CHAPTER 514 NURSING FACILITY SERVICES

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BACKGROUND

This chapter sets forth the West Virginia Department of Human Services, Bureau for Medical Services (the State) requirements for payment of services provided by nursing facilities to eligible West Virginia Medicaid members.

The governing body or designee of a nursing facility participating in the Medicaid program must fully meet the standards established by the State; all applicable state and federal laws governing the provision of these services as currently promulgated or amended in the future; and all regulations contained herein or issued as Medicaid policy. The Federal standards take precedence over State requirements except where State requirements are more restrictive.

A nursing facility is defined as an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases and in accordance with Soc. Sec. Act, Sect. §1819 (a)(2), has in effect a transfer agreement (meeting the requirements of section Soc. Sec. Act, Sect. §1861(l)) with one or more hospitals having agreements in effect under Soc. Sec. Act, Sect. §1866.) (42 CFR, Part §483).

POLICY

514.1 PROVIDER PARTICIPATION REQUIREMENTS

A nursing facility may be a freestanding entity qualifying and serving as a long-term care provider or it may be a distinct part of a larger institution. If the distinct part is operating as another part of an institution, the distinct part must be an identifiable unit and meet all of the requirements for a nursing facility.

514.1.1 State Licensure

As a condition of participation as a nursing facility in the West Virginia Title XIX Medicaid program, a free-standing nursing home or distinct part of a hospital must be currently licensed in accordance with the applicable State Code and Legislative Rule. The nursing home or hospital must meet and maintain the standards for licensure on a continuing basis. When required by the nursing home or hospital licensure rule, the nursing facility must be administered by a licensed nursing home administrator, who is legally responsible for establishing and implementing policies regarding the management and operations of the facility and who holds an approved, current license, as required by State law. The nursing facility must also meet all federal and state standards for participation in the Title XIX Medicaid program and remain in compliance with all other applicable federal, state, and local laws, rules, and regulations affecting the health and safety of all residents.

514.1.2 Provider Enrollment

The nursing facility or hospital distinct part must submit a completed, signed and dated provider enrollment application and a nursing facility agreement in order to apply with the State for approval to

participate in the Title XIX Medicaid program.

514.1.3 Nursing Facility Provider Agreement

A nursing facility provider agreement must be approved by the State prior to eligibility for reimbursement. The nursing facility provider agreement will certify that the nursing facility agrees to follow the Code of Federal Regulations, 42 CFR, Part 483 (the requirements for States and long term care facilities) and WV Legislative Rule 64CSR13 (the Nursing Home Licensure Rule) as updated. Upon acceptance for participation as a nursing facility in the Medicaid program, the administrator of the facility, under the delegated authority of the facility's governing body, becomes responsible for ensuring the nursing facility remains in compliance with the terms of the agreement and Medicaid rules and regulations. It is the responsibility of each nursing facility's administrator to stay apprised of any revisions to the Medicaid Provider Manual. Payment to the nursing facility, for covered items and services it furnishes on or after the approval date of the agreement, will require that the facility have a record keeping capability sufficient for determining the cost of medically necessary services furnished to any Medicaid resident.

As a provider participating in the Medicaid program, the governing body/designee must agree to admit and provide care and services equitably to all individuals, no matter the payment source of the individual seeking care.

The agreement for participation in the Medicaid program by a governing body/designee is limited by compliance with Federal and State laws, certification rules, and regulations. The Office of Health Facility Licensure and Certification (OHFLAC) determines whether a prospective provider is in compliance with the nursing home requirements. When the facility is in compliance, OHFLAC certifies and recommends that the State enter into an agreement with the facility. If the facility is determined to not be in compliance, OHFLAC recommends that the State deny participation. Any nursing facility participating in both the Medicaidprogram and the Medicare program must comply with the higher standards of either program. Additional requirements may be found in Chapter 42 of the Code of Federal Regulations.

If the OHFLAC recommends that the State deny participation and the State accepts that recommendation, the State will notify the facility in writing of the denial of participation in the Medicaid program, and include in the letter the appeal rights available under 42 CFR 431.153 and 42 CFR 498.3(b).

514.1.4 Enforcement

The State is required by federal regulations to impose certain enforcement actions on nursing facilities which are not in compliance with certification rules and regulations. Enforcement action may include, but is not limited to, termination of the provider agreement; temporary management of the nursing facility by a designee appointed by the State; denial of payment for new admissions; civil monetary penalty; state monitoring; transfer of resident; transfer of resident with closure of a facility; and/or reduction of bed quota without reduction of staff (see 42 CFR 488 Subpart F and West Virginia Legislative Rule Title 64, Series 13). The Centers for Medicare and Medicaid Services (CMS) is responsible for enforcement of dually certified facilities.

514.1.5 Ownership

Owners include any individual, organization, partner and all stockholders of organizations, unless publicly traded, that have a financial interest in the facility's operations.

Nursing facilities that are in compliance with all applicable requirements may participate in the Medicaid program and receive payments regardless of the ownership category**,** i.e., proprietary, voluntary, non-profit, etc. The governing body/designee of each nursing facility must provide the State andthe OHFLAC with full and complete information and documentation as to the identity of the owner(s) in the enrollment packet as follows:

- The name and address of each person with an ownership, or five percent controlling interest in the facility, or disclosing entity, or in any subcontractor in which the disclosing entity has direct or indirect ownership;
- The name and address of each officer and director, when a nursing facility is organized as a corporation, must be declared and verified if it is organized as a for-profit entity; and
- The name and address of each partner when a nursing facility is organized as a partnership.

The compensation paid to owners, operators, or their relatives who claim to provide some administrativeor other function required to operate the facility, but who do not actually provide said service, shall not be allowed as a reimbursable expense.

When owners, operators, or their relatives are on salary at a facility, the Medicaid program will reimburse the facility to the extent that said individuals' salaries are not excessive compared to other individuals who perform the same or similar functions, but are not owners, operators, or their relatives.

514.1.6 Change of Ownership

The following events constitute a change of ownership:

- The removal, addition, or substitution of a partner (stock transfer).
- Transfer of title and property to another party by a sole proprietor (asset transfer).
- The merger of a provider corporation into another corporation, or the consolidation of two or more corporations resulting in the creation of a new corporation (asset transfer).
- Leasing all or part of a provider facility (stock transfer). See 42 CFR 489.18; 42 CFR 431.108;WV Code 31D-11-1101 et seq.; WV Code 47B-1-1 et seq.

When there is a change of ownership, the governing body must acquire a Certificate of Need (CON) or an exemption as required under West Virginia State law. Refer to WV Code 16-2D-01 et seq. and WV Legislative Rule 64CSR13 for direction on complying with CON requirements in West Virginia. Note that CONs are nontransferable. The nursing facility may not bill Medicaid for any health service without first obtaining an approved CON.

