Part II

Nursing Home Payment System

Article 4

Operating Cost Component

12VAC30-90-40. Operating cost.

A. Effective July 1, 2001, operating cost shall be the total allowable inpatient cost less plant cost or capital, as appropriate, and NATCEPs costs. See Subpart VII (12 VAC 30-90-170) for rate determination procedures for NATCEPs costs. Operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I (12 VAC 30-90-271). Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs or the actual charges by the Central Criminal Records Exchange for criminal records checks for nursing facility employees (see Appendix I (12 VAC 30-90-272)). For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or 90 percent of the potential patient days for all licensed beds throughout the cost reporting period times the

Medicaid utilization percentage. For facilities that also provide specialized care services, see 12 VAC 30-90-264 section 10, for special procedures for computing the number of patient days required to meet the 90 percent occupancy requirement.

12VAC30-90-41. Nursing facility reimbursement formula.

A. A. ~~Effective on and after October 1, 1990, all NFs subject to the prospective payment system shall be reimbursed under "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NF's per diem rates to the intensity of services required by a NF's patient mix. Three classes were developed which group patients together based on similar functional characteristics and service needs.~~ Effective on and after July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group-III (RUG-III) System." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indexes (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per diem rates to reflect the intensity of services required by a NF's resident mix. See 12VAC 30-90-300 for details on the Resource Utilization Groups.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. Direct and indirect group ceilings and rates.

a. In accordance with 12VAC30-90-20 C, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-

Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in 12 VAC 30-90-271.

b. ~~Effective July 1, 2001, indirect~~ Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, for the rest of the state for facilities with less than 61 licensed beds, and for the rest of the state for facilities with more than 60 licensed beds.

3. ~~Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care Information System (LTCIS). Data will be reported on the multidimensional assessment form prescribed by DMAS (now DMAS-80) at the time of admission and then twice a year for every Medicaid recipient in a NF. The NF's SII, derived from the assessment data, will be normalized by dividing it by the average for all NF's in the state.~~

3. ~~See 12VAC30-90-300 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.~~ Each facility's average case mix index shall be calculated based upon data reported by that nursing facility to the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA) Minimum Data Set (MDS) System. See 12VAC 30-90-301 for the case mix index calculations.

4. The normalized ~~SII~~ facility average Medicaid CMI shall be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective

rates for each semiannual period of a NF's subsequent fiscal ~~years~~ year. See 12 VAC 30-90-301 D 2 for the calculation of the normalized facility average Medicaid CMI.

a. Repealed.

b. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NF's normalized ~~SII~~ facility average Medicaid CMI ~~for the previous semiannual period~~. A NF's direct patient care operating cost prospective ceiling will be calculated semiannually.

c. ~~An SII rate adjustment, if any, shall be applied to a NF's prospective direct patient care operating cost base rate for each semiannual period of a NF's fiscal year. The SII determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The SII determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate.~~ A CMI rate adjustment for each semi-annual period of a nursing facility's prospective fiscal year shall be applied by multiplying the nursing facility's normalized facility average Medicaid CMI applicable to each prospective semi-annual period by the nursing facility's case mix neutralized direct patient care operating cost base rate for the preceding cost reporting period (See 12 VAC 30-90-302).

d. ~~See 12VAC30-90-300 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.~~ See 12 VAC 30-90-302 for the applicability of case mix indices.

5. Effective for services on and after July 1, ~~2001~~ 2002, the following changes shall be made to the direct and indirect payment methods.

a. ~~The direct patient care operating ceiling shall be set at 112% of the median of facility specific direct cost per day. The calculation of the median shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar year 1998. The median used to set the direct ceiling shall be revised every two years using more recent data.~~ The direct patient care operating ceiling shall be set at 112% of the respective peer group day-weighted median of the facilities' case mix neutralized direct care operating costs per day. The calculation of the medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in the most recent base year. The medians used to set the peer group direct patient care operating ceilings shall be revised and case mix neutralized every two years using more recent cost data. ~~In addition, for ceilings effective during July 1, 2000, through June 30, 2002, the ceiling calculated as described herein shall be increased by two per diem amounts. The first per diem amount shall equal $21,716,649, increased for inflation from SFY2000 to SFY 2001, divided by Medicaid days in SFY 2000.~~

~~The second per diem amount shall equal $1,400,000 divided by Medicaid days in SFY2000. When this ceiling calculation is completed for services after June 30, 2002, the per diem amount related to the amount of $21,716,649 shall not be added.~~

~~b. Facility specific direct cost per day amounts used to calculate direct reimbursement rates for dates of service on and after July 1, 2000, shall be increased by the two per diem amounts described in subitem a above. However, the per diem related to the amount of $21,716,649 shall be included only in proportion to the number of calendar days in the provider fiscal year the data are taken from that do not fall after July 1, 1999. That is, for a cost report from a provider fiscal year ending December 31, 1999, the specified increase would apply to about half of the year.~~

~~c.~~b. The indirect patient care operating ceiling shall be set at 106.9% of the respective peer group day weighted median of the ~~facility~~ facility's specific indirect operating cost per day. The calculation of the peer group ~~median~~ medians shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in ~~calendar year 1998~~ the most recent base year. The medians used to set the peer group indirect operating ceilings shall be revised every two years using more recent cost data.

B. ~~The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:~~

~~1. The initial peer group ceilings established under this section shall be the final peer group ceilings for a NF's first or partial cost reporting fiscal year under PIRS. Peer group ceilings for subsequent fiscal years shall be calculated by use of the adjusted medians determined at June 30, 2000, for direct and indirect cost. These adjusted medians shall be considered the 'final' interim ceilings for subsequent fiscal years. The 'final' interim ceilings determined above shall be adjusted by adding 100% of historical inflation from June 30, 2000, to the beginning of the NF's next fiscal year to obtain the new 'interim' ceilings, and 50% of the forecasted inflation to the end of the NF's next fiscal year.~~

~~2. A NF's average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.~~ Adjustment of Ceilings and Costs for Inflation. Effective for provider fiscal years starting on and after July 1, 2002, ceilings and rates shall be adjusted for inflation each year using the moving average of the percent change of the Virginia-Specific Nursing Home Input Price Index, published by Standard & Poor's DRI.

1. For provider years beginning in each calendar year, the percentage used shall be the moving average for the second quarter of the year, taken from the table published for the fourth quarter of the previous year. For example, in setting prospective rates for all provider years beginning in

January through December 2002, ceilings and costs would be inflated using the moving average for the second quarter of 2002, taken from the table published for the fourth quarter of 2001.

2. Provider specific costs shall be adjusted for inflation each year from the cost reporting period to the prospective rate period using the moving average as specified above. If the cost reporting period or the prospective rate period is less than twelve months long, a fraction of the moving average shall be used that is equal to the fraction of a year from the midpoint of the cost reporting period to the midpoint of the prospective rate period.

