

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING FACILITY CRITERIA

The following sections can be found in the Cost Allocation Plan:

12 VAC 30-60-301. Definitions.

12 VAC 30-60-302. Introduction; access to Medicaid-funded long-term services and supports.

12 VAC 30-60-303. Screening criteria for Medicaid-funded long-term care services and supports.

12VAC30-60-305. Screenings in the community and hospitals for Medicaid-funded long-term services and supports.

12VAC30-60-306. Submission of screenings.

12VAC30-60-308. NF admission and level of care determination requirements.

12VAC30-60-310. Competency training and testing requirements.

12VAC30-60-313. Individuals determined to not meet criteria for Medicaid-funded long-term services and supports.

12VAC30-60-315. Periodic evaluations for individuals receiving Medicaid-funded long-term services and supports.

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12 VAC 30-60-316 CRITERIA FOR CONTINUED NURSING FACILITY CARE USING THE MINIMUM DATA SET (MDS)

Individuals may be considered appropriate for nursing facility care when one of the following describes their medical or nursing needs and functional capacity as recorded on the Minimum Data Set (MDS) of the Resident Assessment Instrument that is specified by the Commonwealth:

- A. Functional Capacity:
 - 1. The individual meets criteria for two to four of the Activities of Daily Living, plus Behavior and Orientation, and Joint Motion; or
 - 2. The individual meets criteria for five to seven of the Activities of Daily Living and also for Locomotion, or
 - 3. The individual meets criteria for two to seven of the Activities of Daily Living and also for Locomotion, and Behavior and Orientation. An individual in this category will not be appropriate for nursing facility care unless he also has a medical condition requiring treatment or observation by a nurse.
- B. Medical or Nursing Needs: The individual has health needs which require medical or nursing supervision or care above the level which could be provided through assistance with activities of daily living, medication administration and general supervision and is not primarily for the care and treatment of mental diseases.

12 VAC 30-60-318. DEFINITIONS TO BE APPLIED WHEN COMPLETING THE MDS

- A. Activities of Daily Living (ADLs):
 - 1. Transfer (§E(1)(b)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:
 - a. (0) Independent - No help or oversight - OR -help/oversight provided only 1 or 2 times during last 7 days
 - b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR -supervision plus physical assistance provided on 1 or 2 times during last 7 days
 - c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days
 - d. (3) Extensive assistance - While resident performed part of activity, over last 7 day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days

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- e. (4) Total dependence - Full staff performance of activity during entire 7 days
 - f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.
2. Dressing (§E(1)(d)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:
- a. (0) Independent - No help or oversight - OR -help/oversight provided only 1 or 2 times during last 7 days
 - b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR -supervision plus physical assistance provided on 1 or 2 times during last 7 days
 - c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days
 - d. (3) Extensive assistance - While resident performed part of activity, over last 7-day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days
 - e. (4) Total dependence - Full staff performance of activity during entire 7 days
 - f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.
3. Eating (§E(1)(e)). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:
- a. (0) Independent - No help or oversight - OR -help/oversight provided only 1 or 2 times during last 7 days
 - b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR -supervision plus physical assistance provided on 1 or 2 times during last 7 days
 - c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days
 - d. (3) Extensive assistance - While resident performed part of activity, over last 7 day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days
 - e. (4) Total dependence - Full staff performance of activity during entire 7 days

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- f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period, or
 - g. To meet this ADL, one of the following is checked:
 - (1) §L(4)(a) Parenteral or intravenous
 - (2) §L(4)(b) Feeding tube
 - (3) §L(4)(d) Syringe (oral feeding)
4. Toilet Use §E(1)(f). In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:
- a. (0) Independent - No help or oversight - OR -help/oversight provided only 1 or 2 times during last 7 days
 - b. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR -supervision plus physical assistance provided on 1 or 2 times during last 7 days
 - c. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days
 - d. (3) Extensive assistance - While resident performed part of activity, over last 7 day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days
 - e. (4) Total dependence - Full staff performance of activity during entire 7 days
 - f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.
5. Bathing (§E(3)(a)). To meet this ADL, the individual must score a 1, 2, 3, 4, or 8 as described below:
- a. (0) Independent - no help provided.
 - b. (1) Supervision - oversight help only
 - c. (2) Physical help limited to transfer only
 - d. (3) Physical help in part of bathing activity
 - e. (4) Total dependence
 - f. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.