West Virginia Medicaid recognizes two types of changes in ownership:

1. Stock transfer, and
2. Asset transfer.

A change in ownership of a nursing facility as a result of an asset transfer requires the execution of a new Provider Agreement, new enrollment application Notification of the change is required to be submitted, in writing, to the State 90 days prior to the effective date of the change of ownership.

A change of ownership as a result of a transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership for a corporation. A stock transfer of a nursing facility without a change in administrative personnel of that facility does not require the execution of a new Provider Agreement; however, the enrollment packet must be updated to identify all interested parties for the exclusions list.

The governing body must comply with West Virginia law when changing ownership, merging corporations or transferring corporate stock. Partnerships are governed in West Virginia by the West Virginia Uniform Partnership Act. This act is codified at WV Code 47B-1-1 et seq.

Effect on the Provider Agreement of a Change of Ownership

An agreement is subject to all applicable statutes and regulations and to the terms and conditions underwhich it was originally issued including, but not limited to, the following:

- Any existing plan of correction;
- Compliance with applicable health and safety standards;
- Compliance with the ownership and financial interest disclosure requirements of 42 CFR 420,subpart C, IF; and
- Compliance with Civil Rights requirements set forth in 45 CFR parts 80, 84, and 90. See 42 CFR489,18 (d).

Enrollment of a New Provider Resulting from an Asset Transfer

A new provider must enroll in Medicaid. Providers are required to submit a complete and accurate enrollment packet. A change of ownership requires that all parties involved shall collaborate to ensure that services are billed and paid to the correct owner using the correct National Provider Identifier (NPI) number. The effective date of the new owner's enrollment is determined when the enrollment application is approved by the State. Providers are required to submit a complete and accurate enrollment packet and inform the State and the State' fiscal agent's Provider Enrollment Unit of the proposed date of the change in ownership to ensure a seamless transition. It is recommended that changes of ownership occur at the first of the month. Services rendered prior to the effective date of the change in ownership will not be payable through Medicaid. However, in cases of a change of ownership of a nursing facility that is dually certified for participation in both Medicare and Medicaid, the State will follow Medicare policy regarding effective dates of the actual change of ownership

A provider agreement shall not be approved if the owner fails to comply with 42 CFR 455.104 and 42CFR 455.105, which requires the owner to provide information to the State fiscal agent on ownership interests and certain business transactions.

If a partnership purchases a dissociated partner's interest in the partnership and the partnership is not winding up business, under WV Code 47B-7-1(d), the partnership "shall indemnify a dissociated partner whose interest is being purchased against all partnership liabilities, whether incurred before or after the dissociation, except liabilities incurred by an act of the dissociated partner under section two 47B-7-2, article seven of this chapter." Whenever a partnership purchases a dissociated partner's interest in the partnership, it shall send to the Office of Accountability and Management Reporting (OAMR) a copy of the indemnification agreement.

When there is a change of ownership, the provider shall supply the OAMR a copy of the executed contract or other agreement effecting the transfer between the buyer and seller, and shall also include a separate statement, signed by authorized representatives of both the buyer and seller, stating whether the prior owner or new owner retains the liability for any over/under payment related to cost reporting periods that have not been audited by the State at the time of the transfer.

A provider may request a final audit, in writing, prior to the change in ownership, resulting from an asset purchase. Requests should be submitted to the following address:

Office of Accountability and Management Reporting
Attention: Division of Audit
One Davis Square,
Suite 304Charleston,
WV 25301

514.1.7 Bed Configuration

The following apply to bed configuration:

- **Bed Transfer**: A licensed nursing facility or hospital based distinct part may not add any beds to its license without first obtaining an exemption from the West Virginia Health Care Authority (HCA). The governing body or designee of a licensed nursing facility or hospital distinct part mustsubmit a written copy of the request for the exemption to the Commissioner of the State.
- **Dual Certification**: When the request is to gain dual certification on beds that are currently licensed but do not have Medicaid certification, the CON process is not needed. The facility asking for dual certification must submit a written request to the Commissioner of the Bureau for Medical Services and the request must show the need for the Medicaid certification on the current licensed beds in the facility. The need must be proven by indicating the overall census, using the most recent two cost reporting periods. The overall census must be at least 95% or greater on average for each cost reporting period and the Medicaid census must be at 85% or higher for each cost reporting period.

The Commissioner, in his or her discretion, shall determine whether to approve or deny the request of Medicaid reimbursement for the dual certification of currently licensed beds. In determining whether or not to approve the requests for dual certification, the Commissioner shall take into consideration the fiscal impact of the request as well as the need for the dual certified beds as stated by the request.

514.1.8 Non-Compliance of Nursing Facilities

The OHFLAC conducts surveys on all nursing facilities for compliance or noncompliance with the requirements for long-term care nursing facilities. When the OHFLAC completes a survey, the CMS may follow up with a validation survey. A determination is final except in the case of a complaint or validation survey conducted by the CMS.

Under Federal guidelines, the OHFLAC certifies the compliance or noncompliance of a non-State operated skilled nursing facility. The OHFLAC also certifies compliance or noncompliance for a dually participating skilled nursing facility/nursing facility. If there is a disagreement between the CMS and the OHFLAC, the CMS' determination as to the facility's noncompliance is binding and takes precedence

over a determination of compliance by the OHFLAC (see 42 CFR 488.330 (a)).

A certification of compliance constitutes a determination that the facility is in substantial compliance and is eligible to participate in Medicaid as a nursing facility, or in Medicare as a skilled nursing facility, or in Medicare and Medicaid as a dually participating facility.

A certification of noncompliance requires denial of participation for prospective providers and enforcement action for current providers in accordance with Federal guidelines. Enforcement action must include either termination of the Medicaid provider agreement or the application of alternative remedies instead of, or in addition to, termination procedures. In cases where either the State or the CMS is taking action, notice of noncompliance resulting in action will be sent in accordance with 42 CFR 488.402 (f).

Termination of a provider agreement with a nursing facility may result from, but not be limited to, any of the following:

- Failure to comply with licensure and certification standards as identified by the OHFLAC and theCMS;
- Failure to implement the corrective action plan accepted by the OHFLAC and the CMS forcorrection of non-compliance with license and certification standards; or
- Failure to comply with all of the provisions of the provider agreement executed with the State.
- Exclusion Proceedings – see *Chapter 300, Provider Participation Requirements*

When an agreement is terminated, Medicaid may continue reimbursement to the nursing facility for a period not to exceed 30 days from the date of termination. The 30-day continuation is only for Medicaid members admitted to the nursing facility prior to the date of termination of the provider agreement. It is the responsibility of the governing body or designee of the nursing facility to provide a safe and orderly transfer and quality of care for all residents of the facility affected by the termination of the provider agreement.

