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MEMORANDUM

TO: EMILY MCCLELLAN
Regulatory Supervisor
Department of Medical Assistance Services

FROM: ELIZABETH M. GUGGENHEIM
Assistant Attorney General

DATE: January 23, 2018

SUBJECT: Exempt final regulations regarding Provider Reimbursement Changes

I have reviewed the final exempt regulations that would make changes to provider reimbursement. You have asked the Office of the Attorney General to review the proposed regulations to determine if DMAS has the legal authority to promulgate the amended regulations as final exempt and if it would comport with state and federal law.

Based on that review, it is this Office's view that DMAS has the authority, subject to compliance with the provisions of Article 2 of the Administrative Process Act (APA), and has not exceeded that authority.

The amended regulations and their authority are as follows: 12 VAC 30-70-281 is required by the 2016 *Acts of Assembly*, Chapter 780, Item 306.FFFF and 2017 *Acts of Assembly*, Chapter 836, Item 306.FFFF; 12 VAC 30-70-291 is required by the 2017 *Acts of Assembly*, Chapter 836, Item 306.ZZZZ; 12 VAC 30-70-351(C) is required by the 2016 *Acts of Assembly,* Chapter 780, Item 306.GGGG and the 2017 *Acts of Assembly,* Chapter 836, Item 306.GGGG; 12 VAC 30-80-30(A)(1) is required by the 2015 *Acts of Assembly,* Chapter 665, Item 301.OOOO, the 2016 *Acts of Assembly,* Chapter 780, Item 306.YYY, and the 2017 *Acts of Assembly,* Chapter 836, Item 306.YYY; 12 VAC 30-80-30(A)(17)(b) is required by the 2016 *Acts of Assembly,* Chapter 780, Item 306.ZZZ and the 2017 *Acts of Assembly,* Chapter 836, Item 306.ZZZ; 12 VAC 30-80-30(A)(18.1) is required by the 2016 *Acts of Assembly,* Chapter 708, Item 306.RRR.5 and the 2017 *Acts of Assembly,* Chapter 836, Item 306.RRR.5; 12 VAC 30-80-36(4)(a) is required by the 2016 *Acts of Assembly,* Chapter 780, Item 306.GGGG and the 2017 *Acts of Assembly*, Chapter 836, Item 306.GGG; 12 VAC 30-80-180 is required by the 2016 *Acts*

of Assembly, Chapter 780, Item 306.IIII and the 2017 *Acts of Assembly*, Chapter 836, Item 306.IIII; 12 VAC 30-80-200 is required by the 2016 *Acts of Assembly*, Chapter 780, Item 306.IIII and the 2017 *Acts of Assembly*, Chapter 836, Item 306.IIII; 12 VAC 30-90-44 is required by the 2016 *Acts of Assembly,* Chapter 780, Item 306.CCC and the 2017 *Acts of Assembly*, Chapter 836, Item 306.CCC; and 12 VAC 30-90-264 is required by the 2016 *Acts of Assembly,* Chapter 780, Item 306.NNNN and the 2017 *Acts of Assembly,* Chapter 836, Item 306.NNNN . It is my view that the promulgation of these amended regulations are exempt from the procedures of Article 2 of the Administrative Process Act pursuant to Virginia Code § 2.2-4006(A)(4)(a).

If you have any questions, please feel free to contact me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Final Text

Action: 2016 and 2017 Provider Reimbursement Changes

Stage: Final

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12VAC30-70-221
Article 2
Prospective (DRG-Based) Payment Methodology

12VAC30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

1. As stipulated in 12VAC30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times relative weight of the DRG to which the case is assigned.

2. As stipulated in 12VAC30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12VAC30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12VAC30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12VAC30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12VAC30-70-281, payments for direct medical education costs of nursing schools and paramedical programs shall be made on an allowable cost basis. For Type Two hospitals, payment for direct graduate medical education (GME) costs for interns and residents shall be made quarterly on a prospective basis, subject to cost settlement based on the number of ~~full-time~~ full-time equivalent (FTE) interns and residents as reported on the cost report. Effective April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs.

7. As stipulated in 12VAC30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12VAC30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"AP-DRG" means all patient diagnosis related groups.

"APR-DRG" means all patient refined diagnosis related groups.

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated. In subsequent rebasings, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" means the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" means the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12VAC30-70-10 through 12VAC30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid inpatient utilization rate in excess of 14%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subdivision 2 of this definition does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

"DRG" means diagnosis related groups.

"DRG cases" means ~~medical/surgical~~ medical or surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" or "Medicaid inpatient utilization rate" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage or Medicaid inpatient utilization rate includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This definition includes all paid Medicaid days and ~~nonpaid/denied~~ nonpaid or denied Medicaid days to include medically unnecessary days, inappropriate level of care service days, and days that exceed any maximum day limits (with appropriate documentation). The definition of Medicaid days does not include any general assistance, Family Access to Medical Insurance Security (FAMIS), State and Local Hospitalization (SLH), charity care, low-income care, indigent care, uncompensated care, bad debt, or Medicare dually eligible days. It does not include days for newborns not enrolled in Medicaid during the fiscal year even though the mother was Medicaid eligible during the birth. Effective July 1, 2014, the definition for Medicaid utilization percentage or Medicaid inpatient utilization rate is defined in 12VAC30-70-301 C.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric distinct part unit (DPU), divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The ~~operating cost-to-charge ratio~~ costs shall be calculated ~~using data from cost reports from hospital fiscal years~~ by multiplying the per diems and ancillary cost-to-charge ratios from each hospital's cost ending in the state fiscal year used as the base year to the corresponding days and ancillary charges by revenue code for each hospital's groupable cases.

"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and includes (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD, as defined in 12VAC30-95-5. Not all mental

disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A & B (12VAC30-50-95 through 12VAC30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" means when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as new cases. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits. As used here, the term "ICD" is defined in 12VAC30-95-5.

"Type One hospitals" means those hospitals that were state-owned teaching hospitals on January 1, 1996.

"Type Two hospitals" means all other hospitals.

