Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	Dept. of Medical Assistance Services
Virginia Administrative Code (VAC) citation	12 VAC 30 Chapters 60 and 90
Regulation title	Standards Established and Methods Used to Assure High Quality of Care – Specialized Care Services, and Methods and Standards for Establishing Payment Rates—Long Term Care Services.
Action title	Discontinuation of Adult Specialized Care Services Payments
Document preparation date	4/5/2004; **NEED GOV APPROVAL BY 05/11/2004**

This information is required for executive review (www.townhall.state.va.us/dpbpages/apaintro.htm#execreview) and the Virginia Registrar of Regulations (legis.state.va.us/codecomm/register/regindex.htm), pursuant to the Virginia Administrative Process Act (www.townhall.state.va.us/dpbpages/dpb_apa.htm), Executive Orders 21 (2002) and 58 (1999) (www.governor.state.va.us/Press_Policy/Executive_Orders/EOHome.html), and the *Virginia Register Form, Style, and Procedure Manual* (http://legis.state.va.us/codecomm/register/download/styl8_95.rtf).

Brief summary

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

This final regulatory action discontinues the additional reimbursement to nursing facilities (NFs) for the complex care and rehabilitation parts of Specialized Care Services for adults. Specialized care services are those services provided to NF residents who have special medical needs, such as comprehensive rehabilitation, complex care, ventilator dependent, and persons diagnosed with AIDS. Prior to the adoption of the current Resource Utilization Groups (RUGs) reimbursement methodology, additional reimbursement to NFs was deemed appropriate for the higher levels of care required by specific residents. Once the RUGs methodology was implemented, however, additional reimbursement for comprehensive rehabilitation care and complex health care was no longer necessary as the RUGs system incorporated such additional care costs. The RUGs methodology does not address ventilator dependency and, therefore, it is being retained as a specially reimbursed category of Specialized Care services.

Because ventilator dependency is being retained as the only adult Specialized Care Service, these regulations adjust the specialized care criteria to focus solely on ventilation and tracheostomy care. Finally, Kinetic Therapy Devices are added to the list of covered ancillary services.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended Virginia Administrative Code sections, Standards Established and Methods Used to Assure High Quality of Care – Specialized Care Services, and Methods and Standards for Establishing Payment Rates—Long Term Care Services. (12 VAC 30-60-40, 30-60-32030-90-264 and 30-90-271) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

__4/5/2004_____ _/s/ P. W. Finnerty_____

Date Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the state and/or federal source of legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly bill and chapter numbers, if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements.

The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal and the problems the proposal is intended to solve.

The purpose of this final action is to discontinue an additional layer of reimbursement for Specialized Care Services that became redundant when the agency adopted the Resource Utilization Groups (RUGs) reimbursement methodology for nursing facilities on July 1, 2002. This action does not discontinue the coverage of such specialized care services as they are already incorporated into the RUGs methodology. In addition, this final action narrows the scope of Specialized Care Services to adult ventilator dependent/complex tracheostomy patients and children who meet the requirements for Pediatric Specialized Care. These patients will continue to be included in Specialized Care. In addition, this action adds Kinetic Therapy Devices to the list of covered ancillary services in order to address the higher costs of this service. These changes are not expected to have any affect on the health, safety, or welfare of the citizens of the Commonwealth or of Medicaid residents in nursing facilities.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The sections of the State Plan for Medical Assistance that are affected by this action are Standards Established and Methods Used to Assure High Quality of Care – Specialized Care Services (Attachment 3.1-C (12 VAC 30-60)), and Methods and Standards for Establishing Payment Rates—Long Term Care (Attachment 4.19-D, Supplement 1 (12 VAC 30-90)).

In late 1991, DMAS implemented a new level of nursing facility (NF) reimbursement based on patient care intensity and level of service, called Specialized Care Services, in order to make additional payments to nursing facilities. At the time of this implementation the then-current NF reimbursement methodology did not adequately address the costs of caring for residents who required Specialized Care Services.

Specialized Care patients were initially organized into four categories, Comprehensive Rehabilitation, Complex Care, Ventilator Dependent, and AIDS. The goal of the Specialized Care payment system was to encourage NFs to provide services to residents who require more intense services. Nursing facilities operated separate Specialized Care units within regular nursing facilities in order to accommodate patients who met the criteria for Specialized Care Services.

On July 1, 2002, the Nursing Home Payment System: Resource Utilization Groups (NHPS: RUGS) method was implemented as the regular nursing home payment system; it replaced the

Patient Intensity Rating System (PIRS). The NHPS: RUGS system is facility-specific and is designed to make payment appropriate for the intensity of care that meets the needs of residents by grouping patients according to the severity of their condition and the level of care they require. The prior PIRS methodology was only marginally sensitive to the intensity of care being received by Medicaid nursing facility residents.

With the implementation of NHPS: RUGS, reimbursement more accurately reflected the intensity of care NF residents require, and a separate, additional Specialized Care reimbursement payment was no longer needed. The Comprehensive Rehabilitation and Complex Care components of Specialized Care are included in the NHPS: RUGS method, making these two components redundant. These final regulations change the criteria and scope of services that are included in the Adult Specialized Care reimbursement rate group to exclude the Comprehensive Rehabilitation and Complex Care components. Providers will receive reimbursement that reflects the required level of patient care through the RUGS-III nursing home payment methodology for adults who meet the previous criteria for Comprehensive Rehabilitation Care and Complex Care.

