u></p> <p><u>A. Information shall be submitted electronically.</u></p> <p><u>B. Information shall be submitted using software developed by the board for the use of health institutions in submitting</u></p>

			<p><u>filings.</u></p> <p><u>C. Any health care institution that does not have the computer equipment to submit electronically may apply to the board for an exemption to subsection B of this section. A fee commensurate with the cost of data entry shall be assessed by the board.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-216-60 and 12VAC5-215-130. Language was altered from the language of those previous sections to allow for a necessary stylistic change.</p> <p>Likely impact: Greater clarity and efficacy of the regulations.</p>
<p>12VAC5-215-90 <u>Affiliates. Fees.</u></p>		<p>The information specified in 12VAC5-215-80 shall relate to any legal controls that exist as of the hospital's fiscal year end. The response to the survey shall include the required information for all affiliates in which the hospital or any corporation which controls a hospital has a 25% or greater interest. Information regarding affiliates or organizations that do not have corporate headquarters in Virginia and that do no business in Virginia need not be provided.</p>	<p><del>The information specified in 12VAC5-215-80 shall relate to any legal controls that exist as of the hospital's fiscal year end. The response to the survey shall include the required information for all affiliates in which the hospital or any corporation which controls a hospital has a 25% or greater interest. Information regarding affiliates or organizations that do not have corporate headquarters in Virginia and that do no business in Virginia need not be provided.</del> <u>A fee based on an adjusted patient days rate shall be set by the board, based on the needs to meet annual board expenses. The fee shall be established at least annually and reviewed for its sufficiency at least annually by the board. All fees shall be paid directly to the board. The fee shall be no more than 11 cents per adjusted patient day for each health care institution. Prior to the beginning of each new fiscal year, the board shall determine a fee for hospitals and a fee for nursing homes based upon the board's proportionate costs of operation for review of hospital and nursing home filings in the current fiscal year, as well as the anticipated costs for such review in the upcoming year.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-215-140.</p>

<p>12VAC5-215-100 <del>Financial statement (healthcare institution)- Schedule.</del></p>		<p>Each hospital that reports to the board or any corporation which controls a hospital that reports to the board shall submit audited consolidated financial statements and consolidating financial schedules to the board which include its total assets, liabilities, revenues, expenses, and net worth.</p>	<p>Likely impact: Greater clarity and efficiency of the regulations.</p> <p><del>Each hospital that reports to the board or any corporation which controls a hospital that reports to the board shall submit audited consolidated financial statements and consolidating financial schedules to the board which include its total assets, liabilities, revenues, expenses, and net worth. Fifty percent of the fee shall be paid to the board no later than 30 days before the beginning of the health care institution's fiscal year. The fee shall be based on the health care institution's most recently submitted annual historical adjusted patient days. If there have been no previous annual historical performance filings, the health care institution's fee shall be based on its projected adjusted patient days for the fiscal year. The balance of the fee shall be paid to the board at the same time the health care institution submits its annual historical performance filing under the provisions of 12VAC5-215-70.</del></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-215-150.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-215-110 <del>Deadline. Late Charges.</del></p>		<p>The information required by 12VAC5-215-80, 12VAC5-215-90, and 12VAC5-215-100 shall be due 120 days after the hospital's fiscal year end.</p>	<p><del>The information required by 12VAC5-215-80, 12VAC5-215-90, and 12VAC5-215-100 shall be due 120 days after the hospital's fiscal year end.</del></p> <p>A. A late charge shall be paid to the board by a health care institution that files reports or fees past the due date. <u>The late charge may be waived if such a waiver is requested prior to the due date and the health care institution can show that an extenuating circumstance exists. Requests for waivers shall be submitted to the board in writing. Examples of extenuating circumstances include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.</u></p>

			<p><u>B. A late charge of \$10 per working day shall be paid to the board by a health care institution that files its annual historical performance filing, unconsolidated audited financial statements, unconsolidated unaudited financial statements filed by publicly held companies, schedule of imputed taxes, or fees past the due date.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-215-160. Language was altered from the language of that previous section to remove references to sections the agency proposes repealing.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-215-120 IRS Forms. <u>Ranking; other peer groupings.</u></p>		<p>Each health care institution that reports to the board, any corporation controlling a hospital, and each affiliate of the hospital or corporation that controls a hospital shall submit, if the health care institution, corporation, or affiliate is an organization exempt from taxes pursuant to § 501(C)(3) of the Internal Revenue Code, a copy of the most recent federal information return (Form 990) which was filed on behalf of the institution, corporation, or affiliate together with all accompanying schedules that are required to be made available to the public by the Internal Revenue Service. Information regarding not-for-profit affiliates which do no business in Virginia need not be submitted.</p> <p>The information required by this section shall be due to the board 120 days after the completion of the health care institution's fiscal year end. If the information return (Form 990) has not been filed with the Internal</p>	<p><del>Each health care institution that reports to the board, any corporation controlling a hospital, and each affiliate of the hospital or corporation that controls a hospital shall submit, if the health care institution, corporation, or affiliate is an organization exempt from taxes pursuant to § 501(C)(3) of the Internal Revenue Code, a copy of the most recent federal information return (Form 990) which was filed on behalf of the institution, corporation, or affiliate together with all accompanying schedules that are required to be made available to the public by the Internal Revenue Service. Information regarding not-for-profit affiliates which do no business in Virginia need not be submitted.</del></p> <p><del>The information required by this section shall be due to the board 120 days after the completion of the health care institution's fiscal year end. If the information return (Form 990) has not been filed with the Internal Revenue Service, the due date will be extended to no later than the normal due date to the IRS or any extensions granted.</del></p> <p><u>Unless exempted as provided for in 12VAC5-215-130, each health care institution shall be subject to the following geographical peer grouping</u></p>

		<p>Revenue Service, the due date will be extended to no later than the normal due date to the IRS or any extensions granted.</p>	<p><u>and ranking procedure.</u></p> <p>1. <u>Geographical peer grouping. Similar types of health care institutions (e.g., all hospitals or all nursing homes) shall be grouped into geographical peer groups and ranked in relation to other institutions within their peer group.</u></p> <p>2. <u>Ranking procedure. Each health care institution shall be ranked on each indicator and given a quartile score on each indicator. Each quartile represents 25% of institutions within the peer group. Each institution shall be given a score of 1, 2, 3, or 4 on each indicator depending upon the quartile in which it falls. A quartile score of 1 on an indicator means that an institution ranked in the top quartile (top 25%) on that indicator.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-216-90.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p><u>12VAC5-215-130 Filing Exemptions from the ranking procedure.</u></p>		<p>All filings required by this chapter will be made to the board.</p>	<p><del>All filings required by this chapter will be made to the board.</del> <u>Until such time as a resource utilization adjustor, similar to the case mix index for acute care hospitals referenced in subdivision 1 of 12VAC5-215-50 is developed and adopted by the board, some institutions shall be exempt from the ranking procedure as described below:</u></p> <ol style="list-style-type: none"> <li><u>1. Psychiatric hospitals.</u></li> <li><u>2. Rehabilitation hospitals.</u></li> <li><u>3. Ambulatory surgery hospitals.</u></li> <li><u>4. Critical access hospitals.</u></li> <li><u>5. Children's specialty hospitals.</u></li> <li><u>6. Subacute care hospitals. (Longterm acute care hospital.)</u></li> </ol> <p><u>Health care institutions may be sorted into other peer groupings (e.g., bed size,</u></p>

