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State Name: Virginia

State Plan Amendment (SPA)#: 19-0013

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Twelve (12) SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

November 26, 2019

Ms. Karen Kimsey, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

RE: State Plan Amendment (SPA) 19-0013

Dear Ms. Kimsey:

We have completed our review of State Plan Amendment (SPA) 19-0013. This SPA modifies Attachment 4.19-D of Virginia's Title XIX State Plan. Specifically, the amendment clarifies rules surrounding capital renovations that qualify for mid-year rate adjustments.

We conducted our review of this SPA according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Virginia State plan amendment 19-0013 with an effective date of October 1, 2019. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, or require additional information, please call Gary Knight at (304) 347-5723.

Sincerely,

/S/

Kristin Fan
Director

cc:
Lisa Carroll
Gary Knight

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

OR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19-013

2. STATE: Virginia

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 10/1/2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 0
b. FFY 2020 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19-D, revised pages 1, 2, 4, 5, 16, 17, 18, 18.1, 26.7, 56.

4.19D, new pages 2.1 and 16.1.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: Fair Rental Value of New and Renovated Nursing Facilities

GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2019
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: /S/

13. TYPED NAME: Karen Kimsey

14. TITLE: Director

15. DATE SUBMITTED: 10-29-19

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: NOV 26 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

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

Part II - Nursing Home Payment System

12 VAC 30-90-20. ***REPEALED IN SPA 14-019 EFFECTIVE 7/1/2014***

12 VAC 30-90-21. Reimbursement for Individuals in a Disaster Struck Nursing Facility.

Reimbursement to a Disaster Struck Nursing Facility for individuals that must be temporarily evacuated to another facility (Resident Accepting Nursing Facility) may continue for up to 30 days after the disaster event. Reimbursement will be the same as if the individual was residing in the Disaster Struck Facility. No other reimbursement will be made to either the Disaster Struck Nursing Facility or the Resident Accepting Facility. The Disaster Struck Nursing Facility must meet the following conditions.

a. The Disaster Struck Nursing Facility must have a contract with the Resident Accepting Nursing Facility. The contract must (i) include terms of reimbursement and mechanisms to resolve any contract disputes; (ii) protocols for sharing care and treatment information between the two facilities, and (iii) requirements that both facilities meet all conditions of Medicaid participation determined by the Virginia Department of Health. The Virginia Long-Term Mutual Aid Plan Memorandum of Understanding is an acceptable contract.
b. The Disaster Struck Facility must notify DMAS of the disaster event, maintain records of evacuated individuals with names, dates and destinations of evacuated residents and update DMAS on the status of repairs.
c. The Disaster Struck Facility must determine within 15 days of the event whether individuals will be able to return to the facility within 30 days of the disaster event. If the Disaster Struck Facility determines that it is not able to reopen within 30 days, it must discharge the individuals and work with them to choose admission to other facilities or alternative placements. Nothing shall preclude an individual from asking to be discharged and admitted to another facility or alternative placement. Reimbursement to the Disaster Struck Facility shall cease when the individual is discharged.

12 VAC 30-90-22 through 12 VAC 30-90-27. Reserved.

12 VAC 30-90-28. Mid-year Fair Rental Value (FRV) rate determination.

A. New facilities and facilities undergoing a major renovation may apply for a mid-year FRV rate determination or change if putting into service a major renovation or new beds. Providers are allowed only one mid-year FRV rate change during a state fiscal year (SFY).

1. New Facilities. A new nursing facility is defined as a facility that is required to obtain a certificate of occupancy prior to the admittance of a resident. New nursing facilities should file their mid-year FRV report when the facility's certificate of occupancy has been issued. The nursing facility shall submit complete pro forma documentation at least 60 days prior to the certificate of occupancy effective date, and the new FRV rate shall be effective at the beginning of the month following the end of the 60 days subject to confirmation that the new beds are operational.