"Uncompensated care costs" or "UCC" means unreimbursed costs incurred by hospitals from serving self-pay, charity, or Medicaid patients without regard to disproportionate share adjustment payments.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper. Effective October 1, 2014, "ungroupable cases" means cases assigned to DRG 955 (ungroupable) and DRG 956 (ungroupable) as determined by the APR-DRG grouper.

D. The all patient diagnosis related groups (AP-DRG) grouper shall be used in the DRG payment system. Effective October 1, 2014, DMAS shall replace the AP-DRG grouper with the all patient refined diagnosis related groups (APR-DRG) grouper for hospital inpatient reimbursement. The APR-DRG grouper will produce a DRG as well as a severity level ranging from 1 to 4. DMAS shall phase in the APR-DRG weights by blending in 50% of the full APR-DRG weights with 50% of fiscal year (FY) 2014 AP-DRG weights for each APR-DRG group and severity level in the first year. In the second year, the blend will be 75% of full APR-DRG weights and 25% of the FY 2014 AP-DRG weights. Full APR-DRG weights shall be used in the third year and succeeding years for each APR-DRG group and

severity. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology	
Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims history file
Outlier adjustment factor	Federal Register

12VAC30-70-281

12VAC30-70-281. Payment for direct medical education costs of nursing schools, paramedical programs, and graduate medical education for interns and residents.

A. Direct medical education costs of nursing schools and paramedical programs shall continue to be paid on an allowable cost basis.

1. Payments for these direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

2. Final payment for these direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

B. Effective with cost reporting periods beginning on or after July 1, 2002, direct graduate medical education (GME) costs for interns and residents shall be reimbursed on a per-resident prospective basis, subject to cost settlement as outlined in this subsection except that on or after April 1, 2012, payment for direct GME for interns and residents for Type One hospitals shall be 100% of allowable costs as outlined in subsection C of this section.

1. The methodology provides for the determination of a hospital-specific base period per-resident amount to initially be calculated from cost reports with fiscal years ending in state fiscal year 1998 or as may be rebased in the future and provided to the public in an agency guidance document. The ~~per resident~~ per-resident amount for new qualifying facilities shall be calculated from the most recently settled cost report. This per-resident amount shall be calculated by dividing a hospital's Medicaid allowable direct GME costs for the base period by its number of interns and residents in the base period yielding the base amount.

2. The base amount shall be updated annually by the moving average values in the Virginia-Specific Hospital Input Price Index as described in 12VAC30-70-351. The updated per-resident base amount will then be multiplied by the weighted number of full-time equivalent (FTE) interns and residents as reported on the annual cost report to determine the total Medicaid direct GME amount allowable for each year. Payments for direct GME costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end based on the actual number of FTEs reported in the cost reporting period. The total Medicaid direct GME allowable amount shall be allocated to inpatient and outpatient services based on Medicaid's share of costs under each part.

C. Effective April 1, 2012, Type One hospitals shall be reimbursed 100% of Medicaid allowable fee-for-service (FFS) and managed care organization (MCO) GME costs for interns and residents.

1. Type One hospitals shall submit annually separate FFS and MCO GME cost schedules, approved by the agency, using GME per diems and GME ratios of cost to charges (RCCs) from the Medicare and Medicaid cost reports and FFS and MCO days and charges. Type One hospitals shall provide information on managed care days and charges in a format similar to FFS.

2. Interim lump sum GME payments for interns and residents shall be made quarterly based on the total cost from the most recently audited cost report divided by four and will be final settled in the audited cost report for the fiscal year end in which the payments are made.

D. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

E. Effective July 1, 2017, the Department of Medical Assistance Services (DMAS) shall make supplemental payments to the following hospitals for the specified number of primary care residencies: Sentara Norfolk General (two residencies), Carilion Medical Center (six residencies), Centra Lynchburg General Hospital (one residency), Riverside Regional Medical Center (two residencies), and Bon Secours St. Francis Medical Center (two residencies). DMAS shall make supplemental payments to Carilion Medical Center for two psychiatric residencies. The supplemental payment for each residency shall be $100,000 annually minus any Medicare residency payment for which the hospital is eligible. Supplemental payments shall be made for up to four years for each new qualifying resident. A hospital will be eligible for the supplemental payments as long as the hospital maintains the number of residency slots in total and by category. Payments shall be made quarterly following the same schedule for other medical education payments. Subsequent to the new award of a supplemental payment, the hospital must provide documentation annually by August 1, 2017, that it continues to meet the criteria for the supplemental payments and must report any changes during the year to the number of residents.

12VAC30-70-291
12VAC30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education (IME). Out-of-state cost reporting hospitals are eligible for this payment only if they have Virginia Medicaid utilization in the base year of at least 12% of total Medicaid days. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows (this formula also applies to Children's Hospital of the King's Daughters effective July 1, 2013):

IME Percentage for Type One Hospitals = $[1.89 \times ((1 + r)^{0.405}-1)] \times$ (IME Factor)

An IME factor shall be calculated for each Type One hospital and shall equal a factor that, when used in the calculation of the IME percentage, shall cause the resulting IME payments to equal what the IME payments would be with an IME factor of one, plus an amount equal to the difference between operating payments using the adjustment factor specified in subdivision B 1 of 12VAC30-70-331 and operating payments using an adjustment factor of one in place of the adjustment factor specified in subdivision B 1 of 12VAC30-70-331.

2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows (excluding Children's Hospital of the King's Daughters):

IME Percentage for Type Two Hospitals = $[1.89 \times ((1 + r)^{0.405}-1)] \times 0.5695$

In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

1. For Type Two hospitals, this payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

2. For Type One hospitals, this payment shall be equal to the hospital's hospital-specific operating rate per case, as determined in 12VAC30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section. Effective April 1, 2012, the operating rate per case used in the formula shall be revised to reflect an adjustment factor of one and case-mix adjusted by multiplying the operating rate per case in this subsection by the weight per case for FFS discharges that is determined during rebasing. This formula applies to Children's Hospital of the King's Daughters effective July 1, 2017.

D. An additional IME payment not to exceed $200,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU utilization in excess of 50% as reported to the Department of Medical Assistance Services as of March 1, 2004. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2004.