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6. Bladder Continence (§F(1)(b)). In order to meet this ADL, the individual must score a 2, 3, or 4 in this category:
- a. (0) Continent - Complete control
 - b. (1) Usually continent - incontinent episodes once a week or less
 - c. (2) Occasionally incontinent - 2+ times a week but not daily
 - d. (3) Frequently incontinent - tended to be incontinent daily, but some control present (e.g., on day shift)
 - e. (4) Incontinent - Had inadequate control; multiple daily episodes or
 - f. To meet this ADL, one of the following is checked:
 - (1) §F(3)(b) external catheter
 - (2) §F(3)(c) indwelling catheter
7. Bowel Continence (§F(1)(a)). In order to meet this ADL, the individual must score a 2, 3, or 4 in this category:
- a. (0) Continent - Complete control
 - b. (1) Usually continent - control problems less than weekly
 - c. (2) Occasionally incontinent - once a week
 - d. (3) Frequently incontinent - 2-3 times a week
 - e. (4) Incontinent - Had inadequate control all (or almost all) of the time, or
 - f. To meet this ADL, §F(3)(h) ostomy is checked.

B. Joint Motion (§E(4)).

In order to meet this category, at least one of the following must be CHECKED:

- 1. §E(4)(c) Contracture to arms, legs, shoulders, or hands
- 2. (d) Hemiplegia/hemiparesis
- 3. (e) Quadriplegia
- 4. (f) Arm - partial or total loss of voluntary movement
- 5. (g) Hand - lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid)
- 6. (h) Leg - partial or total loss of voluntary movement
- 7. (i) Leg - unsteady gait
- 8. (j) Trunk - partial or total loss of ability to position, balance, or turn body

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C. Locomotion (§E(1)(c)).

In order to meet this ADL, the individual must score a 1, 2, 3, 4, or 8 in this category:

1. (0) Independent - No help or oversight - OR -help/oversight provided only 1 or 2 times during last 7 days
2. (1) Supervision - Oversight, encouragement or cueing provided 3+ times during last 7 days - OR -supervision plus physical assistance provided on 1 or 2 times during last 7 days
3. (2) Limited assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times - OR - more help provided only 1 or 2 times during last 7 days
4. (3) Extensive assistance - While resident performed part of activity, over last 7 day period, help of following type or types was provided 3 or more times: weight-bearing support or full staff performance during part (but not all) of last 7 days
5. (4) Total dependence - Full staff performance of activity during entire 7 days
6. (8) Activity did not occur during the entire 7-day period. Use of this code is limited to situations where the ADL activity was not performed and is primarily applicable to fully bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period.

D. Nursing Observation

In order to meet this category, at least one of the following special treatments, procedures and skin conditions must be CHECKED:

1. §N(4)(a) Open lesions other than stasis or pressure ulcers (e.g., cuts)
(f) Wound care or treatment (e.g., pressure ulcer care, surgical wound)
(g) Other skin care or treatment
2. §P(1)(a) Chemotherapy
(b) Radiation
(c) Dialysis
(d) Suctioning
(e) Tracheostomy care
(f) Intravenous medications
(g) Transfusions
(h) Oxygen
(i) Other special treatment or procedure

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E. Behavior and Orientation

In order to meet this category, the individual must meet at least one of the categories for both behavior AND orientation.

1. Behavior. To meet the criteria for behavior, the individual must meet at least one of the following:
 - a. §H(1)(d) Failure to eat or take medications, withdrawal from self-care or leisure activities (must be CHECKED), or
 - b. One of the following is coded 1 (behavior of this type occurred less than daily) or 2 (behavior of this type occurred daily or more frequently):
 - (1) §H(3)(a) Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)
 - (2) §H(3)(b) Verbally abusive (others were threatened, screamed at, cursed at)
 - (3) §H(3)(c) Physically abusive (others were hit, shoved, scratched, sexually abused)
 - (4) §H(3)(d) Socially inappropriate/disruptive behavior (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)
2. Orientation: To meet this category, the individual must meet at least one of the following:
 - a. §B(3)(d) Awareness that individual is in a nursing home - is NOT CHECKED;
 - b. §B(3)(e) None of the memory/recall ability items are recalled -must be CHECKED;OR
 - c. §B(4) Cognitive skills for daily decision-making - must be coded with a 2 (moderately impaired - decisions poor; cues/supervision required) or 3 (severely impaired -never/rarely made decisions).