			<p><u>urban/rural, system/nonsystem) for the purposes of analysis.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-216-100.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-215-140 <del>Fees.</del> <u>Statistical data.</u></p>		<p>A fee based on an adjusted patient days rate shall be set by the board, based on the needs to meet annual board expenses. The fee shall be established at least annually and reviewed for its sufficiency at least annually by the board. All fees shall be paid directly to the board. The fee shall be no more than 11 cents per adjusted patient day for each health care institution. Prior to the beginning of each new fiscal year, the board shall determine a fee for hospitals and a fee for nursing homes based upon the board's proportionate costs of operation for review of hospital and nursing home filings in the current fiscal year, as well as the anticipated costs for such review in the upcoming year.</p>	<p><del>A fee based on an adjusted patient days rate shall be set by the board, based on the needs to meet annual board expenses. The fee shall be established at least annually and reviewed for its sufficiency at least annually by the board. All fees shall be paid directly to the board. The fee shall be no more than 11 cents per adjusted patient day for each health care institution. Prior to the beginning of each new fiscal year, the board shall determine a fee for hospitals and a fee for nursing homes based upon the board's proportionate costs of operation for review of hospital and nursing home filings in the current fiscal year, as well as the anticipated costs for such review in the upcoming year.</del></p> <p><u>The board shall release historical financial and statistical data reported by health care institutions pursuant to §§ 32.1-276.4 of the Code of Virginia. Under no circumstances shall data be released which contains patient, physician and employer identifier elements pursuant to §32.1-276.9.</u></p> <p>Intent: The substantive requirements of this section originate from the previous 12VAC5-215-210. Language was altered from the language of that previous section to update an outdated or inappropriate Code sections.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-215-150. <del>Schedule.</del></p>		<p>Fifty percent of the fee shall be paid to the board no later than 30 days before the beginning of the health care institution's fiscal year. The fee shall be based on the health care institution's most recently submitted annual</p>	<p><del>Fifty percent of the fee shall be paid to the board no later than 30 days before the beginning of the health care institution's fiscal year. The fee shall be based on the health care institution's most recently submitted annual historical adjusted patient days. If there have been no previous annual historical</del></p>

		<p>historical adjusted patient days. If there have been no previous annual historical filings, the health care institution's fee shall be based on its projected adjusted patient days for the fiscal year. The balance of the fee shall be paid to the board at the same time the health care institution submits its annual historical filing under the provisions of 12VAC5-215-50.</p>	<p><del>filings, the health care institution's fee shall be based on its projected adjusted patient days for the fiscal year. The balance of the fee shall be paid to the board at the same time the health care institution submits its annual historical filing under the provisions of 12VAC5-215-50.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-215-160 <del>Late fees.</del></p>		<p>A. A late charge shall be paid to the board by a health care institution that files reports or fees past the due date. The late charge may be waived if such a waiver is requested prior to the due date and the health care institution can show that an extenuating circumstance exists. Examples of extenuating circumstances include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.</p> <p>B. A late charge of \$10 per working day shall be paid to the board by a health care institution that files its annual historical filing, unconsolidated audited financial statements or fees past the due date.</p> <p>C. A late charge of \$50 shall be paid to the board by the health care institution that files the charge schedule past the due date.</p> <p>D. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to complete</p>	<p><del>A. A late charge shall be paid to the board by a health care institution that files reports or fees past the due date. The late charge may be waived if such a waiver is requested prior to the due date and the health care institution can show that an extenuating circumstance exists. Examples of extenuating circumstances include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.</del></p> <p><del>B. A late charge of \$10 per working day shall be paid to the board by a health care institution that files its annual historical filing, unconsolidated audited financial statements or fees past the due date.</del></p> <p><del>C. A late charge of \$50 shall be paid to the board by the health care institution that files the charge schedule past the due date.</del></p> <p><del>D. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to complete the survey required by 12VAC5-215-80 including the audited consolidated financial statement required by 12VAC5-215-100, or both.</del></p> <p><del>E. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to complete the survey required by 12VAC5-215-70.</del></p>

		<p>the survey required by 12VAC5-215-80 including the audited consolidated financial statement required by 12VAC5-215-100, or both.</p> <p>E. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to complete the survey required by 12VAC5-215-70.</p> <p>F. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to submit the Form 990s as provided by 12VAC5-215-120.</p>	<p><del>F. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to submit the Form 990s as provided by 12VAC5-215-120.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-215-170. <del>Analysis of historical filing data and schedule of charges.</del></p>		<p>A. The annual historical filing data submitted by health care institutions as prescribed in 12VAC5-215-50 shall be analyzed as directed by the board.</p> <p>B. The annual schedule of charges shall be analyzed as directed by the board.</p>	<p><del>A. The annual historical filing data submitted by health care institutions as prescribed in 12VAC5-215-50 shall be analyzed as directed by the board.</del></p> <p><del>B. The annual schedule of charges shall be analyzed as directed by the board.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-215-180. <del>Rate publication.</del></p>		<p>Periodically, but at least annually, the board will publish the rates charged by each health care institution in Virginia for up to 30 of the most frequently used services in Virginia, including each institution's average semi-private and private room rates. The data will be summarized by geographic area in Virginia, and will be kept on file at the board office for public inspection and made available to the news media. In addition, annual charge schedules and subsequent amendments to these schedules filed under the provisions of 12VAC5-215-60 will be kept on file at the</p>	<p><del>Periodically, but at least annually, the board will publish the rates charged by each health care institution in Virginia for up to 30 of the most frequently used services in Virginia, including each institution's average semi-private and private room rates. The data will be summarized by geographic area in Virginia, and will be kept on file at the board office for public inspection and made available to the news media. In addition, annual charge schedules and subsequent amendments to these schedules filed under the provisions of 12VAC5-215-60 will be kept on file at the board office for public inspection.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and</p>