3. Ceilings shall be adjusted from the common point established in the most recent re-basing calculation. Base period costs shall be adjusted to this common point using moving averages from the DRI tables corresponding to the provider fiscal period, as specified in 1 above. Ceilings shall then be adjusted from the common point to the prospective rate period using the moving average(s) for each applicable second quarter, taken from the DRI table published for the fourth quarter of the year immediately preceding the calendar year in which the prospective rate years begin. Re-based ceilings shall be effective on July first of each re-basing year, so in their first application they shall be adjusted to the midpoint of the provider fiscal year then in progress or then beginning. Subsequently they shall be adjusted each year from the common point established in rebasing to the midpoint of the appropriate provider fiscal year. For example, suppose the base year is made up of cost reports from years ending in calendar year 2000, the rebasing year is SFY2003, and the re-basing calculation establishes ceilings that are inflated to the common point of July 1, 2002. Providers with years in progress on July 1, 2002, would receive a ceiling effective July 1, 2002 that would be adjusted to the midpoint of the provider

year then in progress. In some cases this would mean the ceiling would be reduced from the July1, 2002, ceiling level. The following table shows the application of these provisions for different provider fiscal periods.

Table I

Application of Inflation to Different Provider Fiscal Periods

Provider FYE	Effective Date of New Ceiling	First PFYE After Rebasing Date	Inflation Time Span from Ceiling Date to Midpoint of First PFY	Second PFYE After Rebasing Date	Inflation Time Span from Ceiling Date to Midpoint of Second PFY
3/31	7/1/02	3/31/03	+ ¼ year	3/31/04	+ 1¼ years
6/30	7/1/02	6/30/03	+ ½ year	6/30/04	+ 1½ years
9/30	7/1/02	9/30/02	- ¼ year	9/30/03	+ ¾ year
12/31	7/1/02	12/31/02	-0-	12/31/03	+ 1 year

The following table shows the DRI tables that would provide the moving averages for adjusting ceilings for different prospective rate years.

Table II

Source Tables for DRI Moving Average Values

Provider FYE	Effective Date of New Ceiling	First PFYE After Rebasing Date	Source DRI Table for First PFY Ceiling Inflation	Second PFYE After Rebasing Date	Source DRI Table for Second PFY Ceiling Inflation
3/31	7/1/02	3/31/03	4th Qrtr 2001	3/31/04	4th Qrtr 2002
6/30	7/1/02	6/30/03	4th Qrtr 2001	6/30/04	4th Qrtr 2002
9/30	7/1/02	9/30/02	4th Qrtr 2000	9/30/03	4th Qrtr 2001
12/31	7/1/02	12/31/02	4th Qrtr 2000	12/31/03	4th Qrtr 2001

In this example, when ceilings are inflated for the second PFY after the rebasing date, the ceilings will be inflated from July 1, 2002, using moving averages from the DRI table specified for the second PFY. That is, the ceiling for years ending June 30, 2004 will be the June 30, 2002 base period ceiling, adjusted by ½ of the moving average for the second quarter of 2002, compounded with the moving average for the second quarter of 2003. Both these moving averages will be taken from the 4th quarter 2002 DRI table.

C. ~~The PIRS method shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rates or prospective operating ceilings.~~ The RUG-III method shall require

comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rate or prospective operating ceiling.

D. Non-operating costs. Plant or capital, as appropriate, costs shall be reimbursed in accordance with Articles 1, 2, and 3. Plant costs shall not include the component of cost related to making or producing a supply or service. NATCEPs cost shall be reimbursed in accordance with 12VAC30-90-170.

E. The prospective rate for each NF shall be based upon operating cost and plant/capital cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of non-reimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of non-reimbursable plant or capital, as appropriate, costs and NATCEPs costs shall be reflected in the year in which the non-reimbursable costs are included.

F. Effective July 1, 2001, for those NFs whose indirect operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable indirect operating cost rates and the indirect peer group ceilings

1. The following table presents four incentive examples:

Peer Group Ceilings	**Allowable Cost Per**		**%**	**Sliding Scale**	**Scale % Difference**
$ 30.00	$ 27.00	$ 3.00	10 %	$ .30	10 %
30.00	22.50	7.50	25 %	1.88	25 %
30.00	20.00	10.00	33 %	2.50	25 %
30.00	30.00	0	0		

2. Efficiency incentives shall be calculated only for the indirect patient care operating ceilings and costs. Effective July 1, 2001, a direct care efficiency incentive shall no longer be paid.

G. Quality of care requirement. A cost efficiency incentive shall not be paid to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards.

H. Sale of facility. In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

12VAC30-90-42. Repealed.

12VAC30-90-43. Repealed.

12VAC30-90-44 to 12VAC30-90-49. [Reserved]

Article 6

New Nursing Facilities

12VAC30-90-60. Interim rate.

A. A new facility shall be defined as follows:

1. A facility that is newly enrolled and new construction has taken place through the COPN process; or

2. A facility that is newly enrolled which was previously denied payments for new admissions and was subsequently terminated from the program.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. A replacement facility or one that has changed location may not be considered a new facility if it serves the same inpatient population. An exception may be granted by DMAS if the provider can demonstrate that the occupancy substantially changed as a result of the facility being replaced or changing location. A decline in the replacement facility's total occupancy of 20 percentage points, in the replacement facility's first cost reporting period, shall be considered to indicate a substantial change when compared to the lower of the old facility's previous two prior cost reporting periods. The replacement facility shall receive the previous operator's operating rates if it does not qualify to be considered a new facility.

D. A change in either ownership or adverse financial conditions (e.g. bankruptcy), or both, of a provider does not change a nursing facility's status to be considered a new facility.

E. Effective July 1, 2001, for all new NFs the 90% occupancy requirement for indirect and capital costs shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 13 months from the date of the NF's certification.

F. The 90% occupancy requirement for indirect and capital costs shall be applied to the first and subsequent cost reporting periods' actual indirect and capital costs for establishing such NF's second and future cost reporting periods' prospective reimbursement rates. The

90% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 90% occupancy at any point in time during the first cost reporting period.

G. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by the DMAS, or the appropriate operating ceilings or charges.

H. Effective July 1, 2001, on the first day of its second cost reporting period, a new nursing facility's interim plant or capital, as appropriate, rate shall be converted to a per diem amount by dividing ~~it~~ its allowable plant/capital costs for its first cost reporting period by 90 percent of the potential number of patient days for all licensed beds during the first cost reporting period.

I. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned ~~SII~~ CMI based upon its peer group's normalized average ~~SII~~ Medicaid CMI for direct patient care. An expanded NF receiving new NF treatment shall receive the ~~SII~~ CMI calculated for its last semiannual period prior to obtaining new NF status.

12 VAC 30-90-61 through 12 VAC 30-90-64. Reserved.

12VAC30-90-65. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in 12VAC30-90-60 E, F, and H.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If indirect costs are below the ceiling, an efficiency incentive shall be paid at settlement of the first year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable indirect operating cost and the peer group ceiling used to set the interim rate. (Refer to 12VAC30-90-41 F.)

12 VAC 30-90-66 through 12 VAC 30-90-69. Reserved.

Part III

Nursing Home Payment System Appendices

12VAC30-90-270. Uniform Expense Classification. (Appendix I.)

This appendix describes the classification of expenses applicable to the Nursing Facility Payment System.

Allowable expenses shall meet all of the following requirements: necessity, reasonableness, non-duplication, related to patient care, not exceeding the limits and/or ceilings established in the Payment System and meet applicable Medicare principles of reimbursement. All of the references to 12 VAC 30-90-270 occurring in previous Part II shall be understood to include 12 VAC 30-90-270 through 12 VAC 30-90-276.