E. An additional IME payment not to exceed $500,000 in total shall be apportioned among Type Two hospitals, excluding freestanding children's hospitals, with Medicaid NICU days in excess of 4,500 as reported to the Department of Medical Assistance Services as of March 1, 2005, that do not otherwise receive an additional IME payment under subsection D of this section. These payments shall be apportioned based on each eligible hospital's percentage of Medicaid NICU patient days relative to the total of these days among eligible hospitals as reported by March 1, 2003.

F. Effective July 1, 2013, ~~DMAS shall calculate an IME factor for Virginia freestanding children's hospitals with greater than 50% Medicaid utilization in 2009. Total~~ total payments for IME in combination with other payments for freestanding children's hospitals with greater than 50% Medicaid utilization in 2009 shall not exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject. Effective July 1, 2017, IME payments cannot exceed the federal uncompensated care cost limit to which disproportionate share hospital payments are subject, excluding third-party reimbursement for Medicaid eligible patients.

12VAC30-70-351
12VAC30-70-351. Updating rates for inflation.

A. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with the department shall be used to update the base year standardized operating costs per case, as determined in 12VAC30-70-361, and the base year standardized operating costs per day, as determined in 12VAC30-70-371, to the midpoint of the upcoming state fiscal year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by Global Insight (or its successor), in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.

B. The inflation adjustment for hospital operating rates, disproportionate share hospitals (DSH) payments, and graduate medical education payments shall be

~~0.0%~~ eliminated for fiscal year (FY) 2010. The elimination of the inflation adjustments shall not be applicable to rebasing in FY 2011.

C. In FY 2011, hospital operating rates shall be rebased; however the 2008 base year costs shall only be increased 2.58% for inflation. For FY 2011 there shall be no inflation adjustment for graduate medical education (GME) or freestanding psychiatric facility rates. The inflation adjustment shall be eliminated for hospital operating rates, GME payments, and freestanding psychiatric facility rates for FY 2012. The inflation adjustment shall be 2.6% for inpatient hospitals, including hospital operating rates, GME payments, DSH payments, and freestanding psychiatric facility rates for FY 2013, and 0.0% for the same facilities for FY 2014, FY 2015, and FY 2016. For FY 2017, the inflation adjustment for inpatient hospital operating rates, GME, DSH, and freestanding psychiatric hospitals shall be 50% of the adjustment calculated in subsection A of this section. In FY 2018, the inflation adjustment for inpatient hospital operating rates, GME, DSH, and freestanding psychiatric hospitals shall be eliminated for inpatient hospitals.

12VAC30-70-381
12VAC30-70-381. DRG relative weights and hospital case-mix indices.

A. For the purposes of calculating DRG relative weights and hospital case-mix indices, base year claims data for all groupable cases shall be used. Base year claims data for ungroupable cases and per diem cases shall not be used. In calculating the DRG relative weights, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12VAC30-70-221, the following methodology shall be used to calculate the DRG relative weights:

1. The operating costs for each groupable case shall be calculated by multiplying the ~~hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12VAC30-70-221~~ per diems and ancillary cost-to-charge ratios from each hospital's cost report ending in the state fiscal year used as the base year to the corresponding days and ancillary charges by revenue code for each hospital's groupable cases.

2. The standardized operating costs for each groupable case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding the standardized operating costs.

3. The average standardized cost per DRG shall be calculated by dividing the standardized operating costs for all groupable cases in the DRG by the number of groupable cases classified in the DRG.

4. The average standardized cost per case shall be calculated by dividing the standardized operating costs for all groupable cases by the total number of groupable cases.

5. The average standardized cost per DRG shall be divided by the average standardized cost per case to determine the DRG relative weight.

C. Statistical outliers shall be eliminated from the calculation of the DRG relative weights. Within each DRG, cases shall be eliminated if (i) their standardized costs per case are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per case and (ii) their standardized costs per day are outside of 3.0 standard deviations of the mean of the log distribution of the standardized costs per day. To eliminate a case, both conditions must be satisfied.

D. In calculating the DRG relative weights, a threshold of five cases shall be set as the minimum number of cases required to calculate a reasonable DRG relative weight. In those instances where there are five or fewer cases, the department's Medicaid claims data shall be supplemented with Medicaid claims data from another state or other available sources. The DRG relative weights calculated according to this methodology will result in an average case weight that is different from the average case weight before the supplemental claims data was added. Therefore, the DRG relative weights shall be normalized by an adjustment factor so that the average case weight after the supplemental claims data were added is equal to the average case weight before the supplemental claims data were added.

E. The DRG relative weights shall be used to calculate a case-mix index for each hospital. The case-mix index for a hospital is calculated by summing, across all DRGs, the product of the number of groupable cases in each DRG and the relative weight for each DRG and dividing this amount by the total number of groupable cases occurring at the hospital.

12VAC30-80-30
12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public). ~~The following limitations shall apply to emergency physician services.~~

~~a. Definitions. The following words and terms, when used in this subdivision 1 shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:~~

~~"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.~~

~~"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.~~

~~"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.~~

~~"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.~~

~~b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.~~

~~(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services rendered in emergency departments that DMAS determines are nonemergency care.~~

~~(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.~~

~~(3) Services determined by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:~~

~~(a) The initial treatment following a recent obvious injury.~~

~~(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.~~

~~(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.~~

~~(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.~~

~~(e) Services provided for acute vital sign changes as specified in the provider manual.~~

~~(f) Services provided for severe pain when combined with one or more of the other guidelines.~~

~~(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.~~

~~(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.~~

2. Dentists' services.

3. Mental health services including: (i) community mental health services, (ii) services of a licensed clinical psychologist, (iii) mental health services provided by a physician, or (iv) peer support services.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME) and supplies.

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

"DMERC" means the Durable Medical Equipment Regional Carrier rate as published by the Centers for Medicare and Medicaid Services at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html**.

"HCPCS" means the Healthcare Common Procedure Coding System, Medicare's National Level II Codes, HCPCS 2006 (Eighteenth edition), as published by Ingenix, as may be periodically updated.

a. Obtaining prior authorization shall not guarantee Medicaid reimbursement for DME.

b. The following shall be the reimbursement method used for DME services:

(1) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10%. For dates of service on or after July 1, 2014, DME items subject to the Medicare competitive bidding program shall be reimbursed the lower of:

(a) The current DMERC rate minus 10% or

(b) The average of the Medicare competitive bid rates in Virginia markets.

(2) For DME items with no DMERC rate, the agency shall use the agency fee schedule amount. The reimbursement rates for DME and supplies shall be listed in the DMAS Medicaid Durable Medical Equipment (DME) and Supplies Listing and updated periodically. The agency fee schedule shall be available on the agency website at www.dmas.virginia.gov.

(3) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, less shipping and handling, plus 30%. The manufacturer's net charge to the provider shall be the cost to the provider minus all available discounts to the provider. Additional information specific to how DME providers, including manufacturers who are enrolled as providers, establish and document their cost or costs for DME codes that do not have established rates can be found in the relevant agency guidance document.

c. DMAS shall have the authority to amend the agency fee schedule as it deems appropriate and with notice to providers. DMAS shall have the authority to determine alternate pricing, based on agency research, for any code that does not have a rate.

d. The reimbursement for incontinence supplies shall be by selective contract. Pursuant to § 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d), the Commonwealth assures that adequate ~~services/devices~~ services or devices shall be available under such arrangements.

e. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain ~~services/durable~~ services or durable medical equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in

one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include~~, but not be limited to,~~ oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services.

8. Laboratory services (other than inpatient hospital). The agency's rates for clinical laboratory services were set as of July 1, 2014, and are effective for services on or after that date.

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-ray services.

11. Optometry services.

12. ~~Medical supplies and equipment~~ Reserved.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90, except for services in ambulatory surgery clinics reimbursed under 12VAC30-80-35.

16. Supplemental payments for services provided by Type I physicians.

a. In addition to payments for physician services specified elsewhere in this ~~State Plan~~ chapter, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 2, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for Type I physician services and Medicare rates. Effective August 13, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 143% of Medicare rates. Effective January 3, 2012, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 181% of Medicare rates. Effective January 1, 2013, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 197% of Medicare rates. Effective April 8, 2014, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 201% of Medicare rates.

c. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

d. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter.

e. Payment will not be made to the extent that the payment would duplicate payments based on physician costs covered by the supplemental payments.

17. Supplemental payments for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this ~~State Plan~~ chapter, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 143% of Medicare rates as defined in the supplemental payment calculation described in the Medicare equivalent of the average commercial rate methodology (see 12VAC30-80-300), subject to the following reduction. Final payments shall be reduced on a prorated basis so that total payments for freestanding children's hospital physician services are $400,000 less annually than would be calculated based on the formula in the previous sentence. Effective July 1, 2015, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 178% of Medicare rates as defined in the supplemental payment calculation for Type I physician services. Payments shall be made ~~quarterly no later than 90 days after the end of the quarter. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300~~ on the same schedule as Type I physicians.

18. Supplemental payments for services provided by physicians affiliated with ~~publicly funded medical schools in Tidewater~~ Eastern Virginia Medical Center.

a. In addition to payments for physician services specified elsewhere in ~~the State Plan~~ this chapter, the Department of Medical Assistance Services provides supplemental payments to physicians affiliated with ~~publicly funded medical schools in Tidewater~~ Eastern Virginia Medical Center for furnished services provided on or after October 1, 2012. A physician affiliated with ~~a publicly funded medical school~~ Eastern Virginia Medical Center is a physician who is employed by a publicly funded medical school that is a political subdivision of the Commonwealth of Virginia, who provides clinical services through the faculty practice plan affiliated with the publicly funded medical school, and who has entered into contractual ~~agreements~~ arrangements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective October 1, ~~2012~~ 2015, the supplemental payment amount ~~for services furnished by physicians affiliated with publicly funded medical schools in Tidewater~~ shall be the difference between the Medicaid payments otherwise made for physician services and ~~135%~~ 137% of Medicare rates. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

c. Supplemental payments shall be made quarterly, no later than 90 days after the end of the quarter.

19. Supplemental payments for services provided by physicians at freestanding children's hospitals serving children in Planning District 8.

a. In addition to payments for physician services specified elsewhere in this chapter, DMAS shall make supplemental payments for physicians employed at a freestanding children's hospital serving children in Planning District 8 with more than 50% Medicaid inpatient utilization in fiscal year 2014. This applies to physician practices affiliated with Children's National Health System.

b. The supplemental payment amount for qualifying physician services shall be the difference between the Medicaid payments otherwise made and 178% of Medicare rates but no more than $551,000 for all qualifying physicians. The methodology for determining allowable percent of Medicare rates is based on the Medicare equivalent of the average commercial rate described in this chapter.

c. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter. Any quarterly payment that would have been due prior to the approval date shall be made no later than 90 days after the approval date.

~~19.~~ 20. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or government-operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or government-operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision ~~19~~ 20 d of this subsection and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision ~~19~~ 20 b (1) of this subsection for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision ~~19~~ 20 b (2) of this subsection by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section ~~may~~ will be made ~~in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS~~ annually in a lump sum during the last quarter of the fiscal year.

d. To determine the aggregate upper payment limit referred to in subdivision ~~19~~ 20 b (3) of this subsection, Medicaid payments to nonstate government-owned or government-operated clinics will be divided by the "additional factor" whose calculation is described in ~~Attachment 4.19-B, Supplement 4 (~~12VAC30-80-190 B 2~~)~~ in regard to the state agency fee schedule for Resource Based Relative Value Scale. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

~~20.~~ 21. Personal assistance services (PAS) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the DMAS website at http://www.dmas.virginia.gov.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

12VAC30-80-36
12VAC30-80-36. Fee-for-service providers: outpatient hospitals.

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Enhanced ambulatory patient group" or "EAPG" means a defined group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Diseases (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

"EAPG relative weight" means the expected average costs for each EAPG divided by the relative expected average costs for visits assigned to all EAPGs.

"Base year" means the state fiscal year for which data is used to establish the EAPG base rate. The base year will change when the EAPG payment system is rebased and recalibrated. In subsequent rebasings, DMAS shall notify affected providers of the base year to be used in this calculation.

"Cost" means the reported cost as described in 12VAC30-80-20 A and B.

"Cost-to-charge ratio" equals the hospital's total costs divided by the hospital's total charges. The cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

"Medicare wage index" means the Medicare wage index published annually in the Federal Register by the Centers for Medicare and Medicaid Services. The indices used in this section shall be those in effect in the base year.

B. Effective January 1, 2014, the prospective enhanced ambulatory patient group (EAPG) based payment system described in this subsection shall apply to reimbursement for outpatient hospital services (with the exception of laboratory services referred to the hospital but not associated with an outpatient hospital visit, which will be reimbursed according to the laboratory fee schedule).

1. The payments for outpatient hospital visits shall be determined on the basis of a hospital-specific base rate per visit multiplied by the relative weight of the EAPG (and the payment action) assigned for each of the services performed during a hospital visit.

2. The EAPG relative weights shall be the weights determined and published periodically by DMAS and shall be consistent with applicable Medicaid reimbursement limits and policies. The weights shall be updated at least every three years.

3. The statewide base rate shall be equal to the total costs described in this subdivision divided by the wage-adjusted sum of the EAPG weights for each facility. The wage-adjusted sum of the EAPG weights shall equal the sum of the EAPG weights multiplied by the labor percentage times the hospital's Medicare wage index plus the sum of the EAPG weights multiplied by the nonlabor percentage. The base rate shall be determined for outpatient hospital services at least every three years so that total expenditures will equal the following:

a. When using base years prior to January 1, 2014, for all services, excluding all laboratory services and emergency services described in subdivision 3 c of this subsection, a percentage of costs as reported in the available cost reports for the base period for each type of hospital as defined in 12VAC30-70-221.

(1) Type One hospitals. Effective January 1, 2014, hospital outpatient operating reimbursement shall be calculated at 90.2% of cost, and capital reimbursement shall be at 86% of cost inflated to the rate year.

(2) Type Two hospitals. Effective January 1, 2014, hospital outpatient operating and capital reimbursement shall be calculated at 76% of cost inflated to the rate year.

When using base years after January 1, 2014, the percentages described in subdivision 3 a of this subsection shall be adjusted according to subdivision 3 c of this subsection.

b. Laboratory services, excluding laboratory services referred to the hospital but not associated with a hospital visit, are calculated at the fee schedule in effect for the rate year.

c. Services rendered in emergency departments determined to be nonemergencies as prescribed in 12VAC30-80-20 D 1 b shall be calculated at the nonemergency reduced rate reported in the base year for base years prior to January 1, 2014. For base years after January 1, 2014, the cost percentages in subdivision 3 a of this subsection shall be adjusted to reflect services paid at the nonemergency reduced rate in the last year prior to January 1, 2014.

4. Inflation adjustment to base year costs. Each July, the Virginia moving average values as compiled and published by Global Insight (or its successor), under contract with DMAS, shall be used to update the base year costs to the midpoint of the rate year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by Global Insight (or its successor) in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year. Inflation shall be applied to the costs identified in subdivision 3 a of this subsection. The inflation adjustment for state fiscal year 2017 shall be 50% of the full inflation adjustment calculated according to this section. There shall be no inflation adjustment for state fiscal year 2018.

5. Hospital-specific base rate. The hospital-specific base rate per case shall be adjusted for geographic variation. The hospital-specific base rate shall be equal to the labor portion of the statewide base rate multiplied by the hospital's Medicare wage index plus the nonlabor percentage of the statewide base rate. The labor percentage shall be determined at each rebasing based on the most recently reliable data. For rural hospitals, the hospital's Medicare wage index used to calculate the base rate shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher. A base rate differential of 5.0% shall be established for freestanding Type Two children's hospitals. The base rate for non-cost-reporting hospitals shall be the average of the hospital-specific base rates of in-state Type Two hospitals.

6. The total payment shall represent the total allowable amount for a visit including ancillary services and capital.

7. The transition from cost-based reimbursement to EAPG reimbursement shall be transitioned over a four-year period. DMAS shall calculate a cost-based base rate at January 1, 2014, and at each rebasing during the transition.

a. Effective for dates of service on or after January 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 75% of the cost-based base rate and 25% of the EAPG base rate.

b. Effective for dates of service on or after July 1, 2014, DMAS shall calculate the hospital-specific base rate as the sum of 50% of the cost-based base rate and 50% of the EAPG base rate.

c. Effective for dates of service on or after July 1, 2015, DMAS shall calculate the hospital-specific base rate as the sum of 25% of the cost-based base rate and 75% of the EAPG base rate.

d. Effective for dates of service on or after July 1, 2016, DMAS shall calculate the hospital-specific base rate as the EAPG base rate.

8. To maintain budget neutrality during the first six years of the transition to EAPG reimbursement, DMAS shall compare the total reimbursement of hospital claims based on the parameters in subdivision 3 of this subsection to EAPG reimbursement every six months based on the six months of claims ending three months prior to the potential adjustment. If the percentage difference between the reimbursement target in subdivision 3 of this subsection and EAPG reimbursement is greater than 1.0%, plus or minus, DMAS shall adjust the statewide base rate by the percentage difference the following July 1 or January 1. The first possible adjustment would be January 1, 2015, using reimbursement between January 1, 2014, and October 31, 2014.

C. The enhanced ambulatory patient group (EAPG) grouper version used for outpatient hospital services shall be determined by DMAS. Providers or provider representatives shall be given notice prior to implementing a new grouper.

D. The primary data sources used in the development of the EAPG payment methodology are the DMAS hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals. The following table identifies key data elements that are used to develop the EAPG payment methodology. DMAS may supplement this data with similar data for Medicaid services furnished by managed care organizations if DMAS determines that it is reliable.

Data Elements for EAPG Payment Methodology	
Data Elements	Source
Total charges for each outpatient hospital visit	Claims history file
Number of groupable claims lines in each EAPG	Claims history file
Total number of groupable claim lines	Claims history file
Total charges for each outpatient hospital revenue line	Claims history file
Total number of EAPG assignments	Claims history file
Cost-to-charge ratio for each hospital	Cost report file
Medicare wage index for each hospital	Federal Register

12VAC30-80-180

12VAC30-80-180. Establishment of rate per visit for home health services.

A. Effective for dates of services on and after July 1, 1991, the Department of Medical Assistance Services (DMAS) shall reimburse home health agencies (HHAs) at a flat rate per visit for each type of service rendered by HHAs (i.e., nursing, physical therapy, occupational therapy, speech-language pathology services, and home health aide services.) In addition, supplies left in the home and extraordinary transportation costs will be paid at specific rates.

B. Effective for dates of services on and after July 1, 1993, DMAS shall establish a flat rate for each level of service for HHAs by peer group. There shall be three peer groups: (i) the Department of Health's HHAs, (ii) non-Department of Health HHAs whose operating office is located in the Virginia portion of the Washington DC-MD-VA metropolitan statistical area, and (iii) non-Department of Health HHAs whose operating office is located in the rest of Virginia. The use of the Health Care Financing Administration (HCFA) designation of urban metropolitan statistical areas (MSAs) shall be incorporated in determining the appropriate peer group for these classifications.

The Department of Health's agencies are being placed in a separate peer group due to their unique cost characteristics (only one consolidated cost report is filed for all Department of Health agencies).

C. Rates shall be calculated as follows:

1. Each home health agency shall be placed in its appropriate peer group.

2. Department of Health HHAs Medicaid cost per visit (exclusive of medical supplies costs) shall be obtained from its 1989 cost-settled Medicaid cost report. Non-Department of Health HHAs Medicaid cost per visit (exclusive of medical supplies costs) shall be obtained from the 1989 cost-settled Medicaid Cost Reports filed by freestanding HHAs. Costs shall be inflated to a common point in time (June 30, 1991) by using the percent of change in the moving average factor

of the Data Resources Inc., (DRI), National Forecast Tables for the Home Health Agency Market Basket (as published quarterly).

3. To determine the flat rate per visit effective July 1, 1993, the following methodology shall be utilized:

a. The peer group HHAs per visit rates shall be ranked and weighted by the number of Medicaid visits per discipline to determine a median rate per visit for each peer group at July 1, 1991.

b. The HHA's peer group median rate per visit for each peer group at July 1, 1991, shall be the interim peer group rate for calculating the update through January 1, 1992. The interim peer group rate shall be updated by 100% of historical inflation from July 1, 1991, through December 31, 1992, and shall become the final interim peer group rate that shall be updated by 50% of the forecasted inflation to the end of December 31, 1993, to establish the final peer group rates. The lower of the final peer group rates or the Medicare upper limit at January 1, 1993, will be effective for payments from July 1, 1993, through December 1993.

c. Separate rates shall be provided for the initial assessment, follow-up, and comprehensive visits for skilled nursing and for the initial assessment and follow-up visits for physical therapy, occupational therapy, and speech therapy. The comprehensive rate shall be 200% of the follow-up rate, and the initial assessment rates shall be $15 higher than the follow-up rates. The lower of the peer group median or Medicare upper limits shall be adjusted as appropriate to assure budget neutrality when the higher rates for the comprehensive and initial assessment visits are calculated.

4. The fee schedule shall be adjusted annually beginning July 1, 2010, based on the percent of change in the moving average of the National Forecast Tables for the Home Health Agency Market Basket published by Global Insight (or its successor) for the second quarter of the calendar year in which the fiscal year begins. The report shall be the latest published report prior to the fiscal year. The method to calculate the annual update shall be:

a. All subsequent year peer group rates shall be calculated utilizing the previous final peer group rate established on July 1.

b. The annual July 1 update shall be compared to the Medicare upper limit per visit in effect on each January 1, and the HHAs shall receive the lower of the annual update or the Medicare upper limit per visit as the final peer group rate.

D. Effective July 1, 2009, the previous inflation increase effective January 1, 2009, shall be reduced by 50%.

E. Effective July 1, 2010, through June 30, 2016, there shall be no inflation adjustment for home health agencies. Effective July 1, 2017, through June 30, 2018, the annual fee schedule adjustment for inflation shall be reduced by 50%.

12VAC30-80-200

12VAC30-80-200. Prospective reimbursement for rehabilitation agencies or comprehensive outpatient rehabilitation facilities.

A. Rehabilitation agencies or comprehensive outpatient rehabilitation facilities.

1. Effective for dates of service on and after July 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities, excluding those operated by community services boards or state agencies, shall be reimbursed a prospective rate equal to the lesser of the agency's fee schedule amount or billed charges per procedure. The agency shall develop a statewide fee schedule based on ~~CPT~~ Current Procedural Terminology (CPT) codes to reimburse providers what the agency estimates they would have been paid in FY 2010 minus $371,800.

2. Effective for dates of service on and after October 1, 2009, rehabilitation agencies or comprehensive outpatient rehabilitation facilities, excluding those operated by state agencies shall be reimbursed a prospective rate equal to the lesser of the agency's fee schedule amount or billed charges per procedure. The agency shall develop a statewide fee schedule based on CPT codes to reimburse providers what the agency estimates they would have been paid in FY 2010 minus $371,800.

B. Reimbursement for rehabilitation agencies subject to the new fee schedule methodology.

1. Payments for the fiscal year ending or in progress on June 30, 2009, shall be settled for private rehabilitation agencies based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of June 30, 2009.

2. Payments for the fiscal year ending or in progress on September 30, 2009, shall be settled for community services boards based on the previous prospective rate methodology and the ceilings in effect for that fiscal year as of September 30, 2009.

C. Beginning with state fiscal years beginning on or after July 1, 2010, rates shall be adjusted annually for inflation using the Virginia-specific nursing home input price index contracted for by the agency. The agency shall use the percent moving average for the quarter ending at the midpoint of the rate year from the most recently available index prior to the beginning of the rate year.

D. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the nursing facility or any other available source, and provided further, that this subsection shall in no way diminish any obligation of the nursing facility to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

E. Effective July 1, 2010, through June 30, 2016, there will be no inflation adjustment for outpatient rehabilitation facilities. Effective July 1, 2017, through June 30, 2018, outpatient rehabilitation facilities will receive a rate adjustment equal to 50% of inflation as calculated in subsection C of this section.

12VAC30-90-44
12VAC30-90-44. Nursing facility price-based reimbursement methodology.

A. Effective July 1, 2014, DMAS shall convert nursing facility operating rates in 12VAC30-90-41 to a price-based methodology. The department shall calculate prospective operating rates for direct and indirect costs in the following manner:

1. The department shall calculate the cost per day in the base year for direct and indirect operating costs for each nursing facility. The department shall use existing definitions of direct and indirect costs.

2. The initial base year for calculating the cost per day shall be cost reports ending in calendar year 2011. The department shall rebase prices in fiscal year 2018 and every three years thereafter using the most recent, reliable calendar year cost-settled cost reports for freestanding nursing facilities that have been completed as of September 1. No adjustments will be made to the base year data for purposes of rate setting after that date.

3. Each nursing facility's direct cost per day shall be neutralized by dividing the direct cost per day by the raw Medicaid facility case-mix that corresponds to the base year by facility.

4. Costs per day shall be inflated to the midpoint of the fiscal year rate period using the moving average Virginia Nursing Home inflation index for the fourth

quarter of each year (the midpoint of the fiscal year). Costs in the 2011 base year shall be inflated from the midpoint of the cost report year to the midpoint of fiscal year 2012 by prorating fiscal year 2012 inflation and annual inflation after that. Annual inflation adjustments shall be based on the last available report prior to the beginning of the fiscal year and corrected for any revisions to prior year inflation. Effective July 1, 2015, through June 30, 2016, the inflation adjustment for nursing facility operating rates shall be 0.0%.

5. Prices will be established for the peer groups described in this section using a combination of Medicare wage regions and Medicaid rural and bed size modifications based on similar costs.

6. The following definitions shall apply to direct peer groups. The Northern Virginia peer group shall be defined as localities in the Washington DC-MD-VA MSA as published by the Centers for Medicare and Medicaid Services (CMS) for skilled nursing facility rates. The Other ~~MSA~~ MSAs peer group includes localities in any MSA defined by CMS other than the Northern Virginia MSA and non-MSA designations. The Rural peer groups are non-MSA areas of the state divided into Northern Rural and Southern Rural peer groups based on drawing a line between the following points on the Commonwealth of Virginia map with the coordinates: 37.4203914 Latitude, 82.0201219 Longitude and 37.1223664 Latitude, 76.3457773 Longitude. Direct peer groups are:

a. Northern Virginia,

b. Other MSAs,

c. Northern Rural, and

d. Southern Rural.

7. The following definitions shall apply to indirect peer groups. The indirect peer group for Northern Virginia is the same as the direct peer group for Northern Virginia. Rest of State peer groups shall be defined as any localities other than localities in the Northern Virginia peer group for nursing facilities with greater than 60 beds or 60 beds or less. Rest of State - Greater than 60 Beds shall be further subdivided into Other ~~MSA~~ MSAs, Northern Rural and Southern Rural peer groups using the locality definitions for direct peer groups. Indirect peer groups are:

a. Northern Virginia MSA,

b. Rest of State - Greater than 60 Beds,

c. Other MSAs,

d. Northern Rural, and

e. Southern Rural.

Rest of State - 60 Beds or Less.

8. Any changes to peer group assignment based on changes in bed size or MSA will be implemented for reimbursement purposes the July 1 following the effective date of the change. For rebasings effective on or after July 1, 2020, the department shall move nursing facilities located in the former Danville Metropolitan Statistical Area to the Other MSAs peer group.

9. The direct and indirect price for each peer group shall be based on the following adjustment factors:

a. Direct adjustment factor - 105.000% of the peer group day-weighted median neutralized and inflated cost per day for freestanding nursing facilities. Effective July 1, 2017, the direct adjustment factor shall be 106.8% of the peer group day-

weighted median neutralized and inflated cost per day for freestanding nursing facilities.

b. Indirect adjustment factor - 100.735% of the peer group day-weighted median inflated cost per day for freestanding nursing facilities. Effective July 1, 2017, the indirect adjustment factor shall be 101.3% of the peer group day-weighted median inflated cost per day for freestanding nursing facilities.

10. Facilities with costs projected to the rate year below 95% of the price shall have an adjusted price equal to the price minus the difference between the facility's cost and 95% of the unadjusted price. Adjusted prices will be established at each rebasing. New facilities after the base year shall not have an adjusted price until the next rebasing.

11. Special circumstances.

a. Effective July 1, 2017, the department shall increase the direct and indirect operating rates under the nursing facility price based reimbursement methodology by 15% for nursing facilities where at least 80% of the resident population has one or more of the following diagnoses: quadriplegia, traumatic brain injury, multiple sclerosis, paraplegia, or cerebral palsy. In addition, a qualifying facility must have at least 90% Medicaid utilization and a nursing facility case-mix index of 1.15 or higher in fiscal year 2014.

b. Effective July 1, 2017, through June 30, 2020, nursing facilities located in the former Danville Metropolitan Statistical Area shall be paid the operating rates calculated for the Other MSAs peer group.

~~11.~~ 12. Individual claim payment for direct costs shall be based on each resident's Resource Utilization Group (RUG) during the service period times the facility direct price.

~~12.~~ 13. Resource Utilization Group (RUG) is a resident classification system that groups nursing facility residents according to resource utilization and assigns weights related to the resource utilization for each classification. The department shall use RUGs to determine facility case-mix for cost neutralization as defined in 12VAC30-90-306 in determining the direct costs used in setting the price and for adjusting the claim payments for residents.

a. The department shall neutralize direct costs per day in the base year using the most current RUG grouper applicable to the base year.

b. The department shall utilize RUG-III, version 34 groups and weights in fiscal years 2015 through 2017 for claim payments.

c. Beginning in fiscal year 2018, the department shall implement RUG-IV, version 48 Medicaid groups and weights for claim payments.

d. RUG-IV, version 48 weights used for claim payments will be normalized to RUG-III, version 34 weights as long as base year costs are neutralized by the RUG-III 34 group. In that the weights are not the same under RUG-IV as under RUG-III, normalization will ensure that total direct operating payments using the RUG-IV 48 weights will be the same as total direct operating payments using the RUG-III 34 grouper.

B. Transition. The department shall transition to the price-based methodology over a period of four years, blending the adjusted price-based rate with the facility-specific case-mix neutral cost-based rate calculated according to 12VAC30-90-41 as if ceilings had been rebased for fiscal year 2015. The cost-based rates are calculated using the 2011 base year data, inflated to 2015 using the inflation methodology in 12VAC30-90-41 and adjusted to state fiscal year 2015. In

subsequent years of the transition, the cost-based rates shall be increased by inflation described in this section.

1. Based on a four-year transition, the rate will be based on the following blend:

a. Fiscal year 2015 - 25% of the adjusted price-based rate and 75% of the cost-based rate.

b. Fiscal year 2016 - 50% of the adjusted price-based rate and 50% of the cost-based rate.

c. Fiscal year 2017 - 75% of the adjusted price-based rate and 25% of the cost-based rate.

d. Fiscal year 2018 - 100% of the adjusted price-based (fully implemented).

2. During the first transition year for the period July 1, 2014, through October 31, 2014, DMAS shall case-mix adjust each facility's direct cost component of the rates using the average facility case-mix from the two most recent finalized quarters (September and December 2013) instead of adjusting this component claim by claim.

3. Cost-based rates to be used in the transition for facilities without cost data in the base year but placed in service prior to July 1, 2013, shall be determined based on the most recently settled cost data. If there is no settled cost report at the beginning of a fiscal year, then 100% of the price-based rate shall be used for that fiscal year. Facilities placed in service after June 30, 2013, shall be paid 100% of the price-based rate.

4. Effective July 1, 2015, nursing facilities whose licensed bed capacity decreased by at least 30 beds after 2011 and whose occupancy increased from less than 70% in 2011 to more than 80% in 2013 shall be reimbursed the price-based operating rate rather than the transition operating rate.

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

1. Fair rental value (FRV) 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 12VAC30-90-36. There will be no separate calculation for beds subject to or not subject to transition.

2. Nursing facilities that put into service a major renovation or new beds may request a mid-year fair rental value per diem rate change.

a. A major renovation shall be defined as an increase in capital of $3,000 per bed. The nursing facility shall submit complete pro forma documentation at least 60 days prior to the effective date, and the new rate shall be effective at the beginning of the month following the end of the 60 days.

b. The provider shall submit final documentation within 60 days of the new rate effective date, and the department shall review final documentation and modify the rate if necessary effective 90 days after the implementation of the new rate. No mid-year rate changes shall be made for an effective date after April 30 of the fiscal year.

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

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

12VAC30-90-264

Subpart XVII
Specialized Care Services

12VAC30-90-264. Specialized care services.

Specialized care services provided in conformance with 12VAC30-60-40 E and H, 12VAC30-60-320, and 12VAC30-60-340 shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the categories of Ventilator Dependent Care, will be placed in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in 12VAC30-90-271 and 12VAC30-90-272. To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days. Effective July 1, 2016, the base year for routine operating cost shall be the most recently settled cost reports with a fiscal year ending in a calendar year for all specialized care facilities as of the end of the calendar year prior to the prospective rate year.

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article 5 (12VAC30-90-50 et seq.) of Subpart II of Part II of this chapter and of Appendix III (12VAC30-90-290) of Part III of this chapter shall apply to specialized care cost and reimbursement.

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 12VAC30-90-41.

4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:

a. Statewide ceiling. The statewide routine operating ceiling shall be $415 as of July 1, 2002. This routine operating ceiling amount shall be adjusted for inflation based on 12VAC30-90-41. Effective July 1, 2016, the routine operating ceiling shall be $573.09 as of state fiscal year 2015 and shall be adjusted for inflation based on 12VAC-30-90-44 to the upcoming state fiscal year, the prospective rate year.

b. The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the CMS publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after the January 1 for which the normalization is calculated. Effective July 1, 2016, the normalized wage index for the federal fiscal year following the base year shall be applied to the state fiscal year ceiling.

5. Facility-specific prospective routine operating base cost per day. The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted for inflation based on 12VAC30-90-41. Effective July 1, 2016, the routine operating base cost per day in subdivision 1 of this subsection shall be adjusted for inflation based on 12VAC30-90-44 to the upcoming state fiscal year, the prospective rate year.

6. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report available at the time the interim rates must be set, except that failure to submit a cost report timely may result in adjustment to interim rates as provided elsewhere. Effective July 1, 2016, this subdivision is no longer applicable.

7. Ancillary costs. Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:

a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. Effective for specialized care days on or after January 15, 2007, reimbursement for reasonable costs shall be subject to a ceiling. The ceiling shall be $238.81 per day for calendar year 2004 (150% of average costs) and shall be inflated to the appropriate provider fiscal year. For cost report years beginning in each calendar year, ancillary ceilings will be inflated based on 12VAC30-90-41. See 12VAC30-90-290 for the cost reimbursement limitations. Effective July 1, 2016, the ancillary ceiling of $300.38 in state fiscal year 2015, inclusive of kinetic therapy devices, shall be adjusted for inflation to the prospective rate year based on 12VAC30-90-44.

b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See 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~~ or rotating or 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, ~~2001~~ 2016, capital cost reimbursement rate shall be based on subsection C of 12VAC30-90-44 in accordance with 12VAC30-90-35 ~~through~~, 12VAC30-90-36, and 12VAC30-90-37, except that the required occupancy percentage shall not be separately applied to specialized care. ~~Capital cost related to specialized care patients will be cost settled on the respective nursing facility's cost reporting period. In this cost settlement, the required occupancy percentage shall be applied to all the nursing facility's licensed nursing facility beds, inclusive of specialized care.~~ 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. NATCEP 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 12VAC30-90-170.

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.

a. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivision 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.

12. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with ~~the current NHPS~~ subdivision 9 of this section, except that the occupancy requirement shall be 70% rather than the required occupancy percentage.

13. The cost reporting requirements of 12VAC30-90-70 and 12VAC30-90-80 shall apply to specialized care providers.