Children who meet the requirements for Pediatric Specialized Care and adults who require mechanical ventilation or who have a complex tracheostomy and meet additional criteria will continue to be included in Specialized Care. Two sections in 12 VAC 30-60 were revised to accommodate this change in the composition of those patients covered under Specialized Care Services. Finally, Kinetic Therapy Devices were added to the list of covered ancillary service costs under 12 VAC 30-90, because of the higher costs associated with Kinetic Therapy Devices.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.

If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

The advantages of these final regulatory changes include increased access to nursing facilities for Medicaid recipients who require a higher intensity care. The facilities that participate in Specialized Care will receive less in revenue under this revised Specialized Care system, but can expect to see higher rates under the NHPS: RUGS system, commensurate with the movement of high intensity care patients from Specialized Care units to regular nursing facilities. There are no disadvantages to the public or the Commonwealth.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

There was one significant change between the proposed regulation and the final regulation. The agency revised 12 VAC 30-90-271, Direct patient care operating. Specifically, DMAS added Kinetic Therapy Devices to the list of covered ancillary services. This change was not made in either the emergency regulation or the proposed. There were two other minor changes that should be noted between the emergency and the final regulation. 12 VAC 30-60-320(A)(3) of the emergency regulations references 18 VAC 85-40-10 et. seq. regarding respiratory therapist licensure by the Board of Medicine. This reference was dropped, but the meaning and substance of the requirement is unchanged. Finally, 12 VAC 30-60-320(B)(2)(b) of the emergency regulation makes reference to "chest physiotherapy." In the final regulation this reference is changed to "chest PT (physiotherapy)."

Public comment

Please summarize all comment received during the public comment period following the publication of the proposed stage, and provide the agency response. If no public comment was received, please so indicate.

DMAS published its proposed regulations on December 29, 2003, in the *Virginia Register* (VR 20:8, pages 712-718, 12/29/03) for comment period from December 29 through February 27, 2004. Once comment was received from the Virginia Health Care Association (VHCA).

The VHCA commented specifically about the proposed 12 VAC 30-60-320(B)(2)(c), regarding one of the criteria individuals must meet in order to qualify for adult ventilation/tracheostomy specialized care services. 12 VAC 30-60-320(B)(2)(c) proposes as one of the criteria that the patient "[r]equire pulse oximetery monitoring at least every shift due to demonstrated unstable oxygen saturation levels." The VHCA suggested replacement language for this requirement: "Require pulse oximetery monitoring at least every shift to maintain oxygen saturation stability."

The VHCA's rationale for this suggested change was twofold: "instability" is an innocuous term and difficult to define since it would need to be specific for each resident; secondly, the whole intent of oxygenation is to maintain respiratory stability. Therefore, success and continued need for oxygen therapy should not be measured by an incident of instability."

The VHCA also noted that "the regulation already requires that the resident be at risk for requiring subsequent mechanical ventilation so additional requirements defining instability are redundant and unnecessary." The VHCA expressed the belief that its suggested revision does not weaken the intent of the regulation, but rather provides greater clarity and reduces the potential for inconsistent application of the regulation.

Agency response: DMAS is making a distinction between those patients whose condition allows them to maintain stable oxygen saturation levels with proper care, and those more medically fragile patients whose oxygen saturation levels cannot be kept stable despite treatment. The revised criteria are designed to target only these more medically fragile patients because they require added care (and added costs) that stable patients do not require. The language in 12 VAC 30-60--320(B)(2)(c) regarding "demonstrated unstable oxygen saturation levels" is key to making this critical distinction. DMAS interprets the VHCA's suggested language to possibly extend Specialized Care Services coverage to both types of patients; however, the criteria were specifically designed to exclude the less costly, more stable patients. Changing the language of 12 VAC 30-60--320(B)(2)(c) as the VHCA suggests could frustrate the intent of this regulatory change.

All changes made in this regulatory action

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail new provisions and/or all changes to existing sections.

Current section number	Current requirement	Proposed change and rationale
12VAC30-60-40	Provides facility requirements related to services that must be available for persons in Comprehensive Rehabilitation Care.	Adds language to include adult ventilation/ tracheostomy Specialized Care criteria and removes facility requirements related to services that must be available for persons in Comprehensive Rehabilitation Care. These services are no longer required, as the category of Comprehensive Rehabilitation Care is to be discontinued as eligible for additional reimbursement.
12VAC30-60-320	Language specifies criteria that must be met for adults to qualify for additional Specialized Care reimbursement rates.	The proposed change removes the criteria associated with Comprehensive Rehabilitation and Complex Health Care and includes criteria associated with the population requiring mechanical ventilation and complex tracheostomy.
12VAC30-90-264	Language established the Specialized Care categories of Comprehensive Rehabilitation Care and Complex Health Care for rate determination.	Strikes this language as the care for these two categories of patients is now included in the regular nursing facility NHPS: RUGS reimbursement methodology.
12VAC30-90-271	Sets forth a list of nine covered ancillary services.	Adds Kinetic Therapy Devices to the list of covered ancillary services.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may increase disposable family income depending upon which provider the recipient chooses for the item or service prescribed.