		board office for public inspection.	efficiency of the regulations.
12VAC5-215-190. Annual report publication.		Periodically, but at least annually, the board will publish an annual report which will include, but not be limited to the following: cost per admission comparison, cost per patient day comparison, percentage increase in cost per patient day, operating profits and losses, deductions from revenue (contractuals, bad debts, and charity care) and utilization.	<del>Periodically, but at least annually, the board will publish an annual report which will include, but not be limited to the following: cost per admission comparison, cost per patient day comparison, percentage increase in cost per patient day, operating profits and losses, deductions from revenue (contractuals, bad debts, and charity care) and utilization.</del>  Intent: Repeal an unnecessary section of the regulations.  Likely impact: Greater clarity and efficiency of the regulations.
12VAC5-215-200. Comparison report.		The board will also periodically publish and disseminate information which will allow consumers to compare costs and services of hospitals, nursing homes and certified nursing facilities.	<del>The board will also periodically publish and disseminate information which will allow consumers to compare costs and services of hospitals, nursing homes and certified nursing facilities.</del>  Intent: Repeal an unnecessary section of the regulations.  Likely impact: Greater clarity and efficiency of the regulations.
12VAC5-215-210. Statistical data.		The board shall release historical financial and statistical data reported by health care institutions pursuant to §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia. Under no circumstances will data be released which contains "personal information" as defined in § 2.1-379(2) of the Code of Virginia.	<del>The board shall release historical financial and statistical data reported by health care institutions pursuant to §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia. Under no circumstances will data be released which contains "personal information" as defined in § 2.1-379(2) of the Code of Virginia.</del>  Intent: Repeal an unnecessary section of the regulations.  Likely impact: Greater clarity and efficiency of the regulations.
12VAC5-216-10. Purpose; limitations; activities.		A. The methodology set forth in this chapter is market oriented. Consumers and buyers of health care will receive information from the board that will allow them to make prudent health care decisions.  B. Nothing in this chapter or	<del>A. The methodology set forth in this chapter is market oriented. Consumers and buyers of health care will receive information from the board that will allow them to make prudent health care decisions.</del>  <del>B. Nothing in this chapter or the actions taken by the board pursuant to any of its provisions shall be construed as</del>

		<p>the actions taken by the board pursuant to any of its provisions shall be construed as constituting approval by the Commonwealth or any of its agencies or officers of the reasonableness of any charges made or costs incurred by any health care institution.</p> <p>C. The board will collect, analyze, and publish information on health care institutional provider practices relating to efficiency and productivity.</p>	<p><del>constituting approval by the Commonwealth or any of its agencies or officers of the reasonableness of any charges made or costs incurred by any health care institution.</del></p> <p><del>C. The board will collect, analyze, and publish information on health care institutional provider practices relating to efficiency and productivity.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-216-20. Filing-</p>		<p>Each health care institution, except where otherwise indicated, will submit an annual historical performance filing. Each health care institution will submit an annual historical performance filing as prescribed in § 32.1-276.7 of the Code of Virginia. This filing will be used to collect audited financial information and other information for all of the categories listed in 12VAC5-216-40. It will provide the basis for the evaluation by the board. The annual historical performance filing shall be received by the board within 120 days after the close of the health care institution's fiscal year.</p>	<p><del>Each health care institution, except where otherwise indicated, will submit an annual historical performance filing. Each health care institution will submit an annual historical performance filing as prescribed in § 32.1-276.7 of the Code of Virginia. This filing will be used to collect audited financial information and other information for all of the categories listed in 12VAC5-216-40. It will provide the basis for the evaluation by the board. The annual historical performance filing shall be received by the board within 120 days after the close of the health care institution's fiscal year.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-216-30. Eliminating duplication in reporting-</p>		<p>In compliance with § 32.1-276.4 B of the Code of Virginia, information that is collected by other public and private entities that is used by the board in its evaluation of efficiency and productivity shall be received by the board directly from the appropriate agency or entity. Data will also be drawn from the Virginia Patient Level Data System and from other</p>	<p><del>In compliance with § 32.1-276.4 B of the Code of Virginia, information that is collected by other public and private entities that is used by the board in its evaluation of efficiency and productivity shall be received by the board directly from the appropriate agency or entity. Data will also be drawn from the Virginia Patient Level Data System and from other available data bases.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p>

		available data bases.	Likely impact: Greater clarity and efficiency of the regulations.
12VAC5-216-40. <del>Categories of information.</del>		Information concerning charges, costs, elements of costs, productivity, resource utilization, financial viability, and community support services will be assembled from the filings made pursuant to this chapter.	<p><del>Information concerning charges, costs, elements of costs, productivity, resource utilization, financial viability, and community support services will be assembled from the filings made pursuant to this chapter.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
12VAC5-216-50. <del>Efficiency and productivity indicators.</del>		<p>Individual data elements from the general categories identified in 12VAC5-216-40 will be used to form ratio indicators. These indicators will be used to evaluate health care institutions and rank health care institutions in relation to their peers.</p> <p>1. Case mix index. Each acute care hospital shall provide the board with a case mix index for all inpatients and designated categories of inpatients when it submits its annual historical performance filing. The Medicare DRG grouper process shall be utilized by the board.</p> <p>2. Each nursing facility that has received a Patient Intensity Rating System (PIRS) Service Intensity Index (SII) number from the Virginia Department of Medical Assistance Services shall report the four quarterly final PIRS SII scores associated with its fiscal year. These scores are to be reported on the institution's annual historical performance filing.</p>	<p><del>Individual data elements from the general categories identified in 12VAC5-216-40 will be used to form ratio indicators. These indicators will be used to evaluate health care institutions and rank health care institutions in relation to their peers.</del></p> <p><del>1. Case mix index. Each acute care hospital shall provide the board with a case mix index for all inpatients and designated categories of inpatients when it submits its annual historical performance filing. The Medicare DRG grouper process shall be utilized by the board.</del></p> <p><del>2. Each nursing facility that has received a Patient Intensity Rating System (PIRS) Service Intensity Index (SII) number from the Virginia Department of Medical Assistance Services shall report the four quarterly final PIRS SII scores associated with its fiscal year. These scores are to be reported on the institution's annual historical performance filing.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
12VAC5-216-60. <del>Electronic submission of data.</del>		A. Information shall be submitted electronically.	<del>A. Information shall be submitted electronically.</del>

