Virginia Regulatory Town Hall

Exempt Action Final Regulation
Agency Background Document

Agency Name:	Department of Medical Assistance Services (12 VAC 30)
VAC Chapter Number:	12 VAC 30-60-300 through 12 VAC 30-60-318
Regulation Title:	Standards Established and Methods Used to Assure High Quality of Care: Nursing Facility Criteria
Action Title:	Nursing Facility Criteria
Date:	3/29/2002; **Effective 5/22/2002**

Where an agency or regulation is exempt in part or in whole from the requirements of the Administrative Process Act (§ 9-6.14:1 *et seq.* of the *Code of Virginia*) (APA), the agency may provide information pertaining to the action to be included on the Regulatory Town Hall. The agency must still comply the requirements of the Virginia Register Act (§ 9-6.18 *et seq.* of the *Code of Virginia*) and file with the Registrar and publish their regulations in a style and format conforming with the *Virginia Register Form, Style and Procedure Manual*. The agency must also comply with Executive Order Fifty-Eight (99) which requires an assessment of the regulation's impact on the institution of the family and family stability.

This agency background document may be used for actions exempt pursuant to § 9-6.14:4.1(C) at the final stage. Note that agency actions exempt pursuant to § 9-6.14:4.1(C) of the APA do not require filing with the Registrar at the proposed stage.

In addition, agency actions exempt pursuant to § 9-6.14:4.1(B) of the APA are not subject to the requirements of the Virginia Register Act (§ 9-6.18 *et seq.* of the *Code of Virginia*) and therefore are not subject to publication. Please refer to the *Virginia Register Form, Style and Procedure Manual* for more information.

Summary

Please provide a brief summary of the proposed new regulation, amendments to an existing regulation, or the regulation being repealed. There is no need to state each provision or amendment or restate the purpose and intent of the regulation, instead give a summary of the regulatory action and alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

This exempt final regulatory action amends 12 VAC 30-60-300 through 12 VAC 30-60-318 by deleting Pre-Nursing Facility Criteria for evaluating individuals who may need community based services to delay the need for nursing facility placement. Currently, the State Plan contains two

sets of criteria: one for nursing facility placement (Nursing Facility Criteria), and a separate set of criteria (Pre-Nursing Criteria) for admission to the home and community based services. Since DMAS' adoption of these two sets of criteria and federal approval of them, the federal regulations were modified so that only one set of criteria can be used to evaluate the appropriate level of care for a recipient. The deletion of this text is necessary in order for the State Plan to conform to current federal regulations. Failure to establish one criterion for nursing facility placement and admission to the home and community based services program could result in the loss of Federal Financial Participation (FFP or federal matching dollars) for all waiver programs. Additional changes included in this action reflect formatting changes and do not have a substantive impact on these regulations.

Statement of Final Agency Action

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

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages and adopt the action stated therein. Because this final regulation is exempt from the public notice and comment requirements of the Administrative Process Act (Code § 2.2-4006), the Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

3/29/2002

Date

/s/ Patrick W. Finnerty

Patrick W. Finnerty, Director

Department of Medical Assistance Services

Additional Information

Please indicate that the text of the proposed regulation, the reporting forms the agency intends to incorporate or use in administering the proposed regulation, a copy of any documents to be incorporated by reference are attached.

Please state that the Office of the Attorney General (OAG) has certified that the agency has the statutory authority to promulgate the proposed regulation and that it comports with applicable state and/or federal law. Note that the OAG's certification is not required for Marine Resources Commission regulations.

If the exemption claimed falls under § 9-6.14:4.1(C) (4)(c) of the APA *please include the federal law or regulations being relied upon for the final agency action.*

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 the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) § 2.2-4006(A)(4)(c) for the exemption of certain regulatory actions by state agencies due to conformance to federal law and regulations.

The section of the State Plan affected by this action is Standards Established and Methods Used to Assure High Quality of Care, Nursing Facility Criteria (12VAC30-60-300 et seq., Attachment 3.1-C, Supplement 1).

Federal law (42 CFR § 441.302) requires Medicaid to provide satisfactory assurances to the Centers for Medicare and Medicaid Services (CMS) that the Agency has the necessary safeguards to protect the health and welfare of recipients of services. The Agency provides assurance that there is financial accountability for funds expended for home and community-based services. The Agency must also assure that evaluations of recipients to assess the appropriate level of care are provided when there is a reasonable indication that recipients are at risk of institutionalization. The Agency's definition of this risk includes the following: the individual's application to a nursing facility has been submitted and accepted; the individual's deterioration at home is evidenced by recent hospitalization(s), attending physician documentation, and reported findings from medical or social services agencies; and/or there is no change in status, but evidence exists that the individual's functional, medical, and nursing needs are not being met. These criteria indicate that the recipient may need the Medicaid-covered nursing facility services in the near future unless they receive community-based services. The Agency must re-evaluate these recipients annually to determine if the services provided in a community based setting continue to be needed to avoid nursing facility placement.

Currently, the State Plan contains criteria for nursing facility placement and for receipt of home and community-based waiver services. For placement in a nursing facility, the recipient must meet the criteria described in the Nursing Facility Criteria. To participate and receive home and community based waiver services, the recipients must meet criteria described in the Pre-Nursing Facility Criteria. The original intent of these two sets of criteria was to direct a larger number of individuals away from institutional nursing facility care and towards home and community based care services. The application of Pre-Nursing Facility Criteria to recipients' cases has resulted in the admission of individuals to home and community-based care services who did not meet the medical and nursing care standards for nursing facility admission.

Since these regulations were promulgated and subsequently approved in the State Plan by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), the federal regulations were changed to permit only one set of criteria for placement in a nursing facility or admission to home and community based care services. This regulatory action removes the Pre-Nursing Facility Criteria for admission to home and community-based care services because this set of criteria violates the current federal law. Nursing Facility Criteria will be used to assess the need for nursing facility care and for services provided under the home and community based waiver.

Since the Nursing Facility Criteria are more stringent (by requiring the demonstration and documentation of medical, functional, and nursing needs for recipients) than the Pre-Nursing Facility Criteria, the Agency projects potential negative reactions from recipient advocacy groups. These groups may believe that the Nursing Facility Criteria will limit the number of people who are eligible to receive home and community based waiver services. Home health agencies and personal care providers are also expected to object to this regulatory change as these providers may experience a decrease in the number of recipients who will qualify for home and community based care.

However, the removal of the Pre-Nursing Facility Criteria is essential for the Commonwealth's compliance with federal regulations that require that the criteria to enter a waiver program be identical to those for criteria for institutional placement. Failure to comply with federal regulations could result in the loss of federal financial participation for all of the Agency's waiver programs.

The number of recipients who will no longer qualify for the home and community-based waiver service is unknown but it is not expected to be unduly large. Individuals who no longer meet the Nursing Facility Criteria during their annual assessment will no longer be eligible for home and community-based services. If the individual remains Medicaid eligible, they could be eligible for ambulatory care services that may include doctor visits, transportation, and pharmacy. Some individuals may no longer be eligible for any Medicaid services. There are no localities that are uniquely affected by these regulations as they apply statewide.

Funding Source/Cost to Localities/Affected Entities: The Department of Medical Assistance Services is established under the authority of Title 32.1, Chapter 10, of the Code of Virginia and submits, amends and implements the State Plan for Medical Assistance under the authority of Title XIX of the Social Security Act (42 U.S.C. §§ 1396 through 1396v). The Virginia Medicaid Program is funded with both federal and state funds. The current federal funding participation (FFP) for medical assistance expenditures is 51.45%, which became effective October 1, 2001.

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the impact on the institution of the family and family stability including the extent to which the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) 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; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

This regulatory action may have some negative impact on families whose members are currently enrolled in the Home and Community-Based Waiver program. However, those individuals who meet the Nursing Facility Criteria would continue to receive care under the waiver. This regulatory action will not increase or decrease disposable family income or erode the marital commitment. It will not discourage economic self-sufficiency, self-pride, nor the assumption of family responsibilities.