The termination of participation in the Medicaid program does not immediately release the governingbody or designee of a nursing facility from all of the nursing facility's statutory and regulatory responsibilities of its agreement for participation. The nursing facility's governing body or designee remains responsible for the repayment of any overpayment or debt related to the final program cost settlement as well as any other Federal and/or State statutory and/or regulatory mandates.

514.2 PROVIDER CERTIFICATION

The OHFLAC and the CMS will conduct periodic and timely evaluations of nursing facilities for the purpose of certifying nursing facilities for participation in the Medicaid program. Prior to entering into an agreement of participation in the Title XIX Medicaid program with a nursing facility, the State will obtain certification recommendations from OHFLAC to ensure the nursing facility is in compliance with both State and Federal statutes and regulations.

State remedies are found in 42 CFR 488.406 and include termination of the provider agreement, temporary management, denial of payment for all individuals when imposed by CMS, Denial of Payment of New Admissions (DPNA), Civil Money Penalty (CMP), state monitoring, transfer of residents, closure of the facility and transfer of residents, a directed plan of correction, a directed in-service training, and many alternative remedies that have been approved by the CMS in the State Plan.

514.2.1 Denial of Payment for New Admission

A governing body or designee of a nursing facility that no longer meets standards of certification as determined by OHFLAC, in conjunction with CMS, may be denied Medicaid payment for new admissions. If the nursing facility's deficiencies pose Immediate Jeopardy (IJ) to the resident's health and safety, the provider agreement may be terminated and denial of payment for Medicaid members currently residing in the nursing facility may also be imposed. However, if a current resident of the nursing facility who is under a DPNA gets transferred to the acute care hospital, they may be re-admitted to the original nursing facility when re-admission is appropriate, and reimbursement will resume.

514.2.2 Civil Monetary Penalty

A governing body or designee of a nursing facility may have imposed upon it a CMP, when OHFLAC recommends and the State agrees that one or more deficient practices are of such a nature that the potential for more than minimal harm to one or more residents exists or actual harm has occurred.

514.2.3 Temporary Management/Administrator

A temporary manager may be imposed by the State, the CMS or the court system any time a nursing facility is not in compliance with Federal and State regulations. However, when a nursing facility's deficiencies constitute IJ and a decision is made to impose an alternative remedy to termination, the imposition of a temporary manager is required, in accordance with State code.

It is the temporary manager's responsibility to oversee correction of the deficiencies and to assure the health and safety of the nursing facility's resident while the corrections are being made. A temporary manager/administrator may also be imposed to oversee orderly closure of a nursing facility.

Any temporary manager, whether imposed by the State, the CMS or the court system, must be licensedby the West Virginia State Board of Nursing Home Administrators.

514.3 STANDARDS FOR NURSING FACILITIES

All providers participating as a nursing facility in the Title XIX, Medicaid program must comply with Federal standards as published in the Code of Federal Regulations and as later amended; as well as State Laws and Program Regulations governing the State.

514.3.1 Fingerprint-Based Background Check Requirements

Refer to *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for criminal background check information. Requirements specific to nursing facilities include the following:

- A copy of an individual's fitness determination must be maintained in the individual's personnel file.
- Medicaid covered services will not be reimbursed if provided by an individual with a disqualifying conviction unless the individual is working as a provisional employee or has received a variance.

514.3.2 Staffing Requirements

In order to participate in the West Virginia Medicaid Title XIX program, a nursing facility must have sufficient nursing staff (including licensed nurses and certified nurse aides) on a 24-hour basis to provide nursing and related services to obtain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Federal and State requirements for sufficient nursing staff can be found at 42 CFR 483, 42 CFR 488, and WV Legislative Rule 64CSR13. Where there are differences between the specific Federal and State staffing requirements, the nursing facility will be required to comply with the more restrictive requirements.

514.3.3 General Staffing Information

Only qualified staff shall provide services in a nursing facility. The nursing facility must employ staff sufficient in number and in qualifications as required to meet the needs of each resident pursuant to their care plans and to protect their health and safety.

- There must be on duty at all hours of each day sufficient staff in number and qualifications to carry out the policies, responsibilities, and programs of the facility. The nursing facility must employ and maintain sufficient staff on duty, awake and accessible.
- The nursing facility administrator or designee assumes responsibility for the provision of services directly or through outside resources to meet the needs of each resident. The residents and their representatives or volunteers may not perform direct care services for individuals. At a minimum, the administrator or designee of the nursing facility is required to ensure the facility complies with WV Legislative Rule 64CSR13 for services to be provided in a licensed nursing home or an extended care unit of a licensed hospital.
- The nursing facility must assure that all staff are properly licensed and competent to provide appropriate care

514.3.4 General Administration

The governing body is responsible to ensure the nursing facility is administered in a manner that enablesit to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Policies must be documented as to the provision of services to residents in order to address quality of life, quality of care, resident rights and any other services within the scope of nursing facility services.

514.3.5 Governing Body and Management

The management of the nursing facility must identify an individual or individuals as the governingauthority of the facility in accordance with 42 CFR 483.410 and WV Legislative Rule 64CSR13.

514.3.6 Physical Environment Requirements

In order to participate in the West Virginia Medicaid program, nursing facilities must be equipped and maintained to provide a functional, sanitary, and comfortable environment for all residents admitted for care.

The nursing facility must be in compliance with the Current Edition of the National Fire Protection Association (NFPA) of "NFPA 99 Standards for Health Care Facilities" as promulgated and mandatory references issued by CMS as currently published or modified in the future. Additionally, the State requires adherence to the Guidelines for Design and Construction of Hospital and Health Care Facilities in establishing the Standard Appraised Value (SAV) for the capital component of the nursing facility rate.

The State pays for an annual SAV inspection. If the first SAV inspection has been completed and the nursing facility requests an additional SAV inspection, the nursing facility is responsible for payment to the appraisal company approved by the State, who completes the additional SAV inspection.

When the nursing facility has proposed changes to the physical plant, the governing body or designee of the nursing facility is responsible to notify the State, in writing.

514.3.7 Administrative Policies

The governing body of a nursing facility must ensure the development of policies and procedures regarding all aspects of the operation of the facility, including policies and procedures regarding the provision of care and services to residents. These policies must be available to each resident and his/her representative.

All policies and procedures regarding the provision of care and services to residents must reflect current accepted standards and practices and must be reviewed and approved by the governing body or designee at least annually. All of these policies must be written or presented in a language/method of communication that can be understood by any individual admitted to the facility.

Additionally, all individuals residing within the facility must be informed in a language/method of communication which the individual or legal representative can understand regarding all rights andpolicies affecting their acceptance of services provided by the facility.