		<p>B. Information shall be submitted using software developed by the board for the use of health institutions in submitting filings.</p> <p>C. Any health care institution that does not have the computer equipment to submit electronically may apply to the board for an exemption to subsection B of this section. A fee commensurate with the cost of data entry will be assessed by the board.</p>	<p><del>B. Information shall be submitted using software developed by the board for the use of health institutions in submitting filings.</del></p> <p><del>C. Any health care institution that does not have the computer equipment to submit electronically may apply to the board for an exemption to subsection B of this section. A fee commensurate with the cost of data entry will be assessed by the board.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-216-70. <del>Public access to data.</del></p>		<p>The board will publish an annual report which will incorporate the data collected and analysis of the data including, but not limited to, an evaluation of the relative efficiency and productivity of health care institutions. An electronic data base is open to the public.</p>	<p><del>The board will publish an annual report which will incorporate the data collected and analysis of the data including, but not limited to, an evaluation of the relative efficiency and productivity of health care institutions. An electronic data base is open to the public.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-216-80. <del>Initial measurement.</del></p>		<p>The performance of each health care institution will be measured using the indicators referenced in 12VAC5-216-50.</p>	<p><del>The performance of each health care institution will be measured using the indicators referenced in 12VAC5-216-50.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-216-90. <del>Ranking; other peer groupings.</del></p>		<p>A. Unless exempted as provided for in 12VAC5-216-100, each health care institution will be subject to a ranking procedure.</p> <p>1. Geographical peer grouping. Similar types of health care institutions (e.g., all hospitals or all nursing homes) will be grouped into geographical peer groups and ranked in relation to</p>	<p><del>A. Unless exempted as provided for in 12VAC5-216-100, each health care institution will be subject to a ranking procedure.</del></p> <p><del>1. Geographical peer grouping. Similar types of health care institutions (e.g., all hospitals or all nursing homes) will be grouped into geographical peer groups and ranked in relation to other institutions within their peer group.</del></p> <p><del>2. Ranking procedure. Each health care</del></p>

		<p>other institutions within their peer group.</p> <p>2. Ranking procedure. Each health care institution will be ranked on each indicator and given a quartile score on each indicator. Each quartile represents 25% of institutions within the peer group. Each institution will be given a score of 1, 2, 3, or 4 on each indicator depending upon the quartile in which it falls. A quartile score of 1 on an indicator means that an institution ranked in the top quartile (top 25%) on that indicator. Quartile scores are summed over all indicators. The total is divided by the number of indicators to get an average quartile score. The top performers will be selected by using the average quartile score and identifying, to the extent possible, the top 25% of the institutions within each peer group.</p> <p>B. Health care institutions may be sorted into other peer groupings (e.g., bed size, urban/rural, system/nonsystem) for purposes of analysis.</p>	<p><del>institution will be ranked on each indicator and given a quartile score on each indicator. Each quartile represents 25% of institutions within the peer group. Each institution will be given a score of 1, 2, 3, or 4 on each indicator depending upon the quartile in which it falls. A quartile score of 1 on an indicator means that an institution ranked in the top quartile (top 25%) on that indicator. Quartile scores are summed over all indicators. The total is divided by the number of indicators to get an average quartile score. The top performers will be selected by using the average quartile score and identifying, to the extent possible, the top 25% of the institutions within each peer group.</del></p> <p><del>B. Health care institutions may be sorted into other peer groupings (e.g., bed size, urban/rural, system/nonsystem) for purposes of analysis.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
<p>12VAC5-216-100. Exemptions from the ranking procedure.</p>		<p>Until such time as a resource utilization adjustor, similar to the case mix index for acute care hospitals referenced in subdivision 1 of 12VAC5-216-50 is developed and adopted by the board, some institutions will be exempt from the ranking procedure as described below:</p> <p>1. Psychiatric hospitals.</p>	<p><del>Until such time as a resource utilization adjustor, similar to the case mix index for acute care hospitals referenced in subdivision 1 of 12VAC5-216-50 is developed and adopted by the board, some institutions will be exempt from the ranking procedure as described below:</del></p> <p><del>1. Psychiatric hospitals.</del></p> <p><del>2. Rehabilitation hospitals.</del></p>

		<p>2. Rehabilitation hospitals.</p> <p>3. Ambulatory surgery hospitals.</p> <p>4. Continuing care retirement communities.</p> <p>5. Children's specialty hospitals.</p> <p>6. Subacute care hospitals.</p>	<p><del>3. Ambulatory surgery hospitals.</del></p> <p><del>4. Continuing care retirement communities.</del></p> <p><del>5. Children's specialty hospitals.</del></p> <p><del>6. Subacute care hospitals.</del></p> <p>Intent: Repeal an unnecessary section of the regulations.</p> <p>Likely impact: Greater clarity and efficiency of the regulations.</p>
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**DEPARTMENT OF HEALTH**  
**Chp 215 and 216 Combined as a result of a Periodic Review**

CHAPTER 215  
RULES AND REGULATIONS GOVERNING HEALTH DATA REPORTING

Part I  
Definitions

**12VAC5-215-10. Definitions.**

The following words and terms, when used in this chapter, shall have the following meanings:

"Adjusted patient days" means inpatient days divided by the percentage of inpatient revenues to total patient revenues.

"Annual historical performance filing" means facility specific financial indicators that include revenue, deductions from revenue, expenses, assets, liabilities and patient days by payor.

"Board" means the Board of Health.

"Certified nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare or Medicaid provider, or both, pursuant to § 32.1-137 of the Code of Virginia.

~~"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.~~

"Health care institution" means (i) a general hospital, ordinary hospital, or outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, (ii) a mental or psychiatric hospital licensed pursuant to Chapter ~~48~~ (§ ~~37.1-179~~ § 37.2-403 et seq.) of ~~Title 37.1~~ Title 37.2 of the Code of Virginia or (iii) a hospital operated by the Department of Behavioral Health and Developmental Services ~~the University of Virginia or Virginia Commonwealth University~~. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia, any physician's office, nursing care facility of a religious body which depends upon prayer alone for healing, independent laboratory or outpatient clinic.

"Hospital" means any facility licensed pursuant to § 32.1-123 et seq. or ~~§ 37.1-179~~ § 37.2-403 et seq. of the Code of Virginia or a hospital operated by the Department of Behavioral Health and Developmental Services for the care and treatment of individuals with mental illness.

~~"Late charge" means a fee that is assessed a health care institution that submits any of the board's filings past the due date.~~

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise and capacity to execute the powers and duties set forth for such entity in Chapter 7.2 (§ 32.1-276.2 et seq.) of Title 32.1 of the Code of Virginia and with which the Commissioner of Health has entered into a contract as required by the Code of Virginia.

"Nursing home" means any facility or any identifiable component of any facility licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, in

which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.