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a. For any facility whose FRV report has less than 12 months of experience, the department shall develop an occupancy schedule as defined in the Nursing Facility Capital Payment Methodology, in 4.19-D, Supp 1, beginning on page 15, that represents the average statewide occupancy by month of operation for use in calculating the per diem rate in lieu of a minimum occupancy requirement or actual occupancy. After the initial FRV report filing, actual occupancy data shall be used.
b. New facilities shall use the occupancy schedule developed by DMAS to estimate patient days for their first FRV report until actual patient days are available. The occupancy percentage used to calculate estimated patient days shall be based on the number of months remaining within the calendar year from the month of receipt of the certificate of occupancy. For example, if the certificate of occupancy is received in February, then the number of months remaining in the calendar year would be 11 and the occupancy percentage to use would be 85.84% (see Table 1 on p 16 of 4.19-D, Supp 1). The estimated patient days would be equal to the occupancy percentage times the annualized bed days available for the report period.
c. DMAS shall have 15 days from the date of the provider's submission to determine if the filing is complete for purposes of setting a rate for a new facility. The facility shall have 15 days from the date the filing is deemed incomplete to submit the required information. The deadline for setting the rate shall be extended for 30 days after the filing is deemed complete.

2. Major renovations. Facilities undergoing major renovations shall file a mid-year FRV report when there is an increase in capital expenditures of at least $3,000 per total number of beds. The nursing facility shall submit complete pro forma documentation at least 60 days prior to the effective occupancy date and the new rate shall be effective at the beginning of the month following the end of the 60 days subject to confirmation that the renovated beds are operational. No mid-year rate changes shall be made for an effective date after April 30 of the SFY.

a. Any new beds or major renovations placed in service between the reporting year and the rate year shall be treated as a mid-year rate adjustment. No new FRV rate change will be made after April 30. Rate updates that fall between May 1 and June 30 shall be effective as stated below.
b. DMAS shall have 15 days from the date of the provider's submission to determine if the filing is complete for purposes of setting a rate for a renovated facility. The facility shall have 15 days from the date the filing is deemed incomplete to submit the required information.
c. Providers may propose a phased major renovation subject to approval by DMAS. The phased major renovation may include reductions to available beds. Any modifications to the proposed renovation are also subject to approval by DMAS. Phased major renovations include construction or major renovations that span more than one FRV report period. Only one annual FRV report and one mid-year FRV report can be filed in a SFY to change the plant rate. A mid-year FRV report can be filed only if capital cost per bed increases by a minimum of $3000 per bed. Major renovation cost may only be included on Schedule R-1 as it is placed into service. Cost cannot be duplicated throughout the project on Schedule R-1. Major renovations for independent and assisted living are not allowed on the Schedule R-1.

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B. The following are applicable to new facilities and facilities undergoing major renovation:
   1. DMAS shall annualize real estate taxes, property taxes, and property insurance costs that do not represent a full year's cost.
      a. Actual paid tax bills shall be provided to support real estate taxes and personal property taxes. When the taxing authority has not invoiced a new facility, building value per the most recent contractor invoice times the locality's tax rate shall be used to estimate real estate and tax liability for the period. Only the nursing facility's building value can be included in the calculation.
      b. Actual paid insurance premiums shall be provided to support property insurance. For newly constructed nursing facilities, a reasonable estimate from the insurance company can be used to document property insurance cost until the first insurance policy and the premium are incurred. Only the nursing facility's property insurance can be included on the schedule.
   2. Costs shall be based on currently available documentation at the time but are subject to audit. DMAS may use any reasonable method to estimate costs for which there is inadequate documentation. Reasonable method includes using tax rates from the taxing authority in the location of the facility, the most recent contractor's invoice to determine building cost, and estimates from insurance companies related to the nursing facility portion of the building. Any adjustments based on subsequent year documentation or audit for a current rate year shall be applied beginning July 1 of the next rate year.

Subpart II
Rate Determination Procedures
Article 1. Transition to new capital payment methodology.

12 VAC 30-90-29.

A. This section provides for a transition to a new capital payment methodology. The methodology that will be phased out for most facilities is described in Article 2. The methodology that will be phased in for most facilities is described in Article 3. The terms and timing of the transition are described in this article.

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E. Emergency regulations effective July 1, 2000, provided for a facility specific fixed capital per diem applicable to services in SFY 2001, that is not to be adjusted at settlement. After SFY 2001, the per diem that would have been applicable to SFY 2001, under the methodology in Article 2 shall be calculated. If there are two provider fiscal years that overlap SFY 2001, this per diem shall be a combination of the two applicable per diem amounts. If the per diem provided in the emergency regulations is lower than the per diem based on Article 2, the difference, multiplied by the days in SFY 2001, shall be paid to the facility. If the per diem provided in the emergency regulations is higher, the difference, multiplied by the days, shall be collected from the facility in the settlement of the provider year settled after the difference is calculated.

Article 2
Plant Cost Component

12VAC30-90-30. Plant cost.

A. This Article describes a capital payment methodology that will be phased out for most nursing facilities by SFY 2012. The terms and timing of the transition to a different methodology are described in Article 1. The methodology that will eventually replace this one for most facilities is described in Article 3.

B. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

C. Effective July 1, 2001, to calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as the required occupancy percentage of the daily licensed bed complement during the applicable cost reporting period. The required occupancy percentage means the ratio of nursing facility total patient days to total potential patient days for all available licensed beds. The occupancy percentage for dates of service on or before June 30, 2013 shall be 90%, for dates of service on or after July 1, 2013 shall be 88%. For facilities with less than 12 months of occupancy experience, the required occupancy percentage shall be determined from the occupancy schedule in 4.19-D, Supp 1, p 16. For facilities that also provide specialized care services, see 4.19-D, Supp 1, page 56, #9, for special procedures for computing the number of patient days required to meet the occupancy requirement.

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are non-reimbursable plant costs.

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12VAC30-90-31. New nursing facilities and bed additions.

A. Providers shall be required to obtain three competitive bids when (i) constructing a new physical plant or renovating a section of the plant when changing the licensed bed capacity, and (ii) purchasing fixed equipment or major movable equipment related to such projects. All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see 12VAC30-90-51.)

B. Reimbursable costs for building and fixed equipment shall be based upon the 75th percentile square foot costs for NFs published annually in the R.S. Means Building Construction Cost Data as adjusted by the appropriate R.S. Means Square Foot Costs "Location Factor" for Virginia for the locality in which the NF is located. Where the specific location is not listed in the R.S. Means Square Foot Costs "Location Factor" for Virginia, the facility's zip code shall be used to determine the appropriate locality factor from the U.S. Postal Services National Five Digit Zip Code for Virginia and the R.S. Means Square Foot Costs "Location Factors." The provider shall have the option of selecting the construction cost limit, which is effective on the date the Certificate of Public Need (COPN) is issued or the date the NF is licensed. Total cost shall be calculated by multiplying the above 75th percentile square foot cost by 385 square feet (the average per bed square footage). Effective July 1, 2007, the construction cost limit for children's ICF/MR facilities having 50 or more beds shall be calculated using up to 750 square feet per bed. Total costs for building additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data 75th percentile square foot costs for NFs. Attachment 4.19-D, Supp 1, pages 1-3, entitled Mid-year Fair Rental Value rate determination, provides cost documentation requirements for new and renovated nursing homes.

C. New NFs and bed additions to existing NFs must have prior approval under the state's Certificate of Public Need Law and Licensure regulations in order to receive Medicaid reimbursement.

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued (see 12VAC5-220-10 et seq.).

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"Fixed capital replacement value" means an amount equal to the R.S. Means 75th percentile nursing home construction cost per square foot, times the applicable R.S. Means historical cost index factor, times the factor for land and soft costs, times the applicable R.S. Means "Location Factor", times facility imputed gross square feet.

"FRV depreciation rate" means a depreciation rate equal to 2.86% per year.

"Hospital based facility" means one for which a single combined Medicare cost report is filed that includes the costs of both the hospital and the nursing home.

"Major renovation" means an increase in capital of $3,000 per bed.

"Movable capital replacement value" means a value equal to $3,475.00 per bed in SFY2001, and shall be increased each July 1st by the same R.S. Means historical cost index factor that is used to calculate the fixed capital replacement value. Each year's updated movable capital replacement value shall be used in the calculation of each provider's rate for the provider year beginning on or after the date the new value becomes effective.

"Occupancy Schedule" means a table created to represent the average statewide occupancy by month of operation for use in calculating the per diem rate in lieu of a minimum occupancy requirement or actual occupancy for facilities with less than 12 months of experience. The occupancy schedule is shown in Table 1.

Table 1. Occupancy Schedule

Initial Operating Period	Occupancy Percentage
3 Months	58.10%
4 Months	65.68%
5 Months	70.01%
6 Months	73.69%
7 Months	76.69%
8 Months	79.23%
9 Months	81.60%
10 Months	83.88%
11 Months	85.84%
12 Months	88.00%

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"R.S. Means 75th percentile nursing construction cost per square foot" means the 75th percentile value published in the most recent available edition of Building Construction Cost Data. In the 2000 edition of the R.S. Means publication this value is $110, which is reported as a January 2000 value.

"R.S. Means historical cost index factor" means the ratio of the two most recent R.S. Means Historical Cost Indexes published in the most recent available edition of Building Construction Cost Data. In the 2000 edition of this R.S. Means publication these two values are 117.6 (for 1999) and 115.1 (for 1998). The ratio of these values, and therefore the factor to be used would be 1.022. This factor would be used to adjust the January 2000 value for the one year of change from January 2000 to January 2001, the mid-point of the prospective rate year (SFY2001). The resulting cost value that would be used in SFY2001 is $112.42. The indexes used in this calculation do not match the time period for which a factor is needed. They relate to 1998 and 1999, while 2000 and 2001 would be ideal. However, RSMeans does not publish index forecasts, so the most recent available indexes shall be used.

"R.S. Means Location Factors" means those published in the most recent available edition of Square Foot Costs. The 2000 location factors are shown in the following Table 2. The calculation will use the most recently available location factors, which will also be published on the DMAS website.

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TABLE 2.
R.S. MEANS COMMERCIAL CONSTRUCTION COST
LOCATION FACTORS (2000)

Zip Code	**PRINCIPAL CITY**	**Location Factor**
220-221	Fairfax	0.90
222	Arlington	0.90
223	Alexandria	0.91
224-225	Fredericksburg	0.85
226	Winchester	0.80
227	Culpeper	0.80
228	Harrisonburg	0.77
229	Charlottesville	0.82
230-232	Richmond	0.85
233-235	Norfolk	0.82
236	Newport News	0.82
237	Portsmouth	0.81
238	Petersburg	0.84
239	Farmville	0.74
240-241	Roanoke	0.77
242	Bristol	0.75
243	Pulaski	0.70
244	Staunton	0.76
245	Lynchburg	0.77
246	Grundy	0.70

"Rental rate" means for a prospective year a rate equal to two percentage points plus the yield on US Treasury Bonds with maturity over 10 years, averaged over the most recent three calendar years for which data are available, as published by the Federal Reserve (Federal Reserve Statistical Release H.15 Selected Interest Rates (www.Federalreserve.gov/releases/)]. The rate shall be published and distributed to providers annually. Changes in the rental rate shall be effective for the provider's fiscal year beginning on or after July 1st. Rental rates may not fall below 9% or exceed 11% and will be updated annually on or about July 1st each year. Effective July 1, 2010, through September 30, 2010, the floor for the nursing facility rental rates may not fall below 8.75%. Effective October 1, 2010, through June 30, 2011, the floor for the nursing facility rental rates may not fall below 9.0%. Effective July 1, 2011, through June 30, 2012, the floor for the nursing facility rental rates may not fall below 8.0%. Effective July 1, 2012, through June 30, 2014, the floor for the nursing facility rental rates may not fall below 8.5%. Effective July 1, 2014, the floor for the nursing facility rental rates may not fall below 8.0%. The rate will be published and distributed to providers annually. Changes in the rental rate shall be effective for the provider's fiscal year beginning on or after July 1. Effective July 1, 2014, the rental rate shall be effective for the state fiscal year.

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"Required occupancy percentage" means the ratio of nursing facility total patient days to total potential patient days for all available licensed beds. The required occupancy percentage shall be 90% for dates of service on or before June 30, 2013. The required occupancy percentage for dates of service on or after July 1, 2013, shall be 88%. Facilities whose Fair Rental Value report indicates less than 12 months of experience must use the Occupancy Schedule to determine the required occupancy percentage.

"SFY" means State Fiscal Year (July 1st through June 30th.)

A. Fair rental value (FRV) payment for capital.

1. Effective for dates of service on or after July 1, 2001, the DMAS shall pay nursing facility capital related costs under a Fair Rental Value (FRV) methodology. The payment made under this methodology shall be the only payment for capital related costs, and no separate payment shall be made for depreciation or interest expense, lease costs, property taxes, insurance, or any other capital related cost, including home office capital costs. This payment is considered to cover costs related to land, buildings and fixed equipment, major movable equipment, and any other capital related item. This shall be the case regardless of whether the property is owned or leased by the operator.

2. FRV rate year. The FRV payment rate shall be a per diem rate determined each year for each facility, using the most recent available data from settled cost reports, or from other verified sources as specified herein. The per diem rate shall be determined prospectively and shall apply for the entire fiscal year. Each provider shall receive a new capital per diem rate each year effective at the start of the provider's fiscal year, except that the capital per diem rate was revised for the rental rate changes effective July 1, 2010 through June 30, 2012. Data elements that are provider specific shall be revised at that time and shall rely on the settled cost report and schedule of assets of the previous year. Data elements that are not provider specific, including those published by RSMeans and the rental rate, shall be determined annually on or about July 1st, and shall apply to provider fiscal years beginning on or after July 1st. That is, each July 1st DMAS shall determine the RSMeans values and the rental rate, and these shall apply to all provider fiscal years beginning on or after July 1st. Effective July 1, 2014, the FRV rate year shall be the same as the state fiscal year.

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3. Mid-year FRV rate change. Facilities requiring a mid-year FRV rate change must follow the procedures as specified in 4.19-D, Supp 1, pages 1-3.

4. The capital per diem rate for hospital-based nursing facilities shall be the last settled capital per diem.

12 VAC 30-90-37. Calculation of FRV Per Diem Rate for Capital. Calculation of FRV Rental Amount. Change of Ownership.

A. Calculation of FRV Per Diem Rate for Capital. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of actual patient days or the required occupancy percentage of the potential patient days for all licensed beds throughout the cost reporting period. For facilities that also provide specialized care services, see 4.19-D, Supp 1, p 26 (12 VAC 30-90-264) section 10, for special procedures for computing the number of patient days required to meet the required occupancy percentage requirement.

Facilities shall be required to submit a calendar year FRV report covering both NF and specialized care beds to be used to set a prospective FRV rate effective the following July 1 for both the NF and the specialized care facility. The calendar year FRV report shall be submitted by the end of February following the end of the calendar year. FRV reports shall be settled within 90 days of filing the FRV report. For late FRV reports, the prospective rate may be effective 90 days after the date of filing even if after July 1. No capital rate shall be paid between July 1 and the effective date of the prospective FRV rate for a late report.

New nursing facilities or major renovations that qualify for mid-year FRV rate adjustments must follow pro forma submission procedures as specified in 4.19-D, Supp 1, pages 1-3.

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C. Prospective capital rates shall be calculated in the following manner:

1. Fair rental value per diem rates for the fiscal year shall be calculated for all freestanding nursing facilities based on the prior calendar year information aged to the fiscal year and using RS Means factors and rental rates corresponding to the fiscal year as prescribed in 12 VAC 30-90-36. There will be no separate calculation for beds subject to or not subject to transition.

2. FRV per diem rates for new nursing facilities or major renovations that qualify for mid-year rate adjustments shall be calculated as prescribed in 4.19-D, Supp 1, pages 1-3.

a. These FRV changes shall also apply to specialized care facilities.

b. The capital per diem rate for hospital-based nursing facilities shall be the last settled capital per diem.

12VAC30-90-45 to 12VAC30-90-49. Reserved.

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b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See NHPS, Appendix III, page 2 (12VAC30-90-290) for the cost reimbursement limitations.

c. Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet the following wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that cannot be closed, or second to third degree burns covering more than 10% of the body.

8. Covered ancillary services are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services, psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care nursing facility cost reporting period.

9. Capital costs. Effective July 1, 2016, capital cost reimbursement rates shall be based on subsection C of 12 VAC 30-90-44 in accordance with 4.19-D, Supp 1, p 14-19 (12 VAC 30-90-35 through 12 VAC 30-90-37) inclusive, except that the required occupancy percentage shall not be separately applied to specialized care. For new nursing homes or major renovations that qualify for mid-year rate adjustments, capital cost reimbursement shall be based on 4.19-D, Supp 1, p 1-3. To determine the capital cost related to specialized care patients, the following calculation shall be applied:

a. Licensed beds, including specialized care beds, multiplied by days in the cost reporting period, shall equal available days.

b. The required occupancy days shall equal the required occupancy percentage multiplied by available days.

c. The required occupancy days minus actual resident days, including specialized care days, shall equal the shortfall of days. If the shortfall of days is negative, the shortfall of days shall be zero.

d. Actual resident days, not including specialized care days, plus the shortfall of days shall equal the minimum number of days to be used to calculate the capital cost per day.

10. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs. NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS. Effective July 1, 2016, NATCEP costs shall be paid on a prospective basis in accordance with 4.19-D, Supp 1, page 45 (12 VAC 300-90-170).

11. Pediatric routine operating cost rate. For pediatric specialized care in a distinct part pediatric specialized care unit, one routine operating cost ceiling will be developed. The routine operating cost ceiling will be $418 as of July 1, 2002. Effective July 1, 2016, the pediatric routine operating cost ceiling shall be $577.24 as of SFY 15.

a. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivisions 4 of this section.

b. The final routine operating cost reimbursement rate shall be computed as described for other than pediatric units in subdivision 3 of this section.