514.3.8 Emergency/Disaster Preparedness Procedures

The nursing facility's governing body or designee must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents and must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

The nursing facility's emergency / disaster preparedness procedures must include at a minimum:

- How to shelter in place when indicated and how to care for residents when sheltering in place;
- How to evacuate all or part of the facility when indicated and how to care for residents in anemergency shelter when evacuation of the nursing facility is indicated;
- Notification of the attending physician, Emergency Medical System (EMS), law enforcement andother persons responsible for the residents;
- Arrangements for transportation;
- Arrangements for hospitalization;
- Arrangements for other appropriate services;
- Arrangements for emergency physician services, if the attending physician is not

immediatelyavailable;
- Arrangements for securing the residents' medical records; and
- Actions to be taken to locate a missing resident.

The nursing facility's governing body or designee must ensure that staff rehearses and documents, at least annually, actions to be taken in the event of a missing resident.

514.3.9 Notification of Resident Rights

The nursing facility's governing body or designee must:

- Establish a policy statement setting forth the rights of residents to a dignified existence, self-determination, communication and access to persons and services inside and outside the facility to include prohibiting the mistreatment, neglect, misappropriation of resident property or abuse of resident;
- Post the written resident rights policy for staff, resident, families or representatives and all interested parties to view; and
- Provide policies and procedures and ensure that each resident admitted to the facility is fully informed of his/her rights and responsibilities as a resident in the facility.

514.3.10 Hospital Transfer Agreement

Each nursing facility's governing body or designee must show documentation of a written transfer agreement that must be in effect with one or more hospitals approved for participation under the Medicare and Medicaid programs in accordance with 42 CFR 483.70 (j). The agreement must include information necessary to provide quality care and continuation of services by either the hospital or the nursing facility.

The hospital transfer must include information regarding the resident and must include a copy of the Advanced Directives and the most current evaluations including a list of current medications and most recent Pre-Admission Screening Resident Review (PASRR) Level II evaluation, if applicable.

514.3.11 Services Provided by Outside Sources

If a nursing facility does not provide a required service to meet the needs of one or more residents, the governing body or designee may enter into a written agreement / contract with an outside service, program, or resource to provide this service which is to be paid by the facility under the all-inclusive rate. The administrator or designee is responsible and accountable for assuring that outside sources meet the standards for quality of services and the timeliness of providing those services.

The administrator or designee must assure that the vendor and its staff is able to meet all mandatory educational, licensing, certification, and criminal investigation background check requirements for the specific area of service(s) furnished and follow the policies and procedure of the nursing facility. The agreement / contract must clearly state the responsibilities, functions, objectives, and the terms of the agreement and be signed and dated by both parties. See Section 514.7, Mandatory Services Under All-Inclusive Rate and its subparts for specific information regarding the all-inclusive rate.

514.4 QUALIFIED STAFF

514.4.1 Administrator

The day-to-day operations of each nursing facility must be directed by an individual identified as an administrator who is licensed by the West Virginia Nursing Home Administrators Licensing Board (WVNHALB). The WVNHALB may approve the director of nursing or another qualified individual to serve as the "Person in Charge" if a licensed nursing home administrator is not available. It is the responsibility of the Person in Charge to notify the State directly of their designation as a temporary administrator.

In accordance with the West Virginia Nursing Home Administrators Licensing Board, W.Va Code of State Rules, tit.21, ser.1,rule 5.3.a.1. an administrator shall not administer or be the administrator of more than one nursing facility, except that an administrator may oversee the operations of two nursing facilities which are within reasonable proximity (30 minutes or less), provided that such administrator is not administering more than 120 combined beds. The administrator of two facilities shall spend not less than an average of twenty hours per week at each nursing facility, and the administrator must employ the services of a full-time competent assistant at each nursing facility.

If an administrator oversees the operations of two nursing facilities, the amount of time spent each week by the administrator at each of the two nursing facilities is to be documented.

Documentation consists of weekly or monthly timecards, time sheets, or work logs that are signed and maintained on file at the facility. Documentation must be made available immediately upon the request of the State. If the documentation is not produced immediately, the records will be considered non-existent. "On-call" time is not to be used in determining hours of service and will not be accepted.

According to 42 CFR 483.70 (d)(ii) the administrator is responsible for management of the facility.

514.4.2 Medical Director

The administrator shall designate, in writing, a physician (Doctor of Medicine (MD) or Doctor of Osteopathy (DO)) accountable to the governing body to serve as medical director to ensure that medical care provided to all residents is adequate and appropriate.

As a member of the resident care committee, the medical director is responsible and accountable for participating in the development, implementation, evaluation, and revision of resident care policies and procedures, to ensure that such procedures reflect current standards of practice for resident care and quality of life; and coordinating and evaluating medical care in the nursing facility.

514.4.3 Physician Services

According to 42 CFR 483.30, a physician (MD or DO) must personally approve in writing, a recommendation that a person be admitted to a nursing facility. Each resident's care must be supervised by a physician at all times. The administrator or designee shall ensure that the medical care of each resident is supervised by a physician. Another physician must supervise the medical care of residents when their attending physician is unavailable.

The attending physician must review the resident's total program of care, including medications and treatments, and examine the resident personally at each visit. Such examinations shall be performed, to

the extent possible, when the resident is awake to facilitate interaction with and communication directly from the resident. The physician must write, sign and date progress notes at each visit and sign and date all physician orders. Any specialist who is called into the nursing facility must have a physician's order for the service signed prior to the date of service. Standing orders are not allowed and routine screening services are not covered in relation to the specialist.

The resident must be seen within 72 hours following the admission to the nursing facility and at least every 30 days for the first 90 days after the admission and as the resident's condition warrants. After the90-day requirement has been met, the physician must visit every 60 days or more often as the resident'scondition warrants.

After the initial visit, and completion of the visits required during the resident's first 90 days in the nursing facility, at the option of the physician, required visits may alternate between personal visits by the physician (a physician's assistant, an advance practice registered nurse or a clinical nurse specialist) who is licensed as such by the State of West Virginia, performing within their scope of practice, and is under the supervision of the physician following the above requirements. If the physician elects to alternate visits, all requests for reimbursement from the Medicaid program must be submitted under the servicing provider's number. Please refer to *Chapter 519, Practitioner Services.*

The administrator or designee must provide or arrange for the provision of physician services 24 hours of every day.

West Virginia Medicaid covers one nursing facility practitioner visit per 30 days when made by the member's Primary Care Physician (PCP) (i.e. Medical Director of the nursing facility or the resident's attending physician). The appropriate evaluation and management (E&M) Current Procedural Terminology (CPT) code must be used to bill for the visit. West Virginia Medicaid does not reimburse a nursing facility visit if the same physician provides another E&M visit to the same member on the same date of service.

