12VAC30-60-40. Utilization control: Nursing facilities.

A. Long-term care of residents in nursing facilities will be provided in accordance with federal law using practices and procedures that are based on the resident's medical and social needs and requirements. All nursing facility services, including specialized care, shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

B. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

C. The Department of Medical Assistance Services shall periodically conduct a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records.

D. Nursing facilities must submit to the Department of Medical Assistance Services resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

E. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in 12VAC30-60-300 (Nursing facility criteria).

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in 12VAC30-60-320 (Adult ventilation/tracheostomy specialized care criteria) or 12VAC30-60-340 (Pediatric and adolescent specialized care criteria). Reimbursement for specialized care must be preauthorized by the Department of Medical Assistance Services. In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care services requirements are set forth below.

In each case for which payment for nursing facility services is made under the State Plan, a physician must recommend at the time of admission, or if later, the time at which the

individual applies for medical assistance under the State Plan, that the individual requires nursing facility care.

F. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

G. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

H. Specialized care services.

1. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with the Department of Medical Assistance Services to provide nursing facility care. Providers must agree to provide care to at least four residents who meet the specialized care criteria for children/adolescents or adults.

2. Providers must be able to provide the following specialized services to Medicaid specialized care recipients:

a. Physician visits at least once weekly (after initial physician visit, subsequent visits may alternate between physician and physician assistant or nurse practitioner);

b. Skilled nursing services by a registered nurse available 24 hours a day;

c. Coordinated multidisciplinary team approach to meet the needs of the resident;

d. Infection control;

e. For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 90 minutes each day, five days per week;

~~f. For residents over age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of two hours per day, five days a week;~~

g. Ancillary services related to a plan of care;

h. Respiratory therapy services by a board-certified therapist (for ventilator patients, these services must be available 24 hours per day);

i. Psychology services by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric related to a plan of care;

j. Necessary durable medical equipment and supplies as required by the plan of care;

k. Nutritional elements as required;

l. A plan to assure that specialized care residents have the same opportunity to participate in integrated nursing facility activities as other residents;

m. Nonemergency transportation;

n. Discharge planning; and

o. Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care recipients who are under the age of 21.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

_____ _____

Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

12VAC30-60-320. Adult ventilation/tracheostomy specialized care criteria.

§2.0. General description. The resident must have long-term health conditions requiring close medical supervision, 24 hour licensed nursing care, AND specialized services or equipment.

§2.1. ~~Targeted population.~~ The targeted adult population requiring specialized care includes individuals requiring mechanical ventilation and individuals with a complex tracheostomy who require comprehensive respiratory therapy services.

~~A. Individuals requiring mechanical ventilation~~

~~B. Individuals with communicable diseases requiring universal or respiratory precautions~~

~~C. Individuals requiring ongoing intravenous medication or nutrition administration~~

~~D. Individuals requiring comprehensive rehabilitative therapy services~~

§2.2. Criteria.

A. The individual must require at a minimum:

1. Physician visits at least once weekly. ~~(the~~ The initial physician visit must be made by the physician personally~~.~~ and ~~Subsequent~~ subsequent required physician visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.~~)~~

2. Skilled nursing services 24 hours a day. ~~(a~~A registered nurse must be on the nursing unit on which the resident resides, 24 hours a day, whose sole responsibility is the designated unit~~)~~.

3. Respiratory services provided by a licensed board-certified respiratory therapist (these services must be available 24 hours a day) and

~~3~~4. Coordinated multidisciplinary team approach to meet needs

B. In addition, the individual must meet one of the following two requirements:

1. Require a mechanical ventilator or

2. Have a complex tracheostomy that meets **all** of the following criteria. The individual must:

a. Have a tracheostomy, with the potential for weaning off of it, or documentation of attempts to wean, with subsequent inability to wean;

b. Require nebulizer treatments followed by chest PT (physiotherapy) at least four times per day OR nebulizer treatments at least four times a day, which must be provided by a licensed nurse or licensed respiratory therapist.

c. Require pulse oximetery monitoring at least every shift due to demonstrated unstable oxygen saturation levels.

d. Require respiratory assessment and documentation every shift by licensed respiratory therapist or trained nurse.

e. Have a physician's order for oxygen therapy with documented usage.

f. Require tracheostomy care at least daily;

g. Have a physician's order for suctioning as needed, AND

h. Be deemed to be at risk of requiring subsequent mechanical ventilation.

~~1. Must require two out of three of the following rehabilitative services: Physical Therapy, Occupational Therapy, Speech-pathology services; therapy must be provided at a minimum of 2 hours of therapy per day, 5 days per week; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or~~

~~2. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac) kinetic therapy; or~~

~~3. Individuals that require at least one of the following special services:~~

~~a. Ongoing administration of intravenous medications of nutrition (i.e., TPN, antibiotic therapy, narcotic administration, etc.)~~

~~b. Special infection control precautions (universal or respiratory precaution; this does not include handwashing precautions only)~~

~~c. Dialysis treatment that is provided on-unit (i.e., peritoneal dialysis)~~

~~d. Daily respiratory therapy treatments that must be provided by a skilled nurse or respiratory therapist~~

~~e. Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed, second or third degree burns covering more than 10% of the body)~~

~~f. Multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e., suctioning every hour, stabilization of feeding; stabilization of elimination)~~

CERTIFIDED: I hereby certify that these regulations are full, true, and correctly dated.

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Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance 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, ~~Comprehensive Rehabilitation Care, and Complex Health 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.

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 the weighted average (weighted by 1994 days) of specialized care rates in effect on July 1, 1996, reduced by statewide weighted average ancillary and capital cost per day amounts based on audited 1994 cost data from the 12 facilities whose 1994 FY specialized care costs were audited during 1996. This routine operating ceiling amount shall be adjusted for inflation by the percentage of change in the moving average of the Virginia specific Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by DRI/McGraw-Hill, using the second quarter 1996 DRI table. The respective statewide operating ceilings will be adjusted each quarter in which the provider's most recent fiscal year ends, by adjusting the most recent interim ceiling by 100% of historical inflation and 50% of forecasted inflation to the end of the provider's next fiscal 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 Health Care Financing Administration (HCFA) 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.

c. The percentage of the statewide routine operating ceiling relating to the nursing labor and nonlabor costs (as determined by the 1994 audited cost report data or 71.05%) will be adjusted by the nursing facility's specialized care average Resource Utilization Groups, Version III (RUG-III) Nursing-Only Normalized Case Mix Index (NCMI). The NCMI for each nursing facility will be based on all specialized care patient days rendered during the six-month period prior to that in which the ceiling applies (see subdivision 6 of this section).

5. Normalized case mix index (NCMI). Case mix shall be measured by RUG-III nursing-only index scores based on Minimum Data Set (MDS) data. The RUG-III nursing-only weights developed at the national level by the Health Care Financing Administration (HCFA) (see 12VAC30-90-320) shall be used to calculate a facility-specific case mix index (CMI). The facility-specific CMI, divided by the statewide CMI shall be the facility's NCMI. The steps in the calculation are as follows:

a. The facility-specific CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all patient days in the facility during the six months prior to the six-month period to which the NCMI shall be applied to the facility's routine operating cost and ceiling.

b. The statewide CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all specialized care patient days in all Specialized Care Nursing facilities in the state during the six months prior to the six-month period to which the NCMI shall be applied. A new statewide CMI shall be calculated for each six-month period for which a provider-specific rate must be set.

c. The facility-specific NCMI for purposes of this rate calculation shall be the facility-specific CMI from subdivision 5 a of this section divided by the statewide CMI from subdivision 5 b of this section.

d. Each facility's NCMI shall be updated semiannually, at the start and the midpoint of the facility's fiscal year.

e. Patient days for which the lowest RUG-III weight is imputed, as provided in subdivision 14 c of this section, shall not be included in the calculation of the NCMI.

6. 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 (using DRI-Virginia inflation factors) by 50% of historical inflation and 50% of the forecasted inflation, and adjusted for case mix as described below:

a. An NCMI rate adjustment shall be applied to each facility's prospective routine nursing labor and nonlabor operating base cost per day for each semiannual period of the facility's fiscal year.

b. The NCMI calculated for the second semiannual period of the previous fiscal year shall be divided by the average of that (previous) fiscal year's two semiannual NCMIs to yield an "NCMI cost rate adjustment" to the prospective nursing labor and nonlabor operating cost base rate in the first semiannual period of the subsequent fiscal year.

c. The NCMI determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's two semiannual NCMIs to determine the NCMI cost rate adjustment to the prospective nursing labor and nonlabor operating base cost per day in the second semiannual period of the subsequent fiscal year.

See 12VAC30-90-310 for an illustration of how the NCMI is used to adjust routine operating cost ceilings and semiannual NCMI adjustments to the prospective routine operating base cost rates.

7. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report and Minimum Data Set (MDS) data available at the time the interim rates must be set, except that failure to submit cost and MDS data timely may result in adjustment to interim rates as provided elsewhere.

8. 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. See 12VAC30-90-290 for the cost reimbursement limitations.

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 ~~specialized care Complex Health Care Category~~ the following wound

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

9. 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.

10. Capital costs. Effective July 1, 2001, capital cost reimbursement shall be in accordance with 12VAC30-90-35 through 12VAC30-90-37 inclusive, except that the 90% occupancy requirement 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 90% occupancy requirement shall be applied to all the nursing facility's licensed nursing facility beds inclusive of specialized care.

To apply this requirement, the following calculation shall be carried out.

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

b. 90% of available days shall equal 90% occupancy days.

c. 90% occupancy days, minus actual resident days including specialized care days shall equal the shortfall of days if it is positive. It shall be set to zero if it is negative.

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.

11. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs. NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS.

12. 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 computed as follows:

a. The Complex Health Care Payment Rate effective July 1, 1996, and updated for inflation, will be reduced by (i) the weighted average capital cost per day developed from the 1994 audit data and (ii) the weighted average ancillary cost per day from the 1994 audit data updated for inflation in the same manner as described in subdivision 4 a of this subsection.

b. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivisions 4 and 5 of this section.

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

13. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with the current NHPS, except that the occupancy requirement shall be 70% rather than 90%.

14. MDS data submission. MDS data relating to specialized care patients must be submitted to the department in a submission separate from that which applies to all nursing facility patients.

a. Within 30 days of the end of each month, each specialized care nursing facility shall submit to the department, separately from its submission of MDS data for all patients, a copy of each MDS Version 2.0 which has been completed in the month for a Medicaid specialized care patient in the nursing facility. This shall include (i) the MDS required within 14 days of admission to the nursing facility (if the patient is admitted as a specialized care patient), (ii) the one required by the department upon admission to specialized care, (iii) the one required within 12 months of the most recent full assessment, and (iv) the one required whenever there is a significant change of status.

b. In addition to the monthly data submission required in subdivision 14 a of this section, the same categories of MDS data required in subdivision 14 a of this section shall be submitted for all patients receiving specialized care from January 1, 1996, through December 31, 1996, and shall be due February 28, 1997.

c. If a provider does not submit a complete MDS record for any patient within the required timeframe, the department shall assume that the RUG-III weight for that patient, for any time period for which a complete record is not provided, is the lowest RUG-III weight in use for specialized care patients. A complete MDS record is one that is complete for purposes of transmission and acceptance by the Health Care Financing Administration.

15. Case mix measures in the initial semiannual periods. In any semiannual periods for which calculations in 12VAC39-90-310 requires an NCMI from a semiannual period

beginning before January 1996, the case mix used shall be the case mix applicable to the first semiannual period beginning after January 1, 1996, that is a semiannual period in the respective provider's fiscal period. For example, December year-end providers' rates applicable to the month of December 1996, would normally require (in Appendix I (12VAC30-90-270 et seq.) of Part III of this chapter) an NCMI from July to December 1995, and one from January to June 1996, to calculate a rate for July to December 1996. However, because this calculation requires an NCMI from a period before January 1996, the NCMIs that shall be used will be those applicable to the next semiannual period. The NCMI from January to June 1996, and from July to December 1996, shall be applied to December 1996, as well as to January to June 1997. Similarly, a provider with a March year end would have it's rate in December 1996, through March 1997, calculated based on an NCMI from April through September 1996, and October 1996, through March 1997.

16. Cost reports of specialized care providers are due not later than 150 days after the end of the provider's fiscal year. Except for this provision, the requirements of 12VAC30-90-70 and 12VAC30-90-80 shall apply.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

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Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services