12VAC30-90-271. Direct patient care operating.

A. Nursing service expenses.

1. Salary--nursing administration. Gross salary (includes sick pay, holiday pay, vacation pay, staff development pay and overtime pay) of all licensed nurses in supervisory positions defined

as follows (Director of Nursing, Assistant Director of Nursing, nursing unit supervisors and patient care coordinators).

2. Salaries--RNs. Gross salary of registered nurses.

3. Salaries--LPNs. Gross salary of licensed practical nurses.

4. Salaries--Nurse Aides. Gross salary of certified nurse aides.

5. Salaries-- quality assurance nurses. Gross salary of licensed nurse who functions as quality assurance coordinator and is responsible for quality assurance activities and programs. Quality assurance activities and programs are concerned with resident care and not with the administrative support that is needed to document the care. If a quality assurance coordinator is employed by the home office and spends a percentage of time at nursing facilities, report directly allocated costs to the nursing facility in this category rather than under the home office operating costs.

~~5.~~ 6. Nursing employee benefits. Benefits related to registered nurses, licensed practical nurses, certified nurse aides , quality assurance nurses, and nursing administration personnel as defined in subdivision 1 of this subsection. See 12VAC30-90-272 B for description of employee benefits.

~~6.~~ 7. Contract nursing services. Cost of registered nurses, licensed practical nurses, ~~and~~ certified nurse aides , and quality assurance nurses on a contract basis.

~~7.~~ 8. Supplies. Cost of supplies, including nursing and charting forms, medication and treatment records, physician order forms.

~~8.~~ 9. Professional fees. Medical director and pharmacy consultant fees.

B. Minor medical and surgical supplies.

1. Salaries--medical supply. Gross salary of personnel responsible for procurement, inventory and distribution of minor medical and surgical supplies.

2. Medical supply employee benefits. Benefits related to medical supply personnel. See 12VAC30-90-272 B for description of employee benefits.

3. Supplies. Cost of items for which a separate identifiable charge is not customarily made, including, but not limited to, colostomy bags; dressings; chux; rubbing alcohol; syringes; patient gowns; basins; bed pans; ice-bags and canes, crutches, walkers, wheel chairs, traction equipment and other durable medical equipment for multi-patient use.

4. Oxygen. Cost of oxygen for which a separate charge is not customarily made.

5. Nutrient/tube feedings. Cost of nutrients for tube feedings.

6. Incontinence services. Cost of disposable and non-disposable incontinence supplies. The laundry supplies or purchased commercial laundry service for non-disposable incontinent services.

C. Ancillary Service Cost. Allowable ancillary service costs represents gross salary and related employee benefits of those employees engaged in covered ancillary services to Medicaid recipients, cost of all supplies used by the respective ancillary service departments, cost of ancillary services performed on a contract basis by other than employees and all other costs allocated to the ancillary service cost centers in accordance with Medicare principles of reimbursement.

Following is a listing all covered ancillary services:

1. Radiology

2. Laboratory

3. Inhalation therapy

4. Physical therapy

5. Occupational therapy

6. Speech therapy

7. EKG

8. EEG

9. Medical supplies charged to patient.

12VAC30-90-272. Indirect patient care operating costs.

A. Administrative and general.

1. Administrator/owner assistant administrator. Compensation of individuals responsible for administering the operations of the nursing facility. (See 12VAC30-90-50 and Appendix III (12VAC30-90-290) for limitations.)

2. Other administrative and fiscal services. Gross salaries of all personnel in administrative, personnel, fiscal, billing and admitting, communications and purchasing departments.

3. Management fees. Cost of fees for providing necessary management services related to nursing facility operations. (See Appendix III (12VAC30-90-290) for limitations.)

4. Professional fees--accounting. Fees paid to independent outside auditors and accountants.

5. Professional fees--legal. Fees paid to attorneys. (See Appendix III (12VAC30-90-290) for limitations.)

6. Professional fees--other. Fees, other than accounting or legal, for professional services related to nursing facility patient care.

7. Director's fees. Fees paid for attendance at scheduled meetings which serve as reimbursement for time, travel, and services provided. (See Appendix III (12VAC30-90-290) for limitations.)

8. Membership fees. Fees related to membership in health care organizations which promote objectives in the providers' field of health care activities. (See Appendix III (12VAC30-90-290) for limitations.)

9. Advertising (classified). Cost of advertising to recruit new employees and yellow pages advertising.

10. Public relations. Cost of promotional expenses including brochures and other informational documents regarding the nursing facility.

11. Telephone. Cost of telephone service used by employees of the nursing facility.

12. Subscriptions. Cost of subscribing to newspapers, magazines, and periodicals.

13. Office supplies. Cost of supplies used in administrative departments (e.g., pencils, papers, erasers, staples).

14. Minor furniture and equipment. Cost of furniture and equipment which does not qualify as a capital asset.

15. Printing and postage. Cost of reproducing documents which are reasonable, necessary and related to nursing facility patient care and cost of postage and freight charges.

16. Travel. Cost of travel (airfare, auto mileage, lodging, meals, etc. by administrator or other authorized personnel on official nursing facility business). (See 12VAC30-90-290 for limitations.)

17. Auto. All costs of maintaining nursing facility vehicles, including gas, oil, tires, licenses, maintenance of such vehicles.

18. License fees. Fees for licenses, including state, county, and local business licenses, and VHSCRC filing fees.

19. Liability insurance. Cost of insuring the facility against liability claims, including malpractice.

20. Interest. Other than mortgage and equipment.

21. Amortization/start-up costs. Amortization of allowable Start-Up Costs (See 12VAC30-90-220).

22. Amortization/organizational costs. Amortization of allowable organization costs (See 12VAC30-90-220).

B. Employee benefits.

1. FICA (Social Security). Cost of employer's portion of Social Security Tax.

2. State unemployment. State unemployment insurance costs.

3. Federal unemployment. Federal unemployment insurance costs.

4. Workers' compensation. Cost of workers' compensation insurance.

5. Health insurance. Cost of employer's contribution to employee health insurance.

6. Group life insurance. Cost of employer's contribution to employee group life insurance.

7. Pension plan. Employer's cost of providing pension program for employees.

8. Other employee benefits. Cost of awards and recognition ceremonies for recognition and incentive programs, disability insurance, child care, and other commonly offered employee benefits which are nondiscriminatory.

C. Dietary expenses.

1. Salaries. Gross salary of kitchen personnel, including dietary supervisor, cooks, helpers and dishwashers.

2. Supplies. Cost of items such as soap, detergent, napkins, paper cups, and straws.

3. Dishes and utensils. Cost of knives, forks, spoons, plates, cups, saucers, bowls and glasses.

4. Consultants. Fees paid to consulting dietitians.

5. Purchased services. Costs of dietary services performed on a contract basis.

6. Food. Cost of raw food.

7. Nutrient oral feedings. Cost of nutrients in oral feedings.

D. Housekeeping expenses.

1. Salaries. Gross salary of housekeeping personnel, including housekeepers, maids and janitors.

2. Supplies. Cost of cleaners, soap, detergents, brooms, and lavatory supplies.

3. Purchased services. Cost of housekeeping services performed on a contract basis.

E. Laundry expenses.

1. Salaries. Gross salary of laundry personnel.

2. Linen. Cost of sheets, blankets, and pillows.

3. Supplies. Cost of such items as soap, detergent, starch and bleach.

4. Purchased services. Cost of other services, including commercial laundry service.

F. Maintenance and operation of plant.

1. Salaries. Gross salary of personnel involved in operating and maintaining the physical plant, including maintenance men or plant engineer and security services.