Specialist services, including but not limited to those provided by a dentist, podiatrist, or an optometrist, must be provided based on a physician's order written by the PCP. Standing orders for specialist visits are not accepted. The specialist must bill the appropriate CPT code for their services.

514.4.4 Nursing Services

According to 42 CFR 483.35, the nursing facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The administrator and director of nursing at the nursing facility must follow licensure requirements to provide health services which assure that each resident receives treatments, medications, diets and other health services as prescribed and planned all hours of each day:

- The primary duties of certifies nurse aides consist of direct resident care and services, as distinguished from the duties of paid feeding assistants and housekeeping, laundry and dietary functions.
- Where residents are in a nursing facility located in a distinct part of a larger institution, each part of the institution must be separately staffed with adequate nursing personnel regardless of size.

- The 24-hour health service requires that the number and type of personnel be sufficient to meet the total needs of the residents.

514.4.5 Director of Nursing (DON)

The administrator must designate, in writing, a registered nurse (RN), who is licensed by the West Virginia Board of Examiners for Registered Professional Nurses (RN Licensing Board), to serve as the Director of Nursing (DON) on a full-time basis. The administrator and DON are responsible for ensuring the nursing facility has sufficient direct care staff to deploy across all shifts and units to meet the assessed needs of the resident on 24-hour basis.

514.4.6 Licensed Nurse

The administrator or designee is responsible for designating a licensed nurse to serve as a charge nurse on each shift. If an RN is not available in the facility, a licensed practical nurse (LPN) may serve in this capacity. All RNs and LPNs are required to follow the policies and procedures of the nursing facility and work within the scope of their individual licenses.

A nursing facility must have an RN on duty, in the facility, for at least eight consecutive hours, seven days a week. In nursing facilities with fewer than sixty beds, the DON may serve to meet this requirement. During periods when there is not an RN on duty, there must be an RN on call.

514.4.7 Certified Nurse Aide (CNA)

The administrator or designee must receive registry verification from the West Virginia Nurse Aide Registry that a nurse aide has met training and/or competency evaluation requirements prior to hire into the nursing facility and retain these documents in the individual's personnel file.

514.4.8 Social Services

The administrator or designee is responsible for designating a qualified social worker suited by training or experience, in accordance with WV Legislative Rule 64 CSR 13 and 42 CFR 483.70 (p) to provide or arrange for the provision of social services as needed by the resident to promote the residents highest physical, mental and psychosocial wellbeing. These services must be integrated with all other elements of the overall plan of care.

The social worker is an individual who is currently licensed by the West Virginia Board of Social Work Examiners as a licensed social worker (LSW), at entry level or higher and has some background, knowledge or experience related to social service activity in order to perform this function. If the facility's governing body/ designee does not employ an individual qualified by training or experience, arrangements must be made through written agreement/contract with an outside resource (a person or agency) to provide direct medically related social services as needed by the resident or to act as a consultant.

The chief function of the social worker is to help with problems which inhibit or prevent the resident's social adjustment and, because of this, affect his/her ability to benefit from their stay in the nursing facility.

Social service activity is not limited to the resident alone, but will usually include contact with the resident's family, close friends, and the coordination of services with other agencies, such as the West Virginia the State, Social Security Administration (SSA), Veteran's Administration (VA), Aging & Disability Resource Centers, community service organizations, etc. A good working knowledge of community resources is a valuable asset for the social worker.

The social worker is to provide indirect services to the resident through staff education both by participation in the nursing facility's in-service training program and through conferences with staff whoare concerned with the resident's care. To carry out this function, the social worker will need to have a thorough knowledge of the nursing facility's method of operation and its practices and policies.

Sales and marketing activities do not constitute medically related social services.

514.4.9 Activities Director

In compliance with 42 CFR 483.24 (c) the nursing facility administrator or designee must provide for an ongoing program of activities designated to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

The administrator or designee must designate a qualified professional who is a qualified therapeutic recreation specialist or an activities' professional, who is licensed or registered, by an accrediting body on or after October 1, 1990.

The activities director is responsible for developing programs which provide constructive supervision and services directed toward restoring and maintaining each resident at his/her best possible functional level including activities designed to encourage self-care and independence.

The activities director shall develop a plan for independent and group activities for each resident in accordance with his/her needs and interests. The plan is incorporated in the overall plan of care and is reviewed with the resident's participation at least quarterly and revised as documented and needed in the care plans and Minimum Data Set (MDS).

The activities director shall provide opportunities for meaningful activities and social relationships. These may include holiday celebrations, parties, indoor and outdoor games, or personal hobbies. Educational or recreational activities sponsored by groups within the community should be encouraged and planned with these community groups or agencies

514.4.10 Food and Dietary Director

In accordance with 42 CFR 483.60 and WV Legislative Rule 64CSR13, the administrator or designeemust employ a qualified dietitian either full-time, part-time or on a consultant basis.

Rules regarding the frequency of meals, sanitary conditions and emergency supplies may be found at WV Legislative Rule 64 CSR 13 (Nursing Homes) and 64 CSR 17 (Food Establishments).

514.5 MEMBER ELIGIBILITY REQUIREMENTS

514.5.1 Application Procedures

An application for nursing facility benefits may be requested by the resident, the family/representative, the physician, or a health care facility. The steps involved in approval for payment of nursing facility services are:

- The financial application for nursing facility services is made to the local the State office; and
- The medical eligibility determination is based on a physician's assessment of the medical and physical needs of the individual. At the time of application, the prospective resident should be informed of the option to receive home and community-based services. The Pre-Admission Screening (PAS) assessment must have a physician signature dated not more than 60 days prior to admission to the nursing facility. A physician who has knowledge of the individual must certify the need for nursing facility care.

514.5.2 Pre-Admission Screening (PAS)

The PAS for medical necessity of nursing facility services is a two-step process. The first step (Level I) identifies the medical need for nursing facility services based on evaluation of identified deficits and screens for the possible presence of a major mental illness, mental retardation, and/or developmental disability. The second step (Level II) identifies if the individual needs specialized services for a major mental illness, mental retardation, and/or developmental disability.

514.5.3 Medical Eligibility Regarding Pre-Admission Screening

To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care24 hours a day, seven days a week. The State has designated a tool known as the Pre-Admission Screening (PAS) form (Appendix B) to be utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit.

An individual must have a minimum of five deficits identified on the PAS. These deficits will be determined based on the review by the State/designee in order to qualify for the Medicaid nursing facility benefit.