"Patient day" means a unit of measure denoting lodging facilities provided and services rendered to one inpatient, between census-taking-hour on two successive days. The day of admission but not the day of discharge or death is counted a patient day. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day. For purposes of filing fees to the board, newborn patient days would be added. For a medical facility, such as an ambulatory surgery center, which does not provide inpatient services, each patient undergoing surgery ~~during any one~~ which occurs in less than a 24-hour period ~~will~~ shall be equivalent to one patient day.

**Part II**  
**General Information**

**12VAC5-215-20. Authority for regulations. Limitations.**

~~The board, by §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia, is required to collect, analyze and make public certain financial data and findings relating to hospitals which operate within the Commonwealth of Virginia. Sections 32.1-276.7 and 32.1-276.8 of the Code of Virginia direct the board from time to time to make such rules and regulations as may be necessary to carry out its responsibilities as prescribed in the Code of Virginia. Nothing in this chapter or the actions taken by the board pursuant to any of its provisions shall be construed as constituting approval by the Commonwealth or any of its agencies or officers of the reasonableness of any charges made or costs incurred by any health care institution.~~

**12VAC5-215-30. Purpose, administration, application, and effective date of rules and regulations. Eliminating duplication in reporting.**

~~A. The board has promulgated these rules and regulations to set forth an orderly administrative process by which the board may govern its own affairs and require compliance with the provisions of §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia.~~

~~B. These rules and regulations are administered by the board.~~

~~C. These rules and regulations have general applicability throughout the Commonwealth. The requirements of the Virginia Administrative Process Act, codified as § 9-6.14:1 et seq. of the Code of Virginia, apply to their promulgation.~~

~~D. These rules and regulations or any subsequent amendment, modification, or deletion in connection with these rules and regulations shall become effective 30 days after the final regulation is published in The Virginia Register. The board shall direct the nonprofit to obtain information that is collected by other public and private entities that is used by the board in its evaluation of efficiency and productivity directly from the appropriate agency or entity. Data shall also be drawn from the Virginia Patient Level Data System and from other available data bases.~~

**12VAC5-215-40. Powers and procedures of regulations not exclusive. Categories of Information.**

~~The board reserves the right to authorize any procedure for the enforcement of these regulations that is not inconsistent with the provision set forth herein and the provisions of §§ 32.1-27 and 32.1-276.11 of the Code of Virginia. The board shall direct the nonprofit to assemble information concerning charges, costs, elements of costs, efficiency, productivity, resource utilization, financial viability, and community support services from the filings made pursuant to this chapter.~~

Part III  
Filing Requirements and Fee Structure

**12VAC5-215-50. Annual historical filing. Efficiency and Productivity Indicator.**

~~Each individual health care institution shall submit an annual historical filing of revenues, expenses, other income, other outlays, assets and liabilities, units of service, and related statistics as prescribed in § 9-158 (Repealed) of the Code of Virginia on forms provided by the board together with unconsolidated certified audited financial statements. If the health care institution is part of a publicly held company, the individual institution may submit unconsolidated unaudited financial statements. Investor-owned institutions organized as proprietorships, partnerships, or S-corporations that impute income tax on the annual historical filing report an imputed income tax based on the maximum tax rates for federal and state income. The combined rate for 1989 is equal to 34% for individuals and 40% for corporations. Operating losses may be carried forward no more than five years but may not be carried back to prior years. The schedule of imputed income taxes shall be reported as a note to the financial statements or as a supplemental schedule of the certified audited financial statements submitted to the board by the institution. The annual historical filing and the unconsolidated certified audited financial statement shall be received by the board no later than 120 days after the end of the respective applicable health care institution's fiscal year. The requirement for the submission of an annual historical filing and an unconsolidated certified audited financial statement may be waived if a health care institution can show that an extenuating circumstance exists. Requests for a waiver must be submitted in writing prior to the due date. Examples of an extenuating circumstance include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.~~

~~Each health care institution with licensed nursing home beds or certified nursing facility beds shall exclude all revenues, expenses, other income, other outlays, assets and liabilities, units of service and related statistics directly associated with a hospital, continuing care retirement community, or with adult care residence beds in the annual report filed with the board. For those health care institutions that participate in either the Medicare or Medicaid program, the cost allocation methodology required by the Virginia Department of Medical Assistance Services and Medicare for cost reports submitted to it shall be utilized for filings submitted to the board. Any health care institution that does not participate in the Medicare or Medicaid program may develop and utilize an alternative methodology to determine the nursing home portion of its costs if it chooses not to utilize the cost allocation methodology used by the Department of Medical Assistance Services and Medicare. That methodology shall then be approved by the board and the health care institution must continue to utilize that methodology for all subsequent filings unless a subsequent change is approved by the board.~~

~~Individual data elements from the general categories identified in 12VAC5-215-40 shall be used to form ratio indicators. These indicators shall be used to evaluate health care institutions and rank health care institutions in relation to their peers. These indicators shall include:~~

~~1. Case mix index. Using the 3M APR DRG Classification system, the non-profit shall calculate a case-mix index utilizing Virginia patient level data for each licensed hospital.~~

~~2. Each nursing home that has received a Resource Utilization Groups Systems (RUGS) Service Intensity Index (SII) number from the Virginia Department of Medical Assistance Services shall report the four quarterly final RUGS SSI scores associated with its fiscal year. These scores are to be reported on the institution's annual historical performance filing.~~

**12VAC5-215-60. Schedule of charges. Public access to data.**

~~Each health care institution shall file annually a schedule of charges to be in effect on the first day of such fiscal year, as prescribed in § 9-159 A 3 (Repealed) of the Code of Virginia. The~~

~~institution's schedule of charges shall be received by the board within 10 days after the beginning of its respective applicable fiscal year.~~

~~Any subsequent amendment or modification to the annually filed schedule of charges shall be filed within 10 days of the effective date of the revised annual projection. In addition to the requirement above, a new schedule of charges must be submitted if any of the following conditions exist: (i) the creation or revision of a markup or pricing methodology, or (ii) the creation or revision of charges for new services or products. Amendments or modifications to a schedule of charges that are due only to cost adjustments resulting from the pass through of a markup or pricing methodology that had been implemented since the beginning of the fiscal year are considered minimal and need not be reported. The board shall direct the nonprofit to publish an annual report which incorporates the data collected and analysis of the data including, but not limited to an evaluation of the relative efficiency, productivity of health care institutions, cost per admission comparison, cost per patient day comparison, percentage increase in cost per patient day, operating profits and losses, deductions from revenue (contractuals, bad debts, and charity care) and utilization. An electronic database open to the public shall contain information drawn from audited financial statements and detailed operational information provided by facilities required by law to report. The topics included in the database include but are not limited to: cardiac care, hospital patient satisfaction, outpatient procedures, obstetrics, and health care prices. Patient, physician and employer identifying information shall not be included in the database. Information from mental or psychiatric hospital licensed pursuant to Chapter 4 Title 37.2 of the Code of Virginia or hospitals operated by the Department of Behavioral Health and Developmental Services shall not be included in the database.~~

#### **12VAC5-215-70. Survey of rates. Annual historical performance filing.**

~~Each health care institution shall file annually a survey of rates charged. For hospitals, the survey shall consist of up to 30 select charges, including semi-private and private room rates. The survey shall also consist of charges of the most frequently occurring diagnoses or procedures for inpatient and outpatient treatment. The charges shall be calculated by taking an average for one month of all patient bills where the requested CPT or ICD-9 code numbers are indicated as the principal diagnosis or procedure. For hospitals this information shall be received by the board no later than April 30 of each year.~~

~~The annual charge survey for nursing homes shall include up to 30 select charges, including semi-private and private room rates. The select charges shall reflect the rates in effect as of the first day of a sample month to be chosen by the board. For nursing homes this information shall be received by the board no later than March 31 of each year.~~

~~Each individual health care institution shall submit an annual historical performance filing on forms provided by the board together with unconsolidated certified audited financial statements. If the health care institution is part of a publicly held company, the individual institution may submit unconsolidated unaudited financial statements with the annual historical performance filing. Investor-owned institutions organized as proprietorships, partnerships, or S-corporations that impute income tax on the annual historical performance filing shall report an imputed income tax based on the maximum tax rates for federal and state income. Operating losses may be carried forward no more than five years but shall not be carried back to prior years. The schedule of imputed income taxes shall be reported as a note to the financial statements or as a supplemental schedule of the certified audited financial statements submitted to the board by the health care institution. The annual historical performance filing and the unconsolidated certified audited financial statement, or unconsolidated unaudited financial statements submitted by publicly held companies shall be received by the board no later than 120 days after the end of the health care institution's fiscal year. The requirement for the submission of an annual historical performance filing and an unconsolidated certified audited financial statement or~~

unconsolidated unaudited financial statements submitted by publicly held companies may be waived if a health care institution can show that an extenuating circumstance exists. Requests for a waiver shall be submitted to the board in writing prior to the due date. Examples of an extenuating circumstance include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.

Each health care institution with licensed nursing home beds or certified nursing facility beds shall exclude all revenues, expenses, other income, other outlays, assets and liabilities, units of service and related statistics directly associated with a hospital, continuing care retirement community, or with adult care residence beds in the annual historical performance filing submitted to the board. For those health care institutions that participate in either the Medicare or Medicaid program, the cost allocation methodology required by the Virginia Department of Medical Assistance Services and Medicare for cost reports submitted to it shall be utilized for filings submitted to the board. Any health care institution that does not participate in the Medicare or Medicaid program may develop and utilize an alternative methodology to determine the nursing home portion of its costs if it chooses not to utilize the cost allocation methodology used by the Department of Medical Assistance Services and Medicare. That methodology shall then be approved by the board and the health care institution must continue to utilize that methodology for all subsequent filing unless a subsequent change is approved by the board.

**12VAC5-215-80. Commercial diversification survey. Electronic submission of data.**

~~Each hospital or any corporation that controls a hospital shall respond to a survey conducted by the board to determine the extent of commercial diversification by such hospitals in the Commonwealth. The survey shall be in a form and manner prescribed by the board and shall request the information specified in subdivisions a through j below for each affiliate of such hospital or corporation, if any:~~

- ~~a. The name and principal activity;~~
- ~~b. The date of the affiliation;~~
- ~~c. The nature of the affiliation;~~
- ~~d. The method by which each affiliate was acquired or created;~~
- ~~e. The tax status of each affiliate and, if tax-exempt, its Internal Revenue tax exemption code number;~~
- ~~f. The total assets;~~
- ~~g. The total revenues;~~
- ~~h. The net profit after taxes, or if not-for-profit, its excess revenues;~~
- ~~i. The net equity or, if not-for-profit, its fund balance; and~~
- ~~j. Information regarding related party transactions.~~

All filings required by this chapter shall be made to the board, and must meet the following requirements:

A. Information shall be submitted electronically.

B. Information shall be submitted using software developed by the board for the use of health institutions in submitting filings.

C. Any health care institution that does not have the computer equipment to submit electronically may apply to the board for an exemption to subsection B of this section. A fee commensurate with the cost of data entry shall be assessed by the board.

### **12VAC5-215-90. Affiliates. Fees.**

~~The information specified in 12VAC5-215-80 shall relate to any legal controls that exist as of the hospital's fiscal year end. The response to the survey shall include the required information for all affiliates in which the hospital or any corporation which controls a hospital has a 25% or greater interest. Information regarding affiliates or organizations that do not have corporate headquarters in Virginia and that do no business in Virginia need not be provided. A fee based on an adjusted patient days rate shall be set by the board, based on the needs to meet annual board expenses. The fee shall be established at least annually and reviewed for its sufficiency at least annually by the board. All fees shall be paid directly to the board. The fee shall be no more than 11 cents per adjusted patient day for each health care institution. Prior to the beginning of each new fiscal year, the board shall determine a fee for hospitals and a fee for nursing homes based upon the board's proportionate costs of operation for review of hospital and nursing home filings in the current fiscal year, as well as the anticipated costs for such review in the upcoming year.~~

### **12VAC5-215-100. Financial statement (healthcare institution). Schedule.**

~~Each hospital that reports to the board or any corporation which controls a hospital that reports to the board shall submit audited consolidated financial statements and consolidating financial schedules to the board which include its total assets, liabilities, revenues, expenses, and net worth. Fifty percent of the fee shall be paid to the board no later than 30 days before the beginning of the health care institution's fiscal year. The fee shall be based on the health care institution's most recently submitted annual historical adjusted patient days. If there have been no previous annual historical performance filings, the health care institution's fee shall be based on its projected adjusted patient days for the fiscal year. The balance of the fee shall be paid to the board at the same time the health care institution submits its annual historical performance filing under the provisions of 12VAC5-215-70.~~

### **12VAC5-215-110. Deadline. Late Charges.**

~~The information required by 12VAC5-215-80, 12VAC5-215-90, and 12VAC5-215-100 shall be due 120 days after the hospital's fiscal year end.~~

~~A. A late charge shall be paid to the board by a health care institution that files reports or fees past the due date. The late charge may be waived if such a waiver is requested prior to the due date and the health care institution can show that an extenuating circumstance exists. Requests for waivers shall be submitted to the board in writing. Examples of extenuating circumstances include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.~~

~~B. A late charge of \$10 per working day shall be paid to the board by a health care institution that files its annual historical performance filing, unconsolidated audited financial statements, unconsolidated unaudited financial statements filed by publicly held companies, schedule of imputed taxes, or fees past the due date.~~

### **12VAC5-215-120. IRS Forms. Ranking; other peer groupings.**

~~Each health care institution that reports to the board, any corporation controlling a hospital, and each affiliate of the hospital or corporation that controls a hospital shall submit, if the health care institution, corporation, or affiliate is an organization exempt from taxes pursuant to § 501(C)(3) of the Internal Revenue Code, a copy of the most recent federal information return (Form 990) which was filed on behalf of the institution, corporation, or affiliate together with all accompanying schedules that are required to be made available to the public by the Internal Revenue Service. Information regarding not-for-profit affiliates which do no business in Virginia need not be submitted.~~

~~The information required by this section shall be due to the board 120 days after the completion of the health care institution's fiscal year end. If the information return (Form 990) has not been filed with the Internal Revenue Service, the due date will be extended to no later than the normal due date to the IRS or any extensions granted.~~

Unless exempted as provided for in 12VAC5-215-130, each health care institution shall be subject to the following geographical peer grouping and ranking procedure.

1. Geographical peer grouping. Similar types of health care institutions (e.g., all hospitals or all nursing homes) shall be grouped into geographical peer groups and ranked in relation to other institutions within their peer group.

2. Ranking procedure. Each health care institution shall be ranked on each indicator and given a quartile score on each indicator. Each quartile represents 25% of institutions within the peer group. Each institution shall be given a score of 1, 2, 3, or 4 on each indicator depending upon the quartile in which it falls. A quartile score of 1 on an indicator means that an institution ranked in the top quartile (top 25%) on that indicator.

**12VAC5-215-130. Filing. Exemptions from the ranking procedure.**

All filings required by this chapter will be made to the board. Until such time as a resource utilization adjustor, similar to the case mix index for acute care hospitals referenced in subdivision 1 of 12VAC5-215-50 is developed and adopted by the board, some institutions shall be exempt from the ranking procedure as described below:

1. Psychiatric hospitals.
2. Rehabilitation hospitals.
3. Ambulatory surgery hospitals.
4. Critical access hospitals.
5. Children's specialty hospitals.
6. Subacute care hospitals. (Longterm acute care hospital.)

Health care institutions may be sorted into other peer groupings (e.g., bed size, urban/rural, system/nonsystem) for the purposes of analysis.

**12VAC5-215-140. Fees. Statistical data.**

~~A fee based on an adjusted patient days rate shall be set by the board, based on the needs to meet annual board expenses. The fee shall be established at least annually and reviewed for its sufficiency at least annually by the board. All fees shall be paid directly to the board. The fee shall be no more than 11 cents per adjusted patient day for each health care institution. Prior to the beginning of each new fiscal year, the board shall determine a fee for hospitals and a fee for nursing homes based upon the board's proportionate costs of operation for review of hospital and nursing home filings in the current fiscal year, as well as the anticipated costs for such review in the upcoming year.~~

The board shall release historical financial and statistical data reported by health care institutions pursuant to §§ 32.1-276.4 of the Code of Virginia. Under no circumstances shall data be released which contains patient, physician and employer identifier elements pursuant to §32.1-276.9.

**12VAC5-215-150. Schedule. (Repealed.)**

~~Fifty percent of the fee shall be paid to the board no later than 30 days before the beginning of the health care institution's fiscal year. The fee shall be based on the health care institution's most recently submitted annual historical adjusted patient days. If there have been no previous annual historical filings, the health care institution's fee shall be based on its projected adjusted patient days for the fiscal year. The balance of the fee shall be paid to the board at the same~~

~~time the health care institution submits its annual historical filing under the provisions of 12VAC5-215-50.~~

**12VAC5-215-160. Late fees. (Repealed.)**

~~A. A late charge shall be paid to the board by a health care institution that files reports or fees past the due date. The late charge may be waived if such a waiver is requested prior to the due date and the health care institution can show that an extenuating circumstance exists. Examples of extenuating circumstances include, but are not limited to, involvement by the institution in a bankruptcy proceeding, closure of the institution, change of ownership of the institution, or the institution is a new facility that has recently opened.~~

~~B. A late charge of \$10 per working day shall be paid to the board by a health care institution that files its annual historical filing, unconsolidated audited financial statements or fees past the due date.~~

~~C. A late charge of \$50 shall be paid to the board by the health care institution that files the charge schedule past the due date.~~

~~D. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to complete the survey required by 12VAC5-215-80 including the audited consolidated financial statement required by 12VAC5-215-100, or both.~~

~~E. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to complete the survey required by 12VAC5-215-70.~~

~~F. A late charge of \$25 per working day shall be paid to the board by the reporting entity required to submit the Form 990s as provided by 12VAC5-215-120.~~

**Part IV**

**Work Flow and Analysis**

**12VAC5-215-170. Analysis of historical filing data and schedule of charges. (Repealed.)**

~~A. The annual historical filing data submitted by health care institutions as prescribed in 12VAC5-215-50 shall be analyzed as directed by the board.~~

~~B. The annual schedule of charges shall be analyzed as directed by the board.~~

**Part V**

**Publication and Dissemination of Information Related to Health Care Institutions**

**12VAC5-215-180. Rate publication. (Repealed.)**

~~Periodically, but at least annually, the board will publish the rates charged by each health care institution in Virginia for up to 30 of the most frequently used services in Virginia, including each institution's average semi-private and private room rates. The data will be summarized by geographic area in Virginia, and will be kept on file at the board office for public inspection and made available to the news media. In addition, annual charge schedules and subsequent amendments to these schedules filed under the provisions of 12VAC5-215-60 will be kept on file at the board office for public inspection.~~

**12VAC5-215-190. Annual report publication. (Repealed.)**

~~Periodically, but at least annually, the board will publish an annual report which will include, but not be limited to the following: cost per admission comparison, cost per patient day comparison, percentage increase in cost per patient day, operating profits and losses, deductions from revenue (contractuals, bad debts, and charity care) and utilization.~~

**12VAC5-215-200. Comparison report. (Repealed.)**

~~The board will also periodically publish and disseminate information which will allow consumers to compare costs and services of hospitals, nursing homes and certified nursing facilities.~~

**12VAC5-215-210. Statistical data. (Repealed.)**

~~The board shall release historical financial and statistical data reported by health care institutions pursuant to §§ 32.1-276.2 through 32.1-276.11 of the Code of Virginia. Under no circumstances will data be released which contains "personal information" as defined in § 2.1-379(2) of the Code of Virginia.~~

**FORMS (12VAC5-215)**

~~Hospital Annual Historical Filing Form, 03-01, revised 4/30/96.~~

~~Ambulatory Surgical Hospital Annual Historical Filing Form, 03-02, revised 4/30/96.~~

~~Nursing Home Annual Historical Filing Form, 03-03, revised 4/30/96.~~

~~Income Statement Reconciliation Worksheet, 04-04, revised 4/30/96.~~

~~Psychiatric Hospital Annual Historical Filing Form, 03-05, revised 4/30/96.~~

~~Rehabilitation Hospital Annual Historical Filing Form, 03-06, revised 4/30/96.~~

**CHAPTER 216**

**~~METHODOLOGY TO MEASURE EFFICIENCY AND PRODUCTIVITY OF HEALTH CARE INSTITUTIONS~~**

**12VAC5-216-10. Purpose; limitations; activities. (Repealed.)**

~~A. The methodology set forth in this chapter is market oriented. Consumers and buyers of health care will receive information from the board that will allow them to make prudent health care decisions.~~

~~B. Nothing in this chapter or the actions taken by the board pursuant to any of its provisions shall be construed as constituting approval by the Commonwealth or any of its agencies or officers of the reasonableness of any charges made or costs incurred by any health care institution.~~

~~C. The board will collect, analyze, and publish information on health care institutional provider practices relating to efficiency and productivity.~~

**12VAC5-216-20. Filing. (Repealed.)**

~~Each health care institution, except where otherwise indicated, will submit an annual historical performance filing. Each health care institution will submit an annual historical performance filing as prescribed in § 32.1-276.7 of the Code of Virginia. This filing will be used to collect audited financial information and other information for all of the categories listed in 12VAC5-216-40. It will provide the basis for the evaluation by the board. The annual historical performance filing shall be received by the board within 120 days after the close of the health care institution's fiscal year.~~

**12VAC5-216-30. Eliminating duplication in reporting. (Repealed.)**

~~In compliance with § 32.1-276.4 B of the Code of Virginia, information that is collected by other public and private entities that is used by the board in its evaluation of efficiency and productivity shall be received by the board directly from the appropriate agency or entity. Data will also be drawn from the Virginia Patient Level Data System and from other available data bases.~~

**12VAC5-216-40. Categories of information. (Repealed.)**

~~Information concerning charges, costs, elements of costs, productivity, resource utilization, financial viability, and community support services will be assembled from the filings made pursuant to this chapter.~~

**12VAC5-216-50. Efficiency and productivity indicators. (Repealed.)**

Individual data elements from the general categories identified in 12VAC5-216-40 will be used to form ratio indicators. These indicators will be used to evaluate health care institutions and rank health care institutions in relation to their peers.

1. Case mix index. Each acute care hospital shall provide the board with a case mix index for all inpatients and designated categories of inpatients when it submits its annual historical performance filing. The Medicare DRG grouper process shall be utilized by the board.
2. Each nursing facility that has received a Patient Intensity Rating System (PIRS) Service Intensity Index (SII) number from the Virginia Department of Medical Assistance Services shall report the four quarterly final PIRS SII scores associated with its fiscal year. These scores are to be reported on the institution's annual historical performance filing.

**12VAC5-216-60. Electronic submission of data. (Repealed.)**

A. Information shall be submitted electronically.

B. Information shall be submitted using software developed by the board for the use of health institutions in submitting filings.

C. Any health care institution that does not have the computer equipment to submit electronically may apply to the board for an exemption to subsection B of this section. A fee commensurate with the cost of data entry will be assessed by the board.

**12VAC5-216-70. Public access to data. (Repealed.)**

The board will publish an annual report which will incorporate the data collected and analysis of the data including, but not limited to, an evaluation of the relative efficiency and productivity of health care institutions. An electronic data base is open to the public.

**12VAC5-216-80. Initial measurement. (Repealed.)**

The performance of each health care institution will be measured using the indicators referenced in 12VAC5-216-50.

**12VAC5-216-90. Ranking; other peer groupings. (Repealed.)**

A. Unless exempted as provided for in 12VAC5-216-100, each health care institution will be subject to a ranking procedure.

1. Geographical peer grouping. Similar types of health care institutions (e.g., all hospitals or all nursing homes) will be grouped into geographical peer groups and ranked in relation to other institutions within their peer group.
2. Ranking procedure. Each health care institution will be ranked on each indicator and given a quartile score on each indicator. Each quartile represents 25% of institutions within the peer group. Each institution will be given a score of 1, 2, 3, or 4 on each indicator depending upon the quartile in which it falls. A quartile score of 1 on an indicator means that an institution ranked in the top quartile (top 25%) on that indicator. Quartile scores are summed over all indicators. The total is divided by the number of indicators to get an average quartile score. The top performers will be selected by using the average quartile score and identifying, to the extent possible, the top 25% of the institutions within each peer group.

B. Health care institutions may be sorted into other peer groupings (e.g., bed size, urban/rural, system/nonsystem) for purposes of analysis.

**12VAC5-216-100. Exemptions from the ranking procedure. (Repealed.)**

~~Until such time as a resource utilization adjuster, similar to the case mix index for acute care hospitals referenced in subdivision 1 of 12VAC5-216-50 is developed and adopted by the board, some institutions will be exempt from the ranking procedure as described below:~~

- ~~1. Psychiatric hospitals.~~
- ~~2. Rehabilitation hospitals.~~
- ~~3. Ambulatory surgery hospitals.~~
- ~~4. Continuing care retirement communities.~~
- ~~5. Children's specialty hospitals.~~
- ~~6. Subacute care hospitals.~~

FORMS (12VAC5-216)

Hospital Historical Filing, 03-01 (rev. 4/30/96).

Indicator Definitions – Acute Care Hospitals (rev. 10/15/96).

Special Services Utilization Calculations

Ambulatory Surgical Hospital Historical Filing, 03-02 (rev. 4/30/96).

Indicator Definitions – Ambulatory Surgery Hospitals (rev. 10/15/96).

Nursing Home Historical Filing, 03-03 (rev. 4/30/96).

Indicator Definitions – Nursing Homes (rev. 10/15/96).

Psychiatric Hospital Historical Filing, 03-05 (rev. 4/30/96).

Indicator Definitions – Psychiatric Hospitals (rev. 10/15/96).

Rehabilitation Hospital Historical Filing, 03-06 (rev. 4/30/96).

Indicator Definitions – Rehabilitation Hospitals (rev. 10/15/96).

Income Statement Reconciliation Worksheet, 04-04 (rev. 4/30/96).