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PART II

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

- A. GENERAL DESCRIPTION: The resident must have long-term health conditions requiring close medical supervision, 24 hour licensed nursing care, AND specialized services or equipment.
- B. The targeted adult population requiring specialized care includes individuals requiring mechanical ventilation and individuals with a complex tracheotomy who require comprehensive respiratory therapy services.
- C. CRITERIA: The individual must require at a minimum:
 - 1. Physician visits at least once weekly. The initial physician visit must be made by the physician personally and 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 hour a day. 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
 - 4. A coordinated multidisciplinary team approach to meet needs.
- D. In addition, the individual must meet one or more 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 following 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;

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- c. Require pulse oximetry 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 and for;
- f. Require tracheostomy care at least daily;
- g. Have a physician's order for suctioning as needed;
- h. Be deemed to be at risk of requiring subsequent mechanical ventilation.

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NURSING FACILITY CRITERIA**PART III****§ 12VAC30-60-340. Pediatric and adolescent specialized care admission and continued stay criteria.**

- A. General description. A child or adolescent must meet all aspects of the nursing facility criteria as set forth in 12VAC30-60-300 (nursing facility criteria) before being considered for specialized care reimbursement. A provider must also have a contract to provide pediatric specialized care before being eligible to receive specialized care reimbursement. To receive the pediatric specialized care rate for services to children under the age of 14, the provider must provide care to the child within a distinct part unit (DPU) of eight or more dedicated pediatric beds. The child must demonstrate ongoing health conditions requiring close medical supervision in a nursing facility, a need for 24 hour licensed nursing supervision, AND require specialized services defined in the categories of specialized care. Residents must be discharged from specialized care services to the nursing facility level or other appropriate level of care when the program criteria are no longer met. The recipient must be age 21 or under.
- B. Targeted population. A child or adolescent requiring specialized care must meet the specified general program criteria in Subsection C. and the criteria defined in at least one of three specified categories of care in Subsection D. These categories are: Comprehensive Rehabilitation; Mechanical Ventilation; and Complex Health Care. The general program criteria and specific category criteria are set forth below.
- C. Criteria . The child must require:
1. Nursing facility level of care;
 2. Physician visits at least once every 30 days;
 3. Skilled registered nursing services 24 hours a day (a registered nurse must supervise the nursing unit on which the resident resides in a "charge nurse" capacity, whose sole responsibility is that unit);
 4. A coordinated multidisciplinary team approach to meet needs; and
 5. The nursing facility must coordinate with appropriate state and local agencies for services to meet the educational and habilitative needs of the child. Services may include but are not limited to school, active treatment for mental retardation, habilitative therapies, social skills and leisure activities.

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- D. In addition to the general criteria in Subsection C, the child must require one of the following three categories of care:
1. Comprehensive Rehabilitation Category: All of the following category criteria must be met to qualify for the comprehensive rehabilitation category.
 - a. Must require two out of three of the following rehabilitative services which are required at an acuity that is not available at the nursing facility level of care: Physical Therapy, Occupational Therapy, or Speech-pathology services.
 - b. Must receive a minimum of 450 therapy minutes per week. No more than 135 minutes on any one therapy day shall count toward the 450 weekly minutes. Daily therapy should not exceed a resident's ability to effectively participate in the therapeutic regime.
 - c. Must have a stable medical condition which is compatible with an active comprehensive rehabilitation program. In the event the recipient experiences an acute medical instability (one to two day illness or less) providers shall adjust the therapy regime to assure the required weekly 450 minute schedule is completed. If the resident's acute medical instability is too severe or too long to permit completion of the required weekly 450 minute schedule, the resident may be placed on a reduced therapy schedule. For the purposes of this subsection, the period during which the recipient is placed on a reduced therapy schedule is called "medical hold." The Department of Medical Assistance Services (DMAS) shall continue specialized care reimbursement in this category for one medical hold period, of no more than 3 days, per rehabilitation stay. To qualify for reimbursement, the medical hold or reduced therapy schedule must be ordered by the physician and the medical record must support that the resident, due to acute illness or acute medical instability, was unable to tolerate or reasonably make up the required therapy time toward the 450 required weekly minutes. If a resident should require more than one medical hold during a rehabilitative stay, DMAS shall determine, at its sole discretion, whether an additional medical hold period is permitted based on the resident's medical status and overall rehabilitative progress. If any period of medical hold is not ordered by the physician and substantiated in the medical record as determined by DMAS, DMAS shall deny or retract reimbursement for such periods.

If the full 450 minutes of rehabilitation therapies are not provided during any seven day period without an acceptable, substantiated, and ordered " medical hold" period, the Department of Medical Assistance Services shall deny or retract specialized care reimbursement. If the resident does not receive the full 450 minutes of required therapy during a seven day week, the following reimbursement denial or retraction scale shall apply:

360-449 minutes received= 1 day retraction

270-359 minutes received = 2 days retraction

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180-269 minutes received= 3 days retraction

90-179 minutes received = 4 days retraction

0-89 minutes received= 5 days retraction.

In addition to the above scale, if the resident is missing therapy time and is found not to be making significant measurable progress in the rehabilitation program, a full denial of specialized care reimbursement shall occur from the point that the resident is documented, as determined by DMAS, to have ceased making significant rehabilitation progress in the medical record.

- d. Must be able to benefit from the services to be provided, based on physician assessment of rehabilitation potential, with the expectation that the condition of the resident will improve significantly in a reasonable and generally predictable period of time in accordance with medical practice standards; or, based on physician assessment, must require rehabilitative services to establish a safe and effective maintenance program provided for a specific medical diagnosis. Once a resident is no longer able to benefit from this level of rehabilitation, has ceased to make significant progress in the rehabilitation program, or once rehabilitation or maintenance programming can be provided at the nursing facility or other lower level of care, the resident must be discharged from the specialized care program.
- e. Must demonstrate significant, measurable progress in the overall rehabilitative plan of care on a monthly (30 day) basis.

2. Mechanical Ventilation Category:

- a. The recipient must meet both of the following category criteria, and must meet the criteria specified in subsections b. and c. if applicable to the patient's treatment status, to qualify for the mechanical ventilation category.
 - i. Must require daily mechanical ventilation which may be for all or a specified part of a 24 hour period.
 - ii. Must require a visit from a respiratory therapist at least once every 14 days.
- b. If a CPAP (assist device with continuous positive airway pressure), BiPAP (intermittent assist device with inspiratory and expiratory positive airway pressure), or other similar mechanical respiratory assist device is used instead of a continuous mechanical ventilator, the resident must require other 24 hour specialized care services, such as frequent monitoring and nursing intervention for desaturation. A resident would not meet this (mechanical respiratory assist device) criteria if such device is only used without significant other medical/nursing needs which require specialized care.

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- c. If a resident has been successfully weaned from the support of a mechanical ventilator, the Department of Medical Assistance Services will continue specialized care reimbursement for up to five days after the resident has not been ventilator dependent for 24 hours. *This* five day period begins after the resident completes a 24 hour period with no ventilatory support and demonstrates respiratory stability. If during the five days, the resident requires ventilatory support or demonstrates marked respiratory instability, the resident may continue in the Mechanical Ventilation Category until five consecutive days of respiratory stability are demonstrated. Continued instability must be documented by the physician in the medical record.

3. Complex Health Care Category: At least one of the following special services must be met to qualify for the complex health care category:

- a. Must require daily administration of intravenous pain management medications for terminal illness diagnoses, such as cancer, or must require intravenous nutrition (i.e., Total Parenteral Nutrition).
- b. Must require special infection control precautions that necessitate isolation with negative pressure ventilation or other specialized infection control interventions that cannot be adequately managed in a medically necessitated private room.
- c. Must require dialysis treatment that is provided on-unit within the nursing facility (i.e., peritoneal dialysis).
- d. Must require daily respiratory therapy treatments that must be provided by a skilled nurse or respiratory therapist. The respiratory condition being treated must require chest physiotherapy (PT) followed by a nebulizer treatment 4 times per day and suctioning at least every 2 hours; or chest PT followed by a nebulizer treatment 4 times per day for a resident with a tracheostomy; or chest PT 4 times per day for a resident with a tracheostomy requiring suctioning at least every 2 hours; or nebulizer treatments 4 times per day for a resident with a tracheostomy; or ongoing assessment and monitoring of respiratory/cardiac status for a resident with a chest tube. Residents receiving these services must require a visit from a respiratory therapist at least once every 14 days.
- e. Must require extensive wound care for at least one stage IV pressure ulcer (decubitus) ; a large surgical wound that cannot be closed; or second or third degree burns covering more than 10% of the body. These wounds must require debridement, irrigation, packing, etc., more than two times per day or ongoing consistent utilization of kinetic therapy (low air loss, air fluidized, or rotating or turning specialty beds) as ordered by the physician in combination with other appropriate , aggressive wound care treatment.

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Supersedes

TN No. 94-15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING FACILITY CRITERIA

- f. Ostomy care requiring services by a licensed nurse
- g. Care for terminal illness

12VAC30-60-350. Criteria for coverage of specialized treatment beds.

A. DMAS will pay \$10 per day toward the cost of specialized treatment beds for eligible NF recipients who have at least one treatable stage IV pressur ulcer. Specialized treatment bed means either an air-fluidized bed or a low-air-loss bed. To be approved for this service, the following criteria must be met:

1. The individual must have at least one stage IV pressure ulcer as documented on the MDS.
2. The individual msut require the use of a specialized treatment bed as ordered by a physician for the treatment of at least one stage IV pressure ulcer.
3. The nursing facility must obtain authorization by submitting the authorization request to DMAS or the preauthorization agent.

B. Nursing facilities shall not be eligible to receive this additional payment for residents who are enrolled in the specialized care program.

C. Limits. DMAS shall provide the additional \$10 per day reimbursement for recipients meeting criteria for no more than 246 days annually. Nursing facilities may receive the reimbursement for up to 82 days per new occurrence of a Stage IV ulcer. There must be at least 30 days between each reimbursement period. Limits are per recipient, regardless of the number of providers rendering services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING FACILITY CRITERIA

PART IV.

**CRITERIA FOR CARE IN FACILITIES FOR MENTALLY RETARDED PERSONS. REPEALED.
(SPA 18-001)**

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TN No. 18-001

Approval Date 05-15-18

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TN No. 05-12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING FACILITY CRITERIA

The State policy outlining criteria for services in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) is currently reflected in the State regulations at 12 VAC 30-60- 361.

A. This section establishes standard criteria that shall be met by individuals in order to receive Medicaid payment for care in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Once the individual has been screened and found to meet these criteria, Medicaid covers the costs of care only when the individual receives appropriate supports and services and when active treatment, as set forth in 42 CFR 483.440(a), is provided. The State will oversee ICF-IIDs in compliance with 42 CFR 442, Subpart C, and 42 CFR 483, Subpart I, and 42 CFR 456 as applicable.

B. Supports and services which are provided in facilities for individuals with developmental or intellectual disabilities for the purpose of claiming Medicaid reimbursement requires individualized person-centered planned programs (Individual Program Plan (IPP)) of supports and services to address habilitative needs or health needs, or both, as set forth in 42 CFR 483.440(c).

1. Such care may be a combination of habilitative, rehabilitative, and health services directed towards increasing or maintaining the highest mental, physical, and psychosocial skills and abilities of the individual. Individuals with degenerative conditions shall receive services and supports designed to retain skills and functioning, and to prevent further regression to the extent possible. Examples of such care include: (i) skill building in Activities of Daily Living (ADLs); (ii) skill building in task-learning; (iii) learning socially acceptable behaviors; (iv) learning basic community living skills; (v) health care and health maintenance, and; (vi) skill building in self-direction.

2. The overall objective of facility based supports, defined in the person-centered IPP, shall be the attainment of the optimal physical, intellectual, social, or task learning level that the individual can presently or potentially achieve.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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NURSING FACILITY CRITERIA

C. Dependency levels and level of functioning criteria.

1. An individual's need for care shall meet the level of functioning criteria in the Virginia Individual Developmental Disability Eligibility Survey (VIDES) before any authorization for payment by Medicaid will be made for institutional services

2. Dependency level. Level of dependency in each category is indicated from the most dependent to the least dependent. In some categories, the dependency status is rated by the degree of assistance required. In other categories, the dependency is established by the frequency of a behavior or the ability to perform a given task.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING FACILITY CRITERIA

D. Screening process for entrance into an ICF/IID shall be coordinated through DMAS or its designee.

1. ICF/IID screening requests:

a. The screening results will be provided to the selected ICF/IID during its assessment and admission process when requested by the facility.

b. Screenings by the DMAS designee shall be completed or approved prior to an individual's admission to an ICF/IID for which Medicaid reimbursement will be claimed.

2. DMAS or its designee shall also explore and review more integrated community options with the individual and family/guardian at the time of screening and through the established review recommendations and procedures with DBHDS.

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NURSING FACILITY CRITERIA

- A. Upon admission to an ICF/IID, the facility shall perform an assessment and any necessary reassessments of the individual and develop an individualized program plan consistent with 42 CFR 483.440.
- B. The assessment and re-assessment for determination of continued stay in the ICF/IID level of care shall be performed by the interdisciplinary team and based on (i) the needs of the individual; (ii) the individual's capabilities; (iii) the appropriateness of services and supports to be provided; (iv) the progress the individual demonstrates from the skill building; and (v) whether the services and supports could reasonably be provided and are available in a less restrictive environment.
- C. The individual assessment set forth in subsection F of this section will be the basis for the development of an Individual Program Plan (IPP). The assessment process shall indicate a need for an IPP that addresses the individual's skills, abilities, and need for health care services consistent with the functional categories outlined in 42 CFR 483.440(c)(3)(v).

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NURSING FACILITY CRITERIA

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ALTERNATIVE BENEFITS PLAN

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