These deficits may be any of the following (numbers represent questions on the PAS form):

- #24: Decubitus – Stage 3 or 4
- #25: In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) independently and b) with supervision are not considered deficits
- #26: Functional abilities of the individual in the home.
    - Eating: Level 2 or higher (physical assistance to get nourishment, not preparation)
    - Bathing: Level 2 or higher (physical assistance or more)
    - Grooming: Level 2 or higher (physical assistance or more)
    - Dressing: Level 2 or higher (physical assistance or more)
    - Continence: Level 3 or higher (must be incontinent)
    - Orientation: Level 3 or higher (totally disoriented, comatose)
    - Transfer: Level 3 or higher (one person or two persons assist in the home)
    - Walking: Level 3 or higher (one person assists in the home)
    - Wheeling: Level 3 or higher (must be Level 3 or 4 on walking in the home to use, Level 3 or 4 for wheeling in the home.) **Do not count outside the home**.

- #27: Individual has skilled needs in one of these areas – (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations
- #28: Individual is not capable of administering his/her own medications

This assessment tool must be completed, signed and dated by a physician. The physician's signature indicates "to the best of my knowledge, the patient's medical and related needs are essentially as indicated." It is then forwarded to the State or its designee for medical necessity review. The assessment tool must be completed and reviewed for every individual residing in a nursing facility, regardless of the payment source for services.

The PAS may be submitted to the appropriate Utilization Management Contractor (UMC) electronically through a secure website. The faxing option will still be available and is entered into the direct data entry (DDE) by the UMC. When a PAS is submitted electronically, the physician has two options for providing attestation that the patient's medical and related needs are accurate as indicated with their signature:

1. If the physician has the capability for electronic signature (an actual version of their signature, such as when one signs for a credit card or package, the signature is created electronically), not just a typed version of their name; OR
2. Box #39 will be checked on the PAS which certifies the physician has completed this PAS (his or her name will be typed out). Then the PAS MUST be printed off and the physician's physical signature (such as the signature you see when one signs a letter) must be added. The signed page is attached to the electronic record and/or sent to the nursing facility accepting the resident.

On either option for signature, the date is automatically populated and that will be the date for the start of Medicaid reimbursement for services, if the individual meets financial eligibility for the nursing facility benefit. However, the PAS must be signed either electronically or physically by the physician in order for the PAS to be valid.

If an actual written signature either from the resident or responsible party cannot be obtained, verbal consent is necessary. The individuals obtaining verbal consent must sign/date along with the witness who also signs/dates. However, the entity completing the PAS MUST obtain an actual signature from the resident or responsible party on the hard copy of the PAS which will be the PAS on file with the nursing facility and available for review upon request.

Each nursing facility must have a signed, original pre-admission screening tool to qualify the individual for Medicaid benefits and to meet the federal Pre-Admission Screening and Resident Review (PASRR) requirements. Should the receiving nursing facility fail to obtain an approved assessment with an original signature from the resident or responsible party prior to admission of a Medicaid eligible individual, the Medicaid program cannot pay for services rendered at the nursing facility for that individual. The individual cannot be charged for the cost of care during the non-covered period.

A Medicaid member, who had Medicare and reaches the 21st day of Medicare Coverage and will be converting to Medicare Part A coverage with Medicaid as the co-pay, does not need a new PAS as long as the facility has a current PAS that is no more than 60 days old. If the individual has not been a member of Medicaid upon admission to the nursing facility, a new PAS will need to be completed before the Medicare benefit has ended and the Advanced Beneficiary Notice of Medicare Non-Coverage has been issued. This ensures proper placement if circumstances warrant long-term placement for the individual in

the nursing facility after Medicaid becomes the primary payer.

A new medical assessment must be completed for Medicaid medical eligibility for the nursing facility resident for all of the following situations:

- Application for the Medicaid nursing facility benefit;
- Resident transfers from one nursing facility to another nursing facility, even if the transfer is within the same corporation;
- Resident returns to the same nursing facility from any healthcare setting other than an acute care hospital;
- Resident transfers to an acute care hospital, then to a hospital-based skilled nursing unit, and then returns to the original nursing facility;
- Resident converts from private pay or any other payer to Medicaid; or
- Expiration of the current PAS due to time limitation.

514.5.4 Medical Necessity (Level I)

All individuals admitted or requesting admission to a Medicaid certified nursing facility must be screened for the possible presence of a mental illness, and/or an Intellectual/Developmental Disability (I/DD). This review is identified as the Level I (PAS) evaluation. Any individual identified with the possible presence of mental health issues must be further evaluated in the Level II PASRR.

514.5.5 Pre-Admission Screening and Resident Review (PASRR) (Level II)

If the Level I evaluation found the possible presence of mental illness and/or I/DD, further evaluation of the individual must be completed to obtain a definitive diagnosis and the need for specialized services for the mental health condition. This evaluation is identified as a Level II evaluation and must be completed by an individual identified by the State as an approved Level II evaluator. All Level II evaluators are either licensed psychologists or Board-Certified psychiatrists.
It is the responsibility of the facility in which the PAS is completed, to arrange for the Level II evaluation. This evaluation must be completed, including a report of the mental health status and whether specialized services are needed, within seven to nine calendar days following the referral. The Level II must be completed prior to the individual's admission into a nursing facility. Upon completion of the evaluation, both the referring entity and the PASARR Level II evaluator must provide the complete mental health evaluation and the original Level I evaluation to the receiving nursing facility. Additionally, the results of the evaluation shall be sent on the applicable forms to the contracted agent. 42 CFR 483.106 (ii) states "In cases of transfer of a resident with mental illness or I/DD from a nursing facility to a hospital or to another nursing facility, the transferring nursing facility is responsible for ensuring that copies of the resident's most recent PASARR and resident assessment reports accompany the transferring resident." This regulation applies to all residents of nursing facilities.

Repeat Level II evaluations are necessary when there is an acute exacerbation of the mental illness resulting in an inpatient admission to a psychiatric facility/psychiatric unit. The discharging facility must complete a new PAS, assuring that #31 **(**Has an individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness?) on the PAS is completed accurately, in which a Level II will be triggered.

514.5.6 Specialized Services for Intellectual/Developmental Disability (I/DD)

Specialized services for an individual identified as I/DD are a continuous program for an individual requiring aggressive, consistent implementation of a program of specialized and generic training, treatment, health and related services developed by an Interdisciplinary Team (IDT) that is directed towards:

- The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and
- The prevention or deceleration of regression or loss of their current optimal functional status.

These services are generally provided in an intermediate care facility for persons with I/DD or a related condition. If the resident is presently residing in a nursing facility when the Level II is completed and the need for specialized services for I/DD is indicated, and the responsible party refuses this recommendation, this refusal must be documented in the resident's record and readdressed with the responsible party on a continuing quarterly basis or until a Level II evaluation recommends otherwise.

514.5.7 Specialized Services for Mental Illness

Specialized services for an individual with an acute exacerbation of a mental illness are the continuous and aggressive implementation of an individualized plan of care that:

- Is developed under and supervised by a physician in conjunction with an IDT which includes qualified mental health professionals;
- Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of a major mental illness which necessitates supervision by trained mental health professionals; and
- Is directed toward reducing the individual's acute psychotic symptoms that adversely affect the person's ability to perform their activities of daily living. The long-term goal of the specific therapies is to improve the individual's level of independent functioning and to achieve a functional level that permits reduction in the intensity of mental health services at the earliest possible time.