2. Supplies. Cost of supplies used in maintaining the physical plant, including light bulbs, nails, lumber, glass.

3. Painting. Supplies and contract services.

4. Gardening. Supplies and contract services.

5. Heating. Cost of heating oil, natural gas, or coal.

6. Electricity. Self-explanatory.

7. Water, sewer, and trash removal. Self-explanatory.

8. Purchased services. Cost of maintaining the physical plant, fixed equipment, movable equipment and furniture and fixtures on a contract basis.

9. Repairs and maintenance. Supplies and contract services involved with repairing the facility's capital assets.

G. Medical records expenses.

1. Salaries--medical records. Gross salary of licensed medical records personnel and other department personnel.

2. Utilization review. Fees paid to physicians attending utilization review committee meetings.

3. Supplies. All supplies used in the department.

4. Purchased services. Medical records services provided on a contract basis.

H. ~~Quality assurance services~~. Repealed.

~~1. Salaries. Gross salary of personnel providing quality assessment and assurance activities.~~

~~2. Purchased services. Cost of quality assessment and assurance services provided on a contract basis.~~

~~3. Supplies. Cost of all supplies used in the department or activity.~~

I. Social service expenses.

1. Salaries. Salary of personnel providing medically-related social services. A facility with more than 120 beds must employ a full-time qualified social worker.

2. Purchased services. Cost of medically-related social services provided on a contract basis.

3. Supplies. Cost of all supplies used in the department.

J. Patient activity expenses.

1. Salaries. Gross salary of personnel providing recreational programs to patients, such as arts and crafts, church services and other social activities.

2. Supplies. Cost of items used in the activities program (i.e., games, art and craft supplies and puzzles).

3. Purchased services. Cost of services provided on a contract basis.

K. Educational activities expenses. (Other than NATCEPs costs, see 12VAC30-90-270.)

1. Salaries. Gross salaries of training personnel.

2. Supplies. Cost of all supplies used in this activity.

3. Purchased services. Cost of training programs provided on a contract basis.

L. Other nursing Administrative costs.

1. Salaries--other nursing administration. Gross salaries of ward clerks and nursing administration support staff.

2. Subscriptions. Cost of subscribing to newspapers, magazines and periodicals.

3. Office supplies. Cost of supplies used in nursing administrative departments (e.g., pencils, papers, erasers, staples).

4. Purchased services. Cost of nursing administrative consultants, ward clerks, nursing administration support staff performed on a contract basis.

5. Advertising (classified). Cost of advertising to recruit all nursing service personnel.

M. Home office costs. Allowable operating costs incurred by a home office which are directly assigned to the nursing facility or pooled operating costs , with the exception of quality assurance coordinator salary and employee benefits that are reported under direct patient care operating, that are allocated to the nursing facility in accordance with 12VAC30-90-240.

12VAC30-90-273. Plant costs.

A. Interest.

1. Building interest. Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the nursing facility's real property. (See 12VAC30-90-30 for Limitations.)

2. Equipment interest. Interest paid or accrued on notes, chattel mortgages and other loans, the proceeds of which were used to purchase the nursing facility's equipment. (See 12VAC30-90-30 for Limitations.)

B. Depreciation (12VAC30-90-50).

1. Building depreciation. Depreciation on the nursing facility's building.

2. Building improvement depreciation. Depreciation on major additions or improvements to the nursing facility (i.e., new laundry or dining room).

3. Land improvement depreciation. Depreciation of improvements made to the land occupied by the facility (i.e., paving, landscaping).

4. Fixed and movable equipment depreciation. Depreciation on capital assets classified as fixed and movable equipment in compliance with American Hospital Association Guidelines.

5. Leasehold improvement depreciation. Depreciation on major additions or improvements to building or plant where the facility is leased and the costs are incurred by the lessee (tenant).

6. Automobile depreciation. Depreciation of those vehicles utilized solely for facility/patient services.

C. Lease/rental.

1. Building rental. Rental amounts paid by the provider on all rented or leased real property (land and building).

2. Equipment rental. Rental amounts paid by the provider on leased or rented furniture and equipment.

D. Taxes.

1. Property taxes. Amount of taxes paid on the facility's property, plant and equipment.

E. Insurance.

1. Property insurance. Cost of fire and casualty insurance on buildings and equipment.

2. Mortgage insurance. Premiums required by the lending institution, if the lending institution is made a direct beneficiary and if premiums meet Medicare principles of reimbursement criteria for allowability.

F. Amortization--deferred financing costs. Amortization of deferred financing costs (those costs directly incident to obtaining financing of allowable capital costs related to patient care services such as legal fees; guarantee fees; service fees; feasibility studies; loan points; printing and engraving costs; rating agency fees). These deferred financing costs should be capitalized and amortized over the life of the mortgage.

G. Home office capital costs. Allowable plant costs incurred by a home office which are directly identified to the nursing facility or pooled capital costs that are allocated to the nursing facility in accordance with 12VAC30-90-240.

12VAC30-90-274. Non-allowable expenses.

Non-allowable expenses include but are not limited to the following:

A. Barber and beautician. Direct and indirect operating and capital costs related to the provision of beauty and barber services to patients.

B. Personal items. Cost of personal items, such as cigarettes, toothpaste, and shaving cream sold to patients.

C. Vending machines. Cost of items sold to employees and patients including candy bars and soft drinks.

D. Television/telephones. Cost of television sets and telephones used in patient rooms.

E. Gift shop. Direct and indirect operating and capital cost related to the provision of operating a gift shop.

F. Insurance--officers. Cost of life insurance on officers, owners and key employees where the provider is a direct or indirect beneficiary.

G. Income taxes. Taxes on net income levied or expected to be levied by any governmental entity.

H. Contributions. Amounts donated to charitable or other organizations which have no direct effect on patient care.

I. Deductions from revenue. Accounts receivable written off as bad debts, charity, courtesy, or from contractual agreements are non-allowable expenses.

J. Advertising. The cost of advertisements in magazines, newspapers, trade publications, radio, and television and certain home office expenses as defined in PRM-15.

K. Cafeteria. Cost of meals to other than patients.

L. Pharmacy. Cost of all prescribed legend and nonlegend drugs.

M. Medical supplies. Cost of medical supplies to other than patients.

N. Plant costs. All plant costs not available for nursing facility patient care-related activities are nonreimbursable plant costs.

12VAC30-90-275. Nurse Aide Training and Competency Evaluation Programs (NATCEPs) costs.

A. Facility-based NATCEPs costs.

1. Salary--staff development. Gross salary of personnel conducting the nurse aide training and competency evaluation programs.

2. Employee benefits. Benefits related to personnel conducting the nurse aide training and competency evaluation programs. See 12VAC30-90-272 B for description of employee benefits.

3. Contract services. Cost of state qualified nurse aide instructors paid on a contract basis.

4. Supplies. Cost of supplies used in conducting NATCEPs (e.g., pencils, papers, erasers, staples, textbooks and other required course materials).

5. License fees. Cost of nurse aide registry application fees and competency evaluation testing fees paid by the nursing facilities on behalf of the certified nurse aides.

6. Housekeeping expenses. Housekeeping expense as defined in 12VAC30-90-272 D, for nursing facilities which dedicate space in the facility to NATCEPs activities 100%. Housekeeping expenses shall be allocated to the NATCEPs operations in accordance with Medicare Principles of Reimbursement.

7. Maintenance and operation of plant. Maintenance and operation of plant as defined in 12VAC30-90-272 F, for nursing facilities which dedicate space in the facility to NATCEPs activities 100%.

Maintenance and operation of plant expense shall be allocated to the NATCEPs operations in accordance with Medicare Principles of Reimbursement.

8. Other direct expenses. Any other direct costs associated with the operation of the NATCEPs. There shall be no allocation of indirect patient care operating costs as defined in 12VAC30-90-272, except housekeeping and maintenance and operation of plant expenses.

B. Non-facility-based NATCEPs costs.

1. Contract services. Cost of training and competency evaluation of nurse aides paid to an outside state approved nurse aide education program.

2. Supplies. Cost of supplies of textbooks and other required course materials provided during the nurse aide education programs by the nursing facility.

3. License fees. Cost of nurse aide registry application fees and competency evaluation testing fee paid by the nursing facility on behalf of the certified nurse aides.

4. Travel. Cost for transportation provided to the nurse aides to the training or competency evaluation testing site.

12VAC30-90-276. Criminal records background checks.

Included in the Uniform Expense Classifications is the cost of obtaining criminal records checks from the Central Criminal Records Exchange for all persons hired for compensated employment after July 1, 1993.

Appendix IV.

12VAC30-90-300. ~~Patient Intensity Rating System (PIRS).~~ Resource Utilization Groups (RUGs).

~~A. Effective October 1, 1990, the Virginia Medicaid Program reimbursement system for nursing facilities is the Patient Intensity Rating System.~~

~~B. PIRS is a patient-based reimbursement system which links a facility's per diem rate to the level of services required by its patient mix. This methodology uses classes that group patients together based on similar functional characteristics and service needs.~~

~~C. PIRS recognizes four classes of patients:~~

~~1. Class A - Routine I: Patients are classified by their functioning status. Routine I classification includes care for patients with a 0 to 6 Activity of Daily Living (ADL) impairment score.~~

~~2. Class B - Routine II: Patients are classified by their functioning status. Routine II classification includes care for patients with moderate or greater ADL impairment. A moderate or greater ADL score ranges from 7 to 12.~~

~~3. Class C - Heavy Care: Patients are classified by their high impairment score on functioning status and the need for specialized nursing care. These patients have an ADL impairment score of 9 or more and one or more of the following:~~

~~a. Wound/lesions requiring daily care;~~

~~b. Nutritional deficiencies leading to specialized feeding;~~

~~c. Paralysis or paresis, and benefiting from rehabilitation; or~~

~~d. Quadriplegia/paresis, bilateral hemiplegia/paresis, multiple sclerosis.~~

~~4. Specialized Care: This class includes patients who have needs that are so intensive or nontraditional that they cannot be adequately captured by a patient intensity rating system, e.g., ventilator dependent or AIDS patients. Specialized Care reimbursement shall be determined according to the methodology set forth in 12VAC30-90-264.~~

~~D. Patients in each class require similar intensities of nursing and other skilled services. Across classes, however, service intensities are quite different. Since treatment cost depends on overall service need, the patient class system has a direct correlation to nursing and therapy costs.~~

The Resource Utilization Groups-III (RUG-III), Version 5.12, 34-group, index maximizing model shall be used as the resident classification system to determine the RUG-III group for each

resident assessment. RUG-III classifies resident assessments according to the intensity of each resident's needs. Data from the minimum data set (MDS) submitted by each facility to the Centers for Medicare and Medicaid Services (CMS) shall be used to classify the resident assessments into RUG-III groups.

Definitions. The following words and terms when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise.

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

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

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

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

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

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

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

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

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

12VAC30-90-301. ~~Service Intensity Index (SII).~~ Case Mix Index (CMI).

~~A. The function of a service intensity index is to identify the resource needs of a given facility's patient mix relative to the needs in other nursing homes. If the SII value equals 1.20, it indicates that the patient mix in that facility is 20% more resource intensive than the patient mix in the average Virginia nursing facility.~~

~~B. The SII is used to adjust direct patient care cost ceilings and rates for application to individual nursing facilities. Indirect patient care cost ceilings and rates are not adjusted since these costs are not influenced by patient service needs.~~

~~C. To calculate the service intensity index:~~

~~1. Develop a relative resource cost for patient classes.~~

~~a. Average daily nursing resource costs per day for patients in each patient class were determined by using data obtained from (i) the Commonwealth's Long-Term Care Information System (LTCIS) identifying estimates of service needs, (ii) data from a 1987 Maryland time and motion study (1981) to derive nursing time requirements for each service, and (iii) KPGM Peat Marwick Survey of Virginia Long-term Care Nursing Facilities' Nursing Wages (September 5, 1989) to determine the resource indexes for each patient class.~~

~~b. The average daily nursing costs per day for patients (see subdivision 1a of this subsection) were divided by a state average daily nursing resource cost to obtain a relative cost index.~~

~~c. Patients were grouped in three classes and the average relative cost by class is as follows:~~

~~. (1) Class A - Routine I .67~~

~~. (2) Class B - Routine II: 1.09~~

~~. (3) Class C - Heavy Care: 1.64~~

~~The cost for caring for a Class A patient is on the average equal to 67% of the daily nursing costs for the average Virginia nursing facility patient. Class B and C patients are respectively 9.0% and 64% more costly to treat in terms of nursing resources than the average nursing facility patient.~~

~~These resource cost values will remain the same until a new time and motion study is conducted.~~

~~2. Develop an average relative resource cost of all patients in a facility. The result is called a facility score.~~

~~a. The number of patients in each class within a facility is multiplied by the relative resource cost value of that class.~~

~~b. These amounts are totaled and divided by the number of patients in a facility. For example:~~

~~Facility 1~~

~~40 Class A patients x .67 = 26.8~~

~~40 Class B patients x 1.09 = 43.6~~

~~20 Class C patients x 1.64 = 32.8~~

~~100 patients 103.2~~

~~Divided by number of patients 100.0~~

~~Facility score 1.03~~

~~The facility score for facility 1 is 1.03~~

~~3. Finally, the service intensity index for a facility is calculated by standardizing the average resource cost measure, across nursing facilities. The resource values up to this point are standardized or normalized across Virginia nursing facility patients but not across Virginia nursing facilities. To accomplish this step, the mean for the relative resource measure across all Virginia facilities is determined and the facility-specific value is divided by this mean.~~
~~For example: If the state's mean relative resource measure was .92 across all Virginia facilities, the service intensity index for facility 1 identified above would be 1.12, which equals 1.03 divided by .92. The 1.12 value indicates that the patients in facility 1 are 12% (1.12-1.00) more costly to treat than patients in the average Virginia nursing facility.~~
~~4. The service intensity index will be calculated quarterly, and is used to derive the direct patient care cost ceiling and rate components of the facility's payment rate which will be adjusted semiannually. A semiannual SII is calculated by averaging appropriate quarterly SII values for the respective reporting period.~~

A. Each resident in a Virginia Medicaid certified nursing facility on the last day of the calendar quarter with an effective assessment date during the respective quarter shall be assigned to one of the RUG-III 34-groups.

B. Standard case mix indices, developed by CMS for the Medicaid population (B01), shall be assigned to each of the RUG-III 34 groups.

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

D. Using the individual Medicaid resident case-mix indices, a facility average Medicaid case-mix index shall be calculated four times per year for each facility. The facility

average Medicaid case-mix indices shall be used for case mix neutralization of resident care costs and for case-mix adjustment.

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

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

3. The Department shall monitor the case mix indices during the first two years following implementation of the RUG-III system. Effective July 1, 2004, the statewide average case-mix index may be changed to recognize the fact that the costs of all residents are

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

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

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

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

12VAC30-90-302. ~~Applicability of service intensity index.~~ Applicability of case mix indices (CMI).

~~A. Following is an illustration of how a nursing facility's service intensity index is used to adjust direct patient care prospective operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.~~

~~B. Assumptions.~~

~~1. The nursing facility's fiscal years are December 31, 1991, and December 31, 1992.~~

~~2. The average allowable direct patient care operating base rate for December 31, 1991, is $25.~~

~~3. The allowance for inflation is 6.0% for the fiscal year end beginning January 1, 1992.~~

~~4. The nursing facility's peer group ceiling for the fiscal year end beginning January 1, 1992, is $30.~~

~~5. The nursing facility's semiannual normalized SSIs are as follows:~~

~~1991 First semiannual SSI .98~~

~~1991 Second semiannual SSI .99~~

~~1992 First semiannual SSI 1.00~~

~~C. Calculation of nursing facility's Direct Patient Care Prospective Ceiling.~~

~~1. PIRS adjusted ceiling for the period January 1, 1992, through June 30, 1992:~~

~~FYE 1992 Peer Group Ceiling $30.00~~

~~1991 Second semiannual SII x .99~~

~~Facility Ceiling $29.70~~

~~2. PIRS adjusted ceiling for the period July 1, 1992, through December 31, 1992:~~

~~FYE 1992 Peer Group Ceiling $30.00~~

~~1992 First semiannual SII x 1.00~~

~~Facility Ceiling $30.00~~

~~D. Calculation of nursing facility's Prospective Direct Patient Care Operating Cost Rate.~~

~~1. Prospective Direct Patient Care Operating Cost Base Rate:~~

~~FYE 1991 Average Allowable Direct Patient Care~~

~~Operating Base Rate $25.00~~

~~Allowance For Inflation FYE 1992 x 1.06~~

~~_____~~

~~$26.50~~

~~2. Calculation of FYE 1991 Average SII:~~

~~First semiannual Period SII .98~~

~~Second semiannual Period SII .99~~

~~Average FYE 1991 SII .985~~

~~3. Calculation of FYE 1992 SII Rate Adjustments:~~

~~a. Rate adjustment for the period January 1, 1992, through June 30, 1992:~~

~~1991 Second semiannual SII .99~~

~~1991 Average SII (from subdivision 2 of this subsection) .985~~

~~Calculation: .99/.985~~

~~Rate Adjustment Factor = 1.0051~~

~~Prospective Direct Patient Care Operating Cost Base Rate~~
~~$26.50~~

~~(from subdivision 1 of this subsection)~~

~~Calculation: $26.50 x 1.0051~~

~~Prospective Direct Patient Care Operating Cost Rate~~
~~$26.64~~

~~b. Rate adjustment for the period July 1, 1992, through December 31, 1992:~~

~~1999 First semiannual SII 1.000~~

~~1991 Average SII (from subdivision 2 of this subsection) .985~~

~~Calculation: 1.00/.985~~

~~Rate Adjustment Factor 1.0152~~

~~Prospective Direct Patient Care Operating Cost Base Rate (from subdivision 1 of this subsection) $26.50~~

~~Calculation: $26.50 x 1.0152~~

~~Prospective Direct Patient Care Operating Cost Rate $26.90~~

~~E. In this illustration the nursing facility's PIRS Direct Patient Care Operating Reimbursement Rate for FYE 1992 would be as follows:~~

~~1. For the period January 1, 1992, through June 30, 1992, the reimbursement rate would be $26.64 since the rate is lower than the nursing facility's PIRS adjusted ceiling of $29.70 (from subdivision C 1 of this section).~~

~~2. For the period July 1, 1992, through December 31, 1992, the reimbursement rate would be $26.90 since the rate is lower than the nursing facility's PIRS adjusted ceiling of $30.00 (from subdivision C 2 of this section).~~

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

B. When a facility's direct patient care cost ceiling is compared to its facility specific direct patient care cost rate, to determine the direct patient care prospective rate, both the ceiling and the rate shall be case-mix neutral. The direct patient care cost ceiling shall be case-mix neutral because it shall be calculated using base year facility direct patient care cost data that have been case-mix neutralized. To accomplish this neutralization, each facility's base year direct patient care operating cost shall be divided by the facility's average normalized Medicaid CMI developed for the two semi-annual periods of assessment data that most closely match the provider's cost reporting year that ends in the base year (see Table ## below). This shall be the facility's case-mix neutral direct patient care per diem for the base year and shall be used in the calculation of the peer group direct patient care cost ceilings. The following table shows an example of the picture dates used to case-mix neutralize facility specific direct costs for the ceiling calculation. For the first few provider fiscal years for which cost neutralization will be done, a data limitation affects the picture dates that can be used. Accurate case-mix data are available starting with the fourth quarter of Calendar Year (CY) 1999. For providers with cost reporting periods ending during the 1st, 2nd, and 3rd quarters of CY 2000, the picture dates used in cost neutralization shall be modified to reflect only accurate case mix data. For provider cost reporting periods ending in the 4th quarter of 2000 and afterward, this limitation no longer exists and assessment data shall be used that most closely match the cost reporting period.

Table III

Quarter of Provider Cost Report Year End	Picture Dates Used to Neutralize Costs for Ceiling Calculation	
	Preferred Picture Dates if No Data Limitation Applied	Picture Dates That Shall be Used Due to Data Limitation
1st Quarter of CY 2000	3/31/99, 6/30/99, 9/30/99, 12/31/99	12/31/99
2nd Quarter of CY 2000	6/30/99, 9/30/99, 12/31/99, 3/31/00	12/31/99, 3/31/00
3rd Quarter of CY 2000	9/30/99, 12/31/99, 3/31/00, 6/30/00	12/31/99, 3/31/00, 6/30/00
4th Quarter of CY 2000	12/31/99, 3/31/00, 6/30/00, 9/30/00	12/31/99, 3/31/00, 6/30/00, 9/30/00

C. When direct patient care prospective rates are set the direct patient care ceilings used in the calculation shall be the case-mix neutralized ceiling described in B above, adjusted for inflation to the midpoint of the prospective period. However, the facility specific direct patient care cost rates used in the calculation shall not be from the base year, but shall be from the provider fiscal year prior to the period for which a prospective rate is being calculated. Therefore the provider's direct patient care rate from the previous cost reporting period shall be case-mix neutralized using the facility average normalized Medicaid CMI developed for the two semi-annual periods of assessment data that most closely match the cost reporting period prior to the prospective period for which a rate is being calculated. Each year when a new prospective rate is developed, the provider specific direct patient care rate shall be case-mix neutralized using CMI data that uses picture dates that correspond to the cost reporting period used to develop the rate. The

relationship between provider cost reporting period and picture dates shall be that illustrated in the above table, except that in the time period when rates will first be set, the data limitation that affected the picture dates shown in the above table will not apply. Therefore for all provider cost reporting periods picture dates that correspond to the cost reporting period shall be used.

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

Table IV

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

Quarter of Provider Cost Report Year End	Picture Dates Used to Adjust 1st Prospective Semi-Annual Period	Picture Dates Used to Adjust 2nd Prospective Semi-Annual Period
1st Quarter CY 2002	9/30/01, 12/31/01	3/31/02, 6/30/02
2nd Quarter CY 2002	12/31/01, 3/31/02	6/30/02, 9/30/02
3rd Quarter CY 2002	3/31/02, 6/30/02	9/30/02, 12/31/02
4th Quarter CY 2002	6/30/02, 9/30/02	12/31/02, 3/31/03

E. Any out-of-state nursing facility provider that is enrolled in the Virginia Medical Assistance Program and is required to submit a cost report to the Virginia Medical Assistance Program will be assigned the Virginia statewide normalized CMI of 1.0. This CMI of 1.0 will be used to adjust the direct patient care cost ceilings and rates.

F. Example of case mix adjustment of direct operating rate.

1. Following is an illustration of how a nursing facility's case mix index is used to make direct patient care semiannual rate adjustments to the prospective direct patient care operating cost base rate.

2. Assumptions.

a. The nursing facility's fiscal year is January 1, 2002 through December 31, 2002.

b. The average allowable direct patient care operating rate for the year is $50

c. The allowance for inflation is 4.0 percent for the fiscal year beginning January 1, 2003.

d. The nursing facility's case mix neutral direct peer group ceiling for the fiscal year beginning January 1, 2003 is $60.

e. The nursing facility's normalized case mix scores are as follows:

12/31/2001 picture date CMI	1.0100
3/31/2002 picture date CMI	1.0105
6/30/2002 picture date CMI	1.0098
9/30/2002 picture date CMI	1.0305
12/31/2002 picture date CMI	1.0355
3/31/2003 picture date CMI	1.0400

3. Calculation of nursing facility's Direct Patient Care Operating Cost Rate.

1. Direct Patient Care Operating Cost Rate:

Average Allowable Direct Patient Care Operating Rate	$50.00
Allowance For Inflation FYE 2003	x 1.0400
	$52.00

2. Calculation of case mix factor used for case mix neutralization:

12/31/2001 CMI	1.0100
3/31/2002 CMI	1.0105
6/30/2002 CMI	1.0098
9/30/2002 CMI	1.0305

Average of four CMI = 1.0152

c. Case mix neutralized average allowable direct patient care operating rate:

Average Allowable Direct Patient Care Operating Rate for FY 2003	$52.00
Case mix neutralization factor	÷ 1.0152

Case mix neutralized Direct Patient Care Operating Rate for FY 2003 = $51.22

d. Lower of case mix neutralized cost or ceiling:

The case mix neutralized Direct Patient Care Operating Rate, $51.22, is lower than the case mix neutral ceiling, $60.00. $51.22 will be used in the rate calculation.

e. Calculation of case mix rate adjustments:

(1) Case mix rate adjustment for the period January 1, 2003, through June 30, 2003:

First semiannual rate adjustment – Average of (6/30/2002 CMI, 9/30/2002 CMI) = Average(1.0098,1.0305) = 1.0202

(2) Case mix rate adjustment for the period July 1, 2003 through December 31, 2003:

Second semiannual rate adjustment – Average of (12/31/2002 CMI, 3/31/2003 CMI) = Average(1.0355,1.0400) =1.0378

f. Rates for semiannual periods:

(1) Case mix adjusted rate for the period January 1, 2003, through June 30, 2003:

First semiannual rate = 1.0202 * $51.22 = $52.25

(2) Case mix adjusted rate for the period July 1, 2003 through December 31, 2003:

Second semiannual rate = 1.0378 * $51.22 = $53.15

12VAC30-90-303. ~~Applicability of allowance for inflation during phase-in period~~. Repealed.

~~A. The methodology for applying the allowance for inflation to the nursing facility's base "current" operating rate during the phase-in period as outlined in 12VAC30-90-40 is as follows:~~

~~B. Nursing facilities with fiscal years ending in the fourth quarter of 1990 shall have, in effect from October 1, 1990, through the end of the provider's 1990 fiscal year, as the base "current" operating rate, the rate calculated by DMAS to be effective September 30, 1990.~~

~~The base "current" operating rate shall be adjusted for 100% of the historical inflation from the second quarter of 1990 through the fourth quarter of 1990 and 50% of the forecasted inflation from the fourth quarter of 1990 through the fourth quarter of 1991, to determine the prospective "current" operating rate for the provider's 1991 FY.~~

~~The base "current" operating rate shall be adjusted for 100% of the historical inflation from the second quarter of 1990 through the fourth quarter of 1991 and 50% of the forecasted inflation from the fourth quarter of 1991 through the fourth quarter of 1992, to determine the prospective "current" operating rate from the beginning of the provider's subsequent fiscal year end to June 30, 1992.~~

~~C.~~ Nursing facilities with fiscal years ending in the first quarter of 1991 shall have, in effect from October 1, 1990, through the end of the provider's 1991 fiscal year, as the base "current" operating rate, the rate calculated by DMAS to be effective September 30, 1990.

~~The base "current" operating rate shall be adjusted for 100% of the historical inflation from the third quarter of 1990 through the first quarter of 1991 and 50% of the forecasted inflation from the first quarter of 1991 through the first quarter of 1992, to determine the prospective "current" operating rate for the provider's 1992 FY.~~

~~The base "current" operating rate shall be adjusted for 100% of the historical inflation from the third quarter of 1990 through the first quarter of 1992 and 50% of the forecasted inflation from the first quarter of 1992 through the first quarter of 1993, to determine the prospective "current" operating rate from the beginning of the provider's subsequent fiscal year end to June 30, 1992.~~

~~D. Nursing facilities with fiscal years ending in the second quarter of 1991 shall have, in effect from October 1, 1990, through the end of the provider's 1991 fiscal year, as the base "current" operating rate, the rate calculated by DMAS to be effective September 30, 1990.~~

~~The base "current" operating rate shall be adjusted for 100% of the historical inflation from the fourth quarter of 1990 through the second quarter of 1991 and 50% of the forecasted inflation from the second quarter of 1991 through the second quarter of 1992, to determine the prospective "current" operating rate for the provider's 1992 FY or until June 30, 1992, whichever is later.~~

~~E. Nursing facilities with fiscal years ending in the third quarter of 1990 shall have as the base "current" operating rate, the rate calculated by DMAS to be effective September 30, 1990.~~

~~The base "current" operating rate shall be adjusted for 100% of the historical inflation from first quarter of 1990 through the third quarter of 1990 and 50% of the forecasted inflation from the third quarter of 1990 through the third quarter of 1991, to determine the prospective "current" operating rate from October 1, 1990, to the end of the provider's 1991 FY.~~

~~The base "current" operating rate shall be adjusted for 100% of the historical inflation from the first quarter of 1990 through the third quarter of 1991 and 50% of the forecasted inflation from the third quarter of 1991 through the third quarter of 1992, to determine the prospective "current" operating rate from the beginning of the provider's subsequent fiscal year end to June 30, 1992.~~

12VAC30-90-304. ~~Definition of terms.~~ Repealed.

~~"ADL" means activities of daily living.~~

~~"ADL score" means a score constructed by the Virginia Center on Aging of the Medical College of Virginia as a composite measure of patient function in six different ADL areas: bathing, dressing, transferring, ambulation, eating, and continency. A zero score indicates that a patient needs no staff assistance in an ADL area. A score of three indicates the patient requires total assistance in an ADL area. The ADL scores range in value from 0 to 12. Low scores indicate fewer ADL deficiencies and high score indicate more extensive deficits.~~

~~"DMAS 95" means the multidimensional assessment document that is completed by each nursing facility at admission, and semi-annually thereafter, on all of its Medicaid residents. The DMAS 95 assessment data is used to document patient characteristics and is entered into the LTCIS for PIRS.~~

~~"Facility score" means an average resource cost measure of all patients in a facility.~~

~~"LTCIS: DMAS' Long Term Care Information System" means the system that captures data used to identify functional and medical characteristics that have major impacts on the level of nursing resource utilization.~~

~~"Nursing facility" means a facility, other than an intermediate care facility for the mentally retarded, licensed by the Division of Licensure and Certification, State Department of Health, and certified as meeting the participation regulations.~~

~~"Patient Intensity Rating System" or "PIRS" means a patient-based reimbursement system which links a facility's per diem rate to the level of services required by its patient mix.~~

~~"Service Intensity Index (SII)" means a mathematical index used to identify the resource needs of a given facility's patient mix relative to the needs in other nursing homes.~~

12VAC30-90-310. Normalized Case Mix Index (NCMI).

A. This appendix illustrates how a specialized care provider's Normalized Case Mix Index (NCMI) is used to adjust the prospective routine operating cost base rate and prospective operating ceiling.

B. Assumptions.

1. The nursing facility's fiscal years are December 31, 1996, and December 31, 1997.

2. The average allowable routine nursing labor and nonlabor base rate for December 31, 1996, is $205.

3. The average allowable indirect patient care operating base rate for December 31, 1996, is $90.

4. The allowance for inflation is 3.0% for the fiscal year end beginning January 1, 1997.

5. The nursing facility's statewide ceiling for the fiscal year end beginning January 1, 1997, is $300.

6. The nursing facility's normalized HCFA nursing wage index is 1.0941 for the fiscal year end beginning January 1, 1997.

7. The nursing facility's semiannual normalized NCMIs are as follows:

1996 First semiannual NCMI 1.2000

1996 Second semiannual NCMI 1.2400

1997 First semiannual NCMI 1.2600

C. Calculation of nursing facility's operating ceiling.

1. Period January 1, 1997, through June 30, 1997.

FYE 1997 Statewide Ceiling
$300

Nursing Labor Component Percentage x 67.22% =$201.66

Normalized Wage Index x 1.0941

Adjusted Nursing Labor Ceiling Component =$220.64

Nursing Nonlabor Ceiling Component + $11.49

Adjusted Nursing Labor and Nonlabor Ceiling =$232.13

FYE 1996 Second semiannual NCMI x 1.2400 =$287.84

Indirect Patient Care Ceiling Component ($300.00 - 201.66 = $86.85 - 11.49)

Total Facility Operating Ceiling $287.84 =$374.69

2. Period July 1, 1997, through December 31, 1997.

	Adjusted Nursing Labor and Nonlabor Ceiling per subdivision 1 of this subsection	
FYE 1997 First semiannual NCMI	x 1.2600	=$292.48
Indirect Patient Care Ceiling Component		+ 86.85
Total Facility Operating Ceiling		=$379.33

D. Calculation of nursing facility's prospective operating cost rate.

1. Prospective operating cost base rate.

FYE 1996 Nursing Labor and Nonlabor Operating Base Rate		$205
Allowance for Inflation - FYE 1997	x 1.03	
Prospective Nursing Labor and Nonlabor Cost Rate		=$211.15
FYE 1996 Indirect Patient Care Operating Base Rate		$90.00
Allowance for Inflation - FYE 1997	x 1.03	
Prospective Indirect Patient Care Operating Cost Rate		=$92.70

2. Calculation of FYE 1996 Average NCMI.

First semiannual Period NCMI	1.2000
Second semiannual Period NCMI	1.2400
Average FYE 1996 NCMI	1.2200

3. Calculation of FYE 1997 NCMI Rate Adjustments.

a. Rate adjustment for the period January 1, 1997, through June 30, 1997.

1996 Second semiannual NCMI 1.2400

1996 Average NCMI (from subdivision 2 of this 1.2200 subsection)

Calculation: 1.24

00/1

.2200

Rate Adjustment Factor = 1.0164

Prospective Nursing Labor and Nonlabor Operating $211.15

Cost Base Rate (from subdivision 1 of this subsection)

x 1.0164 =$214.- 61

Prospective Indirect Patient Care Operating Cost + $92.70

Rate (from subdivision 1 of this subsection)

Total Prospective Operating Cost Rate =$307.- 31

b. Rate Adjustment for the Period July 1, 1997, through December 31, 1997.

1997 First semiannual NCMI 1.2600

1996 Average NCMI (from subdivision 2 of this 1.2200 subsection)

Calculation: 1.26

00/1

.2200

Rate Adjustment Factor = 1.0328

Prospective Nursing Labor and Nonlabor Operating $211.15

Cost Rate (from subdivision 1 of this subsection)

Rate Adjustment Factor x 1.03- 28

Prospective Indirect Patient Care Operating Cost $ 92.70

Rate (from subdivision 1 of this subsection)

Total Prospective Operating Cost Rate =$310.- 78

D. In this illustration the nursing facility's operating reimbursement rate for FYE 1997 would be as follows:

1. For the period January 1, 1997, through June 30, 1997, the operating reimbursement rate would be $307.31 since the prospective operating cost rate is lower than the nursing facility's NCMI adjusted ceiling of $374.69 (from subdivision C 1 of this section).

2. For the period July 1, 1997, through December 31, 1997, the operating reimbursement rate would be $310.78 since the prospective operating cost rate is lower than the nursing facility's NCMI adjusted ceiling of $379.33 (from subdivision C 2 of this section).

CERTIFIED:

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Eric S. Bell, Director
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