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[12VAC30-90-10. Methods and standards for establishing payment rates for long-term care.

The policy and the method to be used in establishing payment rates for nursing facilities listed in §1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs.

1. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan to the extent these are available to the general population.
2. Participation in the Program will be limited to providers of services who accept, as payment in full, the amounts so paid.
3. Payment for care of service will not exceed the amounts indicated to be reimbursed in accord with the policy and the methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.253(b)(2). The state agency has continuing access to data identifying the maximum charges allowed. Such data will be made available to the Secretary of Health and Human Services upon request.
4. Payments for services to nursing facilities shall be on the basis of reasonable cost in accordance with the standards and principles set forth in 42 CFR 447.252 as follows:
  - a. A uniform annual cost report which itemizes allowable cost will be required to be filed within 150 days of each provider's fiscal year end.
  - b. The determination of allowable costs will be in accordance with Medicare principles as established in the Provider Reimbursement Manual (PRM-15) except where otherwise noted in this Plan.
  - c. Field audits will be conducted on the cost data submitted by the provider to verify the accuracy and reasonableness of such data. Audits will be conducted for each facility on a periodic basis as determined from internal desk audits and more often as required. Audit procedures are in conformance with SSA standards set forth in PRM-13-2. Internal desk audits are conducted annually within six months of receipt of a completed cost report from the provider.
  - d. Reports of field audits are retained by the state agency for at least three years following submission of the report.
  - e. Facilities are paid on a cost-related basis in accordance with the methodology described in the Plan.
  - f. Modifications to the Plan for reimbursement will be submitted as Plan amendments.
  - g. Covered cost will include such items as:

- (1) Cost of meeting certification standards.
  - (2) Routine services which include items expense providers normally incur in the provision of services.
  - (3) The cost of such services provided by related organizations except as modified in the payment system at Part II (12VAC30-90-20 et seq.) of this chapter.
- h. Bad debts, charity and courtesy allowances shall be excluded from allowable cost.
- i. Effective for facility cost reporting periods beginning on or after October 1, 1978, the reimbursable amount will be determined prospectively on a facility by facility basis, except that mental institutions and mental retardation facilities shall continue to be reimbursed retrospectively and effective July 1, 2002, the Virginia Veterans Care Center nursing facility shall be reimbursed retrospectively. The prospective rate will be based on the prior period's actual cost (as determined by an annual cost report and verified by audit as set forth in subdivision 4 c of this section) plus an inflation factor. Payments will be made to facilities no less than monthly.
- j. The payment level calculated by the prospective rate will be adequate to reimburse in full such actual allowable costs that an economically and efficiently operated facility must incur. In addition, an incentive plan will be established as described in the payment system at 12VAC30-90-20 et seq.
- k. Upper limits for payment within the prospective payment system shall be as follow:
- (1) Allowable cost shall be determined in accordance with Medicare principles as defined in PRM-15, except as may be modified in this plan.
  - (2) Reimbursement for operating costs will be limited to regional ceilings.
  - (3) Reimbursement, in no instance, will exceed the charges for private patients receiving the same services. In accordance with §1903(a)(2)(B) of the Social Security Act, nursing facility costs incurred in relation to training and competency evaluation of nurse aides will be considered as State administrative expenses and, as such, shall be exempted from this provision.

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l. In accordance with 42 CFR 447.205, an opportunity for public comment was permitted before final implementation of rate setting processes.

m. A detailed description of the prospective reimbursement formula is attached for supporting detail.

n. Item 398D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

5. Reimbursement of nonenrolled long term care facilities.

a. Nonenrolled providers of institutional long term care services shall be reimbursed based upon the average per diem cost, updated annually, reimbursed to enrolled nursing facility providers.

b. Prior approval must be received from the DMAS for recipients to receive institutional services from nonenrolled long-term care facilities. Prior approval can only be granted:

(1) When the nonenrolled long-term care facility with an available bed is closer to the recipient's Virginia residence than the closest facility located in Virginia with an available bed;

(2) When long-term care special services, such as intensive rehabilitation services, are not available in Virginia; or

(3) If there are no available beds in Virginia facilities.

6. Specialized care services. The payment methodology for specialized care services is contained in Part XVII (12VAC30-90-350 et seq.) of the Nursing Home Payment System.]

[12VAC30-90-20. Nursing home payment system; generally.

A. Effective July 1, 2001, the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in this part.

B. Three separate cost components are used: plant or capital, as appropriate, cost; operating cost; and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

C. Effective July 1, 2001, in determining the ceiling limitations, there shall be direct patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA MSA, for NFs with less than 61 beds in the rest of the state, and

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for NFs with more than 60 beds in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A nursing facility located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

D. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in Articles 1 (12VAC30-90-29), 3 (12VAC39-90-35 et seq.), 4 (12VAC39-90-40 et seq.), 6 (12VAC30-90-60 et seq.), and 8 (12VAC30-90-80 et seq.) of this subpart, as are mental retardation facilities and effective July 1, 2002, as is the Virginia Veterans Care Center nursing facility. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare principles of reimbursement and Medicaid principles of reimbursement in effect on June 30, 2000, except that those that are defined as skilled nursing facilities (SNFs) and are operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall not be subject to the routine cost limits that are normally required and applicable under Medicare principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

E. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270 through 12VAC30-90-276) and must be identifiable and verifiable by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of

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reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system. ]

[12VAC30-90-38. Schedule of assets reporting.

A. For the calculation of facility average age, the department shall use a "schedule of assets" that lists, by year of acquisition, the allowable acquisition cost of facilities' assets, including land improvements, buildings and fixed equipment, and major movable equipment. This schedule shall be submitted annually by the provider on forms to be provided by the department, and shall be audited by the department. The principles of reimbursement for plant cost described in Article 2 (12VAC30-90-30 et seq.) of this subpart shall be used to determine allowable cost.

B. The schedule of assets used in the calculation of average age shall be submitted with the provider's cost report.

C. Facilities failing to submit the schedule of assets timely shall have their nursing facility per diem rate set to zero.

D. Capital expenditures are to be included on the schedule of assets. These do not include land purchases, but do include land improvements, renovations, additions, upgrading to new standards, and equipment purchases. Capital expenditures shall be capital related expenditures costing \$50,000 or more each, in aggregate for like items, or in aggregate for a particular project. ~~These include purchases of similar type equipment or like items within a 12-month period.~~ For facilities with 30 or fewer beds, an amount of \$25,000, rather than \$50,000, shall apply. The limits of \$50,000 and \$25,000 shall apply only to expenditures after July 1, 2000. For these purposes like items means those items acquired within a 12-month period that are classified in one of the categories of land improvements, or building improvements, or moveable equipment. Additionally, capital-related expenditures which are part of a particular project may be included on the schedule of assets for the cost reporting date which is after the date the assets have been placed into service, whether or not all the required \$50,000 threshold of costs of the ongoing project have been incurred as of the reporting date.

E. Items reportable on the schedule of assets may be removed only when disposed of.

F. Acquisition costs related to any sale or change in the ownership of a nursing facility or the assets of a nursing facility shall not be included in the schedule of assets if the transaction occurred after June 30, 2000. Whether such a transaction is the result of a sale of assets, acquisition of capital stock, merger, or any other type of change in ownership, related costs shall not be reported on the schedule of assets.

G. In addition to verifying the schedule of assets, audits of NF allowable capital costs shall continue to be performed in accordance with regulations described in Article 2. ]

**12 VAC 30-90-40. Operating cost.**

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 et seq.) of this part 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 ~~in~~ *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% 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 subdivision 10 of 12 VAC 30-90-264 for special procedures for computing the number of patient days required to meet the 90% occupancy requirement.

**12 VAC 30-90-41. Nursing facility reimbursement formula.**

A. Effective on and after ~~October 1, 1990~~ *July 1, 2002*, all NFs subject to the prospective payment system shall be reimbursed under a ~~revised formula entitled "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NFs~~ *Resource Utilization Group-III (RUG-III) System [as defined in Appendix IV (12 VAC 30-90-305 ff)]." RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-mix indices (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 NFs patient NF's resident mix. Three classes were developed which group patients together based on similar functional characteristics and service needs. See 12 VAC 30-90-300 for details on the Resource Utilization Groups.*

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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 12 VAC 30-90-20 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 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 NFs Service Intensity Index (SII) shall be calculated for each semiannual period of a NFs 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 NFs SII, derived from the assessment data, will be normalized by dividing it by the average for all NFs in the state.~~

~~See 2 VAC 30-90-300 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NFs facility score and the methodology of computing the NFs semiannual SHs.~~ 3. *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 12 VAC 30-90-306 for the case-mix index calculations.*

4. The normalized ~~SH~~ *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 NFs subsequent fiscal ~~years~~ *year*. *See 12 VAC 30-90-306 D 2 for the calculation of the normalized facility average Medicaid CMI.*

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

b. ~~An SII rate adjustment, if any, shall be applied to a NFs prospective direct patient care operating cost base rate for each semiannual period of a NFs 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 SHs 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 SHs 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~~

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for each semiannual 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 semiannual 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 30-90-307).

c. See ~~12 VAC 30-90-300~~ 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 12 VAC 30-90-307 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 *respective peer group day-weighted* median of ~~facility specific direct cost~~ *the facilities' case-mix neutralized direct care operating costs* per day. The calculation of the ~~median~~ *medians* shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in ~~calendar~~ *the most recent base year* 1998. The ~~median~~ *medians* used to set the *peer group direct ceiling patient care operating ceilings* shall be revised *and case-mix neutralized* every two years using [more the most] recent [reliable calendar year] cost [data settled cost reports for freestanding nursing facilities that have been completed as of September 1]. 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 SFY 2000 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 SFY 2000. 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 subdivision 5 a of this subsection. 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.~~

e. b. The indirect patient care operating ceiling shall be set at 106.9% of the *respective peer group day-weighted* median of ~~facility~~ *the facility's specific indirect operating cost* per day. The calculation of the ~~median peer group~~ *medians* shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in ~~calendar~~ *the most recent base year* 1998. *The medians used to set the peer group indirect operating ceilings shall be revised every two years using [more the most] recent [reliable calendar year] cost [data settled cost reports for freestanding nursing facilities that have been completed as of September 1].*

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 NFs most recent fiscal year~~



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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 full 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 NFs next fiscal year to obtain the new "interim" ceilings, and 50% of the forecasted inflation to the end of the NFs next fiscal year.~~

~~2. A NFs 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.~~

*B. 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 percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly, 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 in subdivision 1 of this subsection. If the cost reporting period or the prospective rate period is less than 12 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 rebasing 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 subdivision 1 of this subsection. 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. Rebased ceilings shall be effective on July 1 of each rebasing 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 rebasing 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 July 1, 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*

<i>Provider FYE</i>	<i>Effective Date of New Ceiling</i>	<i>First PFYE After Rebasing Date</i>	<i>Inflation Time Span from Ceiling Date to Midpoint of First PFY</i>	<i>Second PFYE After Rebasing Date</i>	<i>Inflation Time Span from Ceiling Date to Midpoint of Second PFY</i>
3/31	7/1/02	3/31/03	+ 1/4 year	3/31/04	+ 1-1/4 years
6/30	7/1/02	6/30/03	+ 1/2 year	6/30/04	+ 1-1/2 years
9/30	7/1/02	9/30/02	- 1/4 year	9/30/03	+ 3/4 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*

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

In this example, when ceilings are inflated for the second PFY after the rebasing date, the ceilings will be inflated from July 1, 2002, using moving averages from the DRI table specified for the second PFY. That is, the ceiling for years ending June 30, 2004, will be the June 30, 2002, base period ceiling, adjusted by 1/2 of the moving average for the second quarter of 2002, compounded with the moving average for the second quarter of 2003. Both these moving averages will be taken from the fourth quarter 2002 DRI table.

C. The ~~PIRS RUG-III~~ method Nursing Home Payment System 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~~ *rate* or prospective operating ~~ceilings~~ *ceiling*.

D. Nonoperating costs. Plant or capital, as appropriate, costs shall be reimbursed in accordance with Articles 1, 2, and 3 of this subpart. 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 12 VAC 30-90-170.

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 nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant or capital, as appropriate, costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable 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 Day	Difference	% of Ceiling	Sliding Scale	Scale % Difference
\$30.00	\$27.00	\$3.00	10%	\$0.30	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~~ for the number of days for which a facility is out of substantial compliance according to the VA Dept. of Health survey findings as based on federal regulations].

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.

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**12 VAC 30-90-60. 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 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 NFs 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 NFs 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 NFs 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 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 its allowable plant/capital costs for its first cost reporting period by 90% 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 ~~SH~~ CMI based upon its peer group's *normalized average* ~~SH~~ Medicaid CMI for direct patient care. An expanded NF receiving new NF treatment shall receive the ~~SH~~ CMI calculated for its last semiannual period prior to obtaining new NF status.

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**12 VAC 30-90-271. 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[and MDS 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 nurses~~] who functions as quality assurance [~~coordinator coordinators~~] and [~~is are~~] 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 12 VAC 30-90-272 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 12 VAC 30-90-272 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.

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6. Incontinence services. Cost of disposable and nondisposable incontinence supplies. The laundry supplies or purchased commercial laundry service for nondisposable 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~~ Respiratory] therapy
4. Physical therapy
5. Occupational therapy
6. Speech therapy
7. EKG
8. EEG
9. Medical supplies charged to patient

**12 VAC 30-90-272. 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 12 VAC 30-90-50 and Appendix III (12 VAC 30-90-290) 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 (12 VAC 30-90-290) 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 (12 VAC 30-90-290) 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 (12 VAC 30-90-290) for limitations.)

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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 (12 VAC 30-90-290) 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 12 VAC 30-90-290 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 12 VAC 30-90-220).
  22. Amortization/organizational costs. Amortization of allowable organization costs (See 12 VAC 30-90-220).

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.

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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.



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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.~~

~~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. H. 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. I. 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. J. Educational activities expenses. (Other than NATCEPs costs, see 12 VAC 30-90-270.)~~

~~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. K. Other nursing administrative costs.~~

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

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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.~~ L. 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 12 VAC 30-90-240.

[12VAC30-90-280. Leasing of facilities.

The substance of this appendix shall apply only to Article 2 (12VAC30-90-30 et seq.) of Subpart II of Part II of this chapter.

I. Determination of allowable lease costs.

A. The provisions of this appendix shall apply to all lease agreements, including sales and leaseback agreements and lease purchase agreements, and including whether or not such agreements are between parties which are related (as defined in 12VAC30-90-50 of the Nursing Home Payment System (NHPS)).

B. Reimbursement of lease costs pursuant to a lease between parties which are not related shall be limited to the DMAS allowable cost of ownership as determined in subsection I E of this section. Reimbursement of lease costs pursuant to a lease between parties which are related (as defined in 12VAC30-90-50) shall be ~~limited~~ adjusted to the DMAS allowable cost of ownership. Whether the lease is between parties which are or are not related, the computation of the allowable annual lease expense shall be subject to DMAS audit.

C. The DMAS allowable cost of ownership shall be determined by the historical cost of the facility to the owner of record at the date the lease becomes effective. When a lease agreement is in effect, whether during the original term or a subsequent renewal, no increase in the reimbursement shall be allowed as a result of a subsequent sale of the facility.

D. When a bona fide sale has taken place, the facility must have been held by the seller for a period of no less than five years for a lease effected subsequent to the sale date to be compared to the buyer's cost of ownership. Where the facility has been held for less than five years, the allowable lease cost shall be computed using the seller's historical cost.

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E. Reimbursement of lease costs pursuant to a lease between parties which are not related (as defined in 12VAC30-90-50) shall be limited to the DMAS allowable cost of ownership. The following reimbursement principles shall apply to leases, other than those covered in 12VAC30-90-50 and subsection IV of this appendix, entered into on or after October 1, 1990:

1. An "Allowable Cost of Ownership" schedule shall be created for the lease period to compare the total lease expense to the allowable cost of ownership.
2. If the lease cost for any cost reporting period is below the cost of ownership for that period, no adjustment shall be made to the lease cost, and a "carryover credit" to the extent of the amount allowable for that period under the "Allowable Cost of Ownership" schedule shall be created but not paid.
3. If the lease cost for a future cost reporting period is greater than the "Cost of Ownership" for that period, the provider shall be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual lease cost, whichever is less. At no time during the lease period shall DMAS reimbursement exceed the actual cumulative "Cost of Ownership."
4. Once DMAS has determined the allowable cost of ownership, the provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of cost of ownership vs. lease cost to support the "carryover credit" as reported in the "Allowable Cost of Ownership" schedule, and shall submit such a schedule with each cost report.

## II. Documentation of costs of ownership.

A. Leases shall provide that the lessee or DMAS shall have access to any and all documents required to establish the underlying cost of ownership.

B. In those instances where the lessor will not share this information with the lessee, the lessor can forward this information direct to DMAS for confidential review.

## III. Computation of cost of ownership.

A. Before any rate determination for allowable lease costs is made, the lessee must supply a schedule comparing lease expense to the underlying cost of ownership for the life of the lease. Supporting documentation, including but not limited to, the lease and the actual cost of ownership (mortgage instruments, financial statements, purchase agreements, etc.) must be included with this schedule.

B. The underlying straight-line depreciation, interest, property taxes, insurance, and amortization of legal and commitment fees shall be used to determine the cost of ownership for comparison to the lease costs. Any cost associated with the acquisition of a lease other than those outlined herein shall not be considered allowable unless specifically approved by the Department of Medical Assistance Services.

1. Straight line depreciation.

- a. Depreciation shall be computed on a straight line basis only.
- b. New or additions facilities shall be depreciated in accordance with AHA Guidelines.
- c. Allowable depreciation for on-going facilities shall be computed on the historical cost of the facility determined in accordance with limits on allowable building and fixed equipment cost.
- d. The limits contained in 12VAC30-90-30, and Part VI (12VAC30-90-160) shall apply, as appropriate, whether the facility is newly constructed or an on-going facility.

2. Interest. Interest expense shall be limited to actual expense incurred by the owner of the facility in servicing long-term debt and shall be subject to the interest rate limitations stated in 12VAC30-90-30.

3. Taxes and insurance. Taxes are limited to actual incurred real estate and property taxes. Insurance is limited to the actual cost of mortgage insurance, fire and property liability insurance. When included in the lease as the direct responsibility of the lessee, such taxes and insurance shall not be a part of the computation of the cost of ownership.

4. Legal and commitment fees. Amortization of actual incurred closing costs paid by the owner, such as attorney's fees, recording fees, transfer taxes and service or "finance" charges from the lending institution may be included in the comparison of the cost of ownership computation. Such fees shall be subject to limitations and tests of reasonableness stated in these regulations. These costs shall be amortized over the life of the mortgage.

5. Return on Equity.

a. Return on equity will be limited to the equity of the facility's owner when determining allowable lease expense. Return on equity shall be equal to the rental rate percentage used in connection with the fair rental value (FRV) methodology described in Article 3 (12VAC30-90-35 et seq.) of Subpart II of Part II of this chapter. For the purpose of determining allowable lease expense, equity will be computed in accordance with PRM-15 principles. The allowable base will be determined by monthly averaging of the annual equity balances. The base will be increased by the amount of paid up principal in a period but will be reduced by depreciation expense in that period.

b. Item 398D of the 1987 Appropriations Act (as amended), effective April 8, 1987 eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

c. Leased facilities shall be eligible for return on equity capital after July 1, 2001, only if they were receiving return on equity capital on June 30, 2000.

IV. Leases approved prior to August 18, 1975.

A. Leases approved prior to August 18, 1975, shall have the terms of those leases honored for reimbursement throughout the duration of the lease.

B. Renewals and extensions to these leases shall be honored for reimbursement purposes only when the dollar amount negotiated at the time of renewal does not exceed the amount in effect at the termination date of the existing lease. No escalation clauses shall be approved.

C. Payments of rental costs for leases reimbursed pursuant to subsection IV A of this section shall be allowed whether the provider occupies the premises as a lessee, sublessee, assignee, or otherwise. Regardless of the terms of any present or future document creating a provider's tenancy or right of possession, and regardless of whether the terms thereof or the parties thereto may change from time to time, future reimbursement shall be limited to the lesser of (1) the amount actually paid by the provider, or (2) the amount reimbursable by DMAS under these regulations as of the effective date this amendment. In the event extensions or renewals are approved pursuant to subsection IV B of this section, no escalation clauses shall be approved or honored for reimbursement purposes.

V. Nothing in this appendix shall be construed as assuring providers that reimbursement for rental costs will continue to be reimbursable under any further revisions of or amendment to these regulations. ]

Appendix IV.

~~Class Resource Cost Assignment, Computation of Service Intensity Index and Ceiling And Rate Adjustments to the Prospective Direct Patient Care Operating Cost Rate; Allowance for Inflation Methodology Base "Current" Operating Rate Resource Utilization Groups (RUGs).~~

**12 VAC 30-90-300. Patient Intensity Rating System (PIRS). (Repealed.)**

~~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.~~

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~~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 12 VAC 30-90-264.~~

~~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.~~

#### **12 VAC 30-90-301. Service Intensity Index (SII). (Repealed.)**

~~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.~~

e. 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.~~

**12 VAC 30-90-302. Applicability of service intensity index. (Repealed.)**

~~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 (from subdivision 1 of this subsection)  
\$26.50

Calculation:  $\$26.50 \times 1.0051$

Prospective Direct Patient Care  
Operating Cost Rate \$26.64

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

1991 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:  $\$26.50 \times 1.0152$

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).

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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).

**12 VAC 30-90-303. ~~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 12 VAC 30-90-40 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.~~

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~~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.~~

**12 VAC 30-90-304. 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.~~

**12 VAC 30-90-305. Resource Utilization Groups (RUGs).**

*A. The Resource Utilization Groups-III (RUG-III), Version 5.12, 34-group, index maximizing model shall be used as the resident classification system to determine the RUG-III group for each resident assessment. RUG-III classifies resident assessments according to the intensity of each resident's needs. Data 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.*

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

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

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

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

*“Day-weighted median” means a weighted median where the weight is Medicaid days.*

*[“Effective assessment date means the date found on the date found on the MDS assessment sec. A.3.a.(the assessment reference date).]*

*“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.*

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

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

*A. 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 [as indicated in Table III].*

*[Table III]**[Case Mix Indices (CMI)]*

<u>RUG CATEGOR Y</u>	<u>RUG Description</u>	<u>CMS "Standard" B01 CMI Set</u>
<u>RAD</u>	<u>Rehabilitation All Levels / ADL 17-18</u>	<u>1.66</u>
<u>RAC</u>	<u>Rehabilitation All Levels / ADL 14-16</u>	<u>1.31</u>
<u>RAB</u>	<u>Rehabilitation All Levels / ADL 9-13</u>	<u>1.24</u>
<u>RAA</u>	<u>Rehabilitation All Levels / ADL 4-8</u>	<u>1.07</u>
<u>SE3</u>	<u>Extensive Special Care 3 / ADL &gt;6</u>	<u>2.10</u>
<u>SE2</u>	<u>Extensive Special Care 2 / ADL &gt;6</u>	<u>1.79</u>
<u>SE1</u>	<u>Extensive Special Care 1 / ADL &gt;6</u>	<u>1.54</u>
<u>SSC</u>	<u>Special Care / ADL 17-18</u>	<u>1.44</u>
<u>SSB</u>	<u>Special Care / ADL 15-16</u>	<u>1.33</u>
<u>SSA</u>	<u>Special Care / ADL 4-14</u>	<u>1.28</u>
<u>CC2</u>	<u>Clinically Complex with Depression / ADL 17-18</u>	<u>1.42</u>
<u>CC1</u>	<u>Clinically Complex / ADL 17-18</u>	<u>1.25</u>
<u>CB2</u>	<u>Clinically Complex with Depression / ADL 12-16</u>	<u>1.15</u>
<u>CB1</u>	<u>Clinically Complex / ADL 12-16</u>	<u>1.07</u>
<u>CA2</u>	<u>Clinically Complex with Depression / ADL 4-11</u>	<u>1.06</u>
<u>CA1</u>	<u>Clinically Complex / ADL 4-11</u>	<u>0.95</u>
<u>IB2</u>	<u>Cognitive Impairment with Nursing Rehab / ADL 6-10</u>	<u>0.88</u>
<u>IB1</u>	<u>Cognitive Impairment / ADL 6-10</u>	<u>0.85</u>
<u>IA2</u>	<u>Cognitive Impairment with Nursing Rehab / ADL 4-5</u>	<u>0.72</u>
	<u>Cognitive Impairment / ADL 4-5</u>	<u>0.67</u>
<u>BB2</u>	<u>Behavior Problem with Nursing Rehab / ADL 6-10</u>	<u>0.86</u>
<u>BB1</u>	<u>Behavior Problem / ADL 6-10</u>	<u>0.82</u>
<u>BA2</u>	<u>Behavior Problem with Nursing Rehab / ADL 4-5</u>	<u>0.71</u>
<u>BA1</u>	<u>Behavior Problem / ADL 4-5</u>	<u>0.60</u>
<u>PE2</u>	<u>Physical Function with Nursing Rehab / ADL 16-18</u>	<u>1.00</u>
<u>PE1</u>	<u>Physical Function / ADL 16-18</u>	<u>0.97</u>
<u>PD2</u>	<u>Physical Function with Nursing Rehab / ADL 11-15</u>	<u>0.91</u>

<u>RUG CATEGOR Y</u>	<u>RUG Description</u>	<u>CMS "Standard" B01 CMI Set</u>
<u>PD1</u>	<u>Physical Function / ADL 11-15</u>	<u>0.89</u>
<u>PC2</u>	<u>Physical Function with Nursing Rehab / ADL 9-10</u>	<u>0.83</u>
<u>PC1</u>	<u>Physical Function / ADL 9-10</u>	<u>0.81</u>
<u>PB2</u>	<u>Physical Function with Nursing Rehab / ADL 6-8</u>	<u>0.65</u>
<u>PB1</u>	<u>Physical Function / ADL 6-8</u>	<u>0.63</u>
<u>PA2</u>	<u>Physical Function with Nursing Rehab / ADL 4-5</u>	<u>0.62</u>
<u>PA1</u>	<u>Physical Function / ADL 4-5</u>	<u>0.59</u>

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 database.

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 [, including the case mix normalization and the neutralization processes,] indices during the first two years following implementation of the RUG-III system. Effective July 1, 2004, the statewide average case-mix index may be changed to recognize the

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

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

*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.*

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

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

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

Table [III IV]

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

C. When direct patient care prospective rates are set, the direct patient care ceilings used in the calculation shall be the case-mix neutralized ceiling described in subsection B of this section, adjusted for inflation to the midpoint of the prospective period. However, the facility-specific direct patient care cost rates used in the calculation shall not be from the base year, but shall be from the provider fiscal year prior to the period for which a prospective rate is being calculated. Therefore, the provider's direct patient care rate from the previous cost reporting period shall be case-mix neutralized using the facility average normalized Medicaid CMI developed for the two semiannual periods of assessment data that most closely match the cost reporting period prior to the prospective period for which a rate is being calculated. Each year when a new prospective rate is developed, the provider specific direct patient care rate shall be case-mix neutralized using CMI data that uses picture dates that correspond to the cost reporting period used to develop the rate. The relationship between provider cost reporting period and picture dates shall be that illustrated in Table [III IV], except that in the time period when rates will first be set, the data limitation that affected the picture dates shown in Table III 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 Table [~~IV~~ V].

Table [~~IV~~ V]  
Example of Picture Dates Used in Case-Mix Adjustment of Prospective Rate

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

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% 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:*

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

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

a. *Direct Patient Care Operating Cost Rate:*

<i>Average Allowable Direct Patient Care Operating Rate</i>	<i>\$50.00</i>
<i>Allowance For Inflation FYE 2003</i>	<i>x 1.0400</i>
	<i>\$52.00</i>

b. *Calculation of case-mix factor used for case-mix neutralization:*

<i>12/31/2001 CMI</i>	<i>1.0100</i>
<i>3/31/2002 CMI</i>	<i>1.0105</i>
<i>6/30/2002 CMI</i>	<i>1.0098</i>
<i>9/30/2002 CMI</i>	<i>1.0305</i>
<i>Average of four CMI =</i>	<i>1.0152</i>

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*

**NOTICE:** The forms used in administering 12 VAC 30-90, Methods and Standards for Establishing Payment Rates for Long-Term Care, are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Certificate of Medical Necessity--Durable Medical Equipment and Supplies, DMAS-352 (rev. 8/95).

Cost Reporting Forms for Nursing Facility with Multiple Level of Care or Hospital-Based Nursing Facilities (~~PIRS~~ RUGS 1090 Series).

Facility Description, Schedule A-1 (eff. 7/93).

Computation of ~~Patient Intensity Reimbursement System~~ Base Operating Costs, Schedule A-3 (eff. 7/93).

Computation of Direct Patient Care Nursing Service Costs, Schedule A-4 (eff. ~~7/99~~ rev. 7/00).

Computation of Title XIX Direct Patient Care Ancillary Service Costs, Schedule C (eff. 7/93).

Statement of Compensation of Owners, Schedule E (eff. 10/90).

Statement of Compensation of Administrators and/or Assistant Administrators, Schedule F (eff. 10/90).

Computation of Title XIX (Medicaid) Base Costs and Prospective ~~Reimbursement Rate/PIRS~~ RUGS, Schedule H (eff. ~~7/99~~ rev. 7/00).

~~Computation of Prospective Direct and Indirect Patient Care Profit Incentive Rates, Schedule H 1 (eff. 10/90).~~

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Calculation of Medical Service Reimbursement Settlement, Schedule J (eff. ~~7/99~~ rev. 7/00).

Calculation of NATCEPs Reimbursement Settlement, Schedule J-1 (eff. 7/92).

Calculation of Criminal Record Check Costs Reimbursement, Schedule J-2 (eff. 7/93).

Debt and Interest Expense, Schedule K (eff. 7/93).

Nurse Aide Training and Competency Evaluation Program Costs and Competency Evaluation Programs (NATCEPs), Schedule N (eff. 10/90).

~~Computation of Nursing Salaries and Benefits Cost Increase Related to July 1, 1999 PIRS Rate Modification, Schedule S (rev. 11/99).~~

*Compilation of Nursing Salaries, Benefits and Hours, Schedule S-1 (eff. 7/00).*

Cost Reporting Forms for Nursing Facility (Single Level of Care) (~~PIRS~~ RUGS 1090 Series).

Facility Description and Statistical Data, Schedule A (eff. 10/90).

Certification by Officer or Administrator of Provider, Schedule A-2 (eff. 10/90).

Reclassification and Adjustment of Trial Balance of Expenses, Schedule B (not dated).

Reclassifications, Schedule B-1 (not dated).

Analysis of Administrative and General--Other, Schedule B-2 (eff. 10/90).

Adjustment to Expenses, Schedule B-4 (eff. 10/90).

Cost Allocation--Employee Benefits, Schedule B-5, Part I (eff. 7/93).

Cost Allocation--Employee Benefits Statistical Basis, Schedule B-5, Part II (eff. 7/93).

Computation of Title XIX Direct Patient Care Ancillary Service Costs, Schedule C (eff. 7/93).

Statement of Cost of Services from Related Organizations, Schedule D (eff. 10/90).

Statement of Compensation of Owners, Schedule E (eff. 10/90).

Statement of Compensation of Administrators and/or Assistant Administrators, Schedule F (eff. 10/90).

Balance Sheet, Schedule G (not dated).

Statement of Patient Revenues, Schedule G-1 (eff. 10/90).

Statement of Operations, Schedule G-2 (eff. 10/90).

Computation of Title XIX (Medicaid) Base Costs and Prospective ~~Reimbursement~~ Rate (RUGs), Schedule H (eff. ~~7/99~~ rev. 7/00).

~~Computation of Prospective Direct and Indirect Patient Care Profit Incentive Rates, Schedule H-1 (eff. 10/90).~~

Calculation of Medical Service Reimbursement Settlement, Schedule J (eff. ~~7/99~~ rev. 7/00).

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Calculation of NATCEPs Reimbursement Settlement, Schedule J-1 (eff. 7/92).

Calculation of Criminal Record Check Costs Reimbursement, Schedule J-2 (eff. 7/93).

Debt and Interest Expense, Schedule K (eff. 7/93).

Limitation on Federal Participation for Capital Expenditures Questionnaire, Schedule L (eff. 10/90).

Nurse Aide Training and Competency Evaluation Program Costs and Competency Evaluation Programs (NATCEPs), Schedule N (eff. 10/90).

~~Computation of Nursing Salaries and Benefits Cost Increase Related to July 1, 1999 PIRS Rate Modification, Schedule S (rev. 11/99).~~

*Compilation of Nursing Salaries, Benefits and Hours, Schedule S-1 (eff. 7/00).*

Computation of Specialized Care Base Operating Costs, Pediatric, Schedule SC-3 (rev. 7/98).

Computation of Specialized Care Direct Patient Care Nursing Service Costs, Pediatric, Schedule SC-4 (rev. 7/98).

Computation of Specialized Care Kinetic Therapy Ancillary Service Costs, Pediatric, Schedule SC-5 (rev. 7/98).

Computation of Specialized Care Direct Patient Care Ancillary Service Costs, Pediatric, Schedule SC-6 (rev. 7/98).

Computation of Specialized Care Base Costs and Prospective Rate, Pediatric, Schedule SC-7P (rev. 7/00).

Computation of Prospective Specialized Care Operating Efficiency Incentive Rates, Pediatric, Schedule SC-8P (rev. 7/98).

Part I Computation of Nursing Facility Specialized Care Settlement, Part II Analysis of Nursing Facility Specialized Care Interim Payments for Title XIX Services, Part III Analysis of Quarterly Title XIX (Medicaid) Specialized Care Patient Days, Pediatric, Schedule SC-9 (rev. 7/00).

Computation of Specialized Care Base Operating Costs, Adult, Schedule SC-3 (rev. 7/98).

Computation of Specialized Care Direct Patient Care Nursing Service Costs, Adult, Schedule SC-4 (rev. 7/98).

Computation of Specialized Care Kinetic Therapy Ancillary Service Costs, Adult, Schedule SC-5 (rev. 7/98).

Computation of Specialized Care Direct Patient Care Ancillary Service Costs, Adult, Schedule SC-6 (rev. 7/98).

Computation of Specialized Care Base Costs and Prospective Rate, Adult, Schedule SC-7 (rev. 7/98).

Computation of Prospective Specialized Care Operating Efficiency Incentive Rates, Adult, Schedule SC-8 (rev. 7/98).

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Part I Computation of Nursing Facility Specialized Care Settlement, Part II Analysis of Nursing Facility Specialized Care Interim Payments for Title XIX Services, Part III Analysis of Quarterly Title XIX (Medicaid) Specialized Care Patient Days, Adult, Schedule SC-9 (rev. 1/00).

Cost Reporting Forms for Nursing Facilities with Other Long-Term Care Services, HCPA-2540-96 Worksheets (eff. 7/96).

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R.S. Means Square Foot Costs, 22nd Annual Edition, 2001.

R.S. Means Repair and Remodeling Cost Data, 22nd Annual Edition, 2001.

Estimated Useful Lives of Depreciable Assets, rev. 1993 Edition, American Hospital Association.

Federal Reserve Statistical Release (H. 15), updated daily.

Provider Reimbursement Manual, HCFA-Pub. 15 (PRM-15), Health Care Financing Administration.

~~Skilled Nursing Facility Market Basket of Routine Service Costs, updated quarterly, DRI/McGraw Hill.~~

*Virginia Input Price Indexes, Updated Quarterly.*

Nursing Facility Reimbursement Report, MMR-240, updated monthly, Department of Medical Assistance Services.

CERTIFIED:

4/30/2002  
Date

/s/ Patrick W. Finnerty  
Patrick W. Finnerty, Director  
Dept. of Medical Assistance Services