These services may only be provided in an acute psychiatric facility. If the resident or responsible party refuses this service, if it is recommended during the Level II review, the individual cannot be admitted tothe nursing facility or continue to reside in the facility.

514.5.8 Fair Hearing Process

A PAS form will be completed to determine Medicaid medical eligibility for nursing facility placement. If the PAS results show the member does not meet Medicaid medical eligibility after being reviewed by the appropriate UMC, the member or their responsible party has the right to request a Fair Hearing. During the appeal, the resident may choose to remain at the facility. If the resident is a Medicaid member at the time of appeal, the facility will receive continued payment during the appeal process. After the hearing, the hearing officer will issue the decision, in writing, to the State, the nursing facility and member/responsible party. This letter, from the hearing officer, will have the effective date of the decision. If the decision is to uphold the denial for Medicaid medical eligibility, the facility will have 35 days of continued Medicaid payment in order to account for mailing time.

At the beginning of the 35-day discharge period, the facility will issue a 30-day discharge letter to the resident so that the facility will be able to conduct a safe and orderly discharge while receiving continued payment, in accordance with 42 CFR 483.15.

514.5.9 Contribution to the Cost of Care

As a part of the financial eligibility determination for the Medicaid nursing facilities benefit, the State calculates the dollar amount the individual must contribute to the cost of care every month. The monthly Medicaid payment to the nursing facility will be reduced by the dollar amount of the contribution to the cost of care/resource.

The administrator or designee is responsible for collecting the monthly contribution to the cost of care. If the administrator or designee is unable to collect the money for any reason, that dollar amount may not be charged to the Medicaid program in any manner.

It is the responsibility of the nursing facility to notify the local the State office when a Medicaid member is admitted to the facility and when a member discharges from the facility in order for the facility and member to receive the appropriate benefit.

514.5.10 Admission Policies

A nursing facility must not require a resident, a potential resident, or his/her representative to waive rights to Medicaid benefits. A governing body or designee of a nursing facility must not charge, solicit, accept or receive any gifts, money, donations or other consideration as a precondition of admission, expedited admission or continued stay in the facility for any person eligible for Medicaid.

The State has established a process of evaluation to determine eligibility for long term care services under the Medicaid program. The evaluation is made on each member from information supplied by a physician, member or family/representative, health care facility and/or eligibility worker in the local the Stateoffice. This determination for the Medicaid benefit for nursing facility services is based on both medical and financial criteria. The State or its designee is responsible for the medical necessity determination andthe West Virginia Bureau for Family Assistance (BFA) is responsible for the financial determination. The administrator or designee is responsible for verifying continued eligibility for residents.

Medical eligibility must be established prior to payment for services. Medicaid will not pay for any services prior to the resident qualifying for services both medically and financially.

The local the State office is responsible for notifying the individual/representative, the State, and the nursingfacility of the date Medicaid eligibility begins.

514.5.11 Physician Recertification of Continued Stay

Recertification of the continuing need for nursing facility care must be documented in the resident's medical record by the physician at 60 days, 180 days, and then annually after the initial certification. The administrator/designee must obtain recertification documentation from the physician for each nursing facility resident for whom payment is requested under the Medicaid program.

514.6 MANDATORY SERVICES

514.6.1 In-Services Education Program

A written orientation program must be received by all new employees. The orientation program must be maintained at the facility. This program must include:

- A review of all policies for the nursing facility that pertain to the employee's position;
- An ongoing, in-service education plan for the development and improvement of skills of all personnel at the nursing facility; and
- All state and federal regulations, including WV Legislative Rule 64 CSR 13 (the Nursing Home Licensure Rule) which are relevant to the employees' position.

The personnel files for each individual employed by the nursing facility must include written documentation indicating the dates the employee participated and completed the orientation program, and any staff development in-service training conducted thereafter.

514.6.2 Pharmacy Services

An administrator or designee must assure that pharmaceutical services are provided as outlined in 42 CFR 483.45 to accurately and safely provide or obtain pharmaceutical services, which include the provision of routine and emergency medications and biologicals and consultation of a licensed pharmacist, in order to meet the needs of its residents.

The administrator or designee shall assure the development and implementation of written procedures based on policies approved by the governing body, including procedures that assure the accurate acquisition, receipt, dispensing, and administration of all medications and biologicals.

The administrator or designee shall assure that pharmaceutical services are provided in accordance with this policy and all other applicable federal, state and local laws and the rules of the West Virginia Board of Pharmacy (BOP). The administrator or designee must employ or obtain the services of a pharmacist who is licensed to practice in West Virginia and is currently registered as a consultant pharmacist with the West Virginia BOP.

The consultant pharmacist shall review the medication regimen of each resident once a month or more frequently based on the resident's needs. The consultant pharmacist shall document the results of each resident's medication regimen review in the resident's medical record. The medication regimen review shall include substances that are regarded as herbal products or dietary supplements. The consultant pharmacist shall report any irregularities in the medication regimen to the attending physician and the director of nursing. The nursing facilities pharmacist consultant must be available to advise the nursing facility regarding Medicaid drug coverage and limitations.

Drugs and biologicals used in the nursing facility must be labeled in accordance with the requirements of federal, state and local laws, rules and regulations. The labels must include the appropriate accessory and cautionary instructions with the expiration date when necessary and must conform to the physician order and must adhere to all applicable State Board of Pharmacy rules for labeling.

In accordance with state and federal laws, the administrator or designee must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The governing body or designee must provide separately locked, permanently affixed compartments for the storage of drugs subject to abuse and controlled drugs as identified by federal regulations. The nursing facility may also use single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

The administrator or designee must establish a policy to assure residents' requests for obtaining prescription medications from sources other than the contracted pharmacy will be honored. Prescription drugs are covered for residents of nursing facilities when prescribed by a qualified practitioner and furnished by a Medicaid participating pharmacy. The coverage rules and regulations may be found in *Chapter 518, Pharmacy Services.*

Residents are exempt from all co-pay requirements. Non-covered drugs are not reimbursed by Medicaid for residents of nursing facilities.

514.6.3 Minimum Data Set (MDS)

The most recent version of the Minimum Data Set (MDS) resident assessment instrument (RAI) and the West Virginia-specific Section S are to be used by NFs for each federally required assessment. Effective for assessments with assessment reference dates on or after October 1, 2023 until September 30, 2024, the State mandates the use of the optional state assessment (OSA) item set. The OSA item set is required to be completed in conjunction with each assessment and at each assessment interval detailed within this Section. The OSA item set must have an assessment reference date that is identical to that of the federally required assessment it was performed in conjunction with. Failure to do so may result in the assessment being assigned the lowest possible case mix score.

These forms may be found in the Resident Assessment Instrument (RAI) Manual as published and periodically updated by CMS; please refer to OHFLAC website for Section S instructions specifications.

The CMS requires that a comprehensive MDS assessment be completed on every resident admitted intoa nursing facility by day 14 of the admission and reassessed on at least a quarterly basis and annually thereafter. Reference should be made to the RAI manual for the complete Omnibus Budget Reconciliation Act (OBRA) assessment schedule.

514.6.4 MDS Submission Criteria for Reimbursement

Effective for reimbursement through September 30, 2024, the State utilizes the MDS assessments to determine (through the West Virginia specific 29 – case mixgrouper), the acuity level of each individual residing in the nursing facility. West Virginia has case mix classes 01-29, (when billed on the UB claim form or 837I format, the scores are depicted as AAA01- AAA29).

Effective October 1, 2024, the State utilizes the MDS assessments to determine (through the Patient Driven Payment Model grouper) the acuity level of each individual residing in the nursing facility. West Virginia uses the nursing component of the Patient-Driven Payment Model (PDPM), (when billed on the UB claim form or 837I format, the scores are determined from the applicable Health Insurance Prospective Payment System [HIPPS] code).

The case mix workbook may be found on the State website. The billing schedule is published annually, which may also be found on the State website with the nursing facility billing deadline dates, aswell as the MDS extraction date.

The nursing facilities must transmit all assessments that correspond with claims scheduled for payment in that month at least 36 hours in advance of this extraction. If MDS transmissions occur on or after the MDS extraction date, the MDS assessment will not be included until the following month's extraction. Therefore, authorizations in the claims payment system will not be loaded manually if the transmissions occur on or after the extraction date.

Upon completion of the MDS extraction, it is forwarded to the fiscal agent for the State to create authorizations for nursing facility payment. Nursing facility providers may review their MDS authorization reports on the web portal to identify which MDS assessments were loaded from the extract received.

Authorizations are created for a three-month period of time and are based upon the Assessment Reference Date (ARD) (i.e., if the MDS assessment has an ARD of 06/30/16, the authorization in the claims processing system will be created for 06/01/16 - 08/31/16). If a resident has two MDS assessments with ARD dates in the same month, the second assessment is to be used for billing, (i.e. assessment with ARD on 08/05/16 and a second assessment was completed with ARD 08/19/16, the second MDS submitted will be the assessment used by the facility for claim submission).

NOTE: If a member's MDS assessment is missed or submitted late, the default rate must be billed.

514.6.5 Care Area Assessment (CAA)

Per federal regulations, each triggered Care Area Assessment (CAA) must be addressed further to facilitate design of the care plan, but it may or may not represent a condition that should be addressed in the care plan. The CAA and the process for their completion are published and periodically updated by CMS and may be found in the RAI Version 3.0 User Manual.

514.6.6 Care Plan (CP)

A comprehensive care plan must be developed by the interdisciplinary care plan team at the nursing facility for each resident that includes measurable objectives and time-tables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment as promulgated in 42 CFR 483.21.

514.7 MANDATORY SERVICES UNDER ALL INCLUSIVE RATE

The State will pay an all-inclusive per diem rate for nursing facility services. This rate represents payment for all medically necessary and medically appropriate services and items that are required to be provided by the nursing facility to achieve optimum quality care and quality of life for each resident.

514.7.1 Nursing Services

Covered services include general nursing and restorative nursing care such as, but not limited to, medication administration, treatments, assessment, care planning, and restorative programs. General

nursing care consists of, but is not limited to, personal care services rendered by the nursing staff or contract nursing staff, and assistance with activities of daily living rendered by any staff including hair and nail hygiene, bathing, and routine foot care.

514.7.2 Rehabilitative Therapy Services

Covered services include medically necessary specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, respiratory therapy, psychological and psychiatric rehabilitative services. Psychological and psychiatric assessment, evaluation, and rehabilitative services are also required. These services must be documented in the resident's physician orders and in the comprehensive plan of care. The administrator or designee must provide the required services directly or in accordance with 42 CFR 483.65.

Rehabilitative services, whether provided either directly or through qualified outside resources must be designed to preserve and improve abilities for independent function, to prevent progressive disabilities,and restore maximum function.

514.7.3 Non-Prescription Items

The nursing facility's all-inclusive rate includes over-the-counter drugs. Additionally, all diabetic supplies including diabetic testing supplies and syringes/needles are covered in the facility's all-inclusive rate.

514.7.4 Medical Supplies, Accessories, and Equipment

Facilities may not charge a resident or the Medicaid program for routine personal hygiene items and services required to meet the needs of a resident, as this cost is included in the all-inclusive rate. These include but are not limited to: hair hygiene supplies; comb; brush; bath soap; disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection; razor; shaving cream; toothbrush; toothpaste; denture adhesive; denture cleaner; dental floss; moisturizing lotion; tissues; cotton balls; cotton swabs; deodorant; incontinence care and supplies; sanitary napkins and related supplies; towels; washcloths; hospital gowns; nail services including routine trimming, cleaning, filing, and care for ingrown or damaged nails; bathing, and basic personal laundry. Also included are nursing supplies including over the counter wound care items: sterile saline; pressure ulcer treatment supplies; dressings; bandages; tape and any other wound care supplies prescribed by the physician, syringes and needles; dietary supplements; salt and sugar substitutes; tube feedings and equipment needed to deliver the feeding; disposable incontinence supplies; supplies such as catheters; colostomy and ileostomy bags and any other incontinence supply items prescribed by a physician.

Medical supplies, accessories, and equipment that the nursing facility is required to have available include, but are not limited to hospital beds, standard wheelchairs, walkers, Geri chairs, crutches, canes, bedside commodes, traction equipment, blood pressure equipment, protective restraints, lifts, nebulizers, air mattresses, weight scales, and gait belts.

514.7.5 Room and Board

Covered services include the resident's room and basic room furnishings, including a bed of proper size, length, and height for each resident; a clean, well–maintained, comfortable mattress of the proper length

for each resident; pillows; clean linens and bedding appropriate to the weather and climate; functional furniture appropriate to the resident's needs; and individual closet space with clothes racks, hangers and shelves.

514.7.6 Laundry

Covered services include laundry services such as basic personal laundry.

514.7.7 Food and Dietary Services

Covered services include all nutritional meals, snacks, food supplements, tube feedings, supplies and equipment required for tube feedings, and food substitutes needed for special diets.

514.7.8 Activities Program

Covered services include the cost for the provision of an activities program for residents.

514.7.9 Social Services

Covered services include the provision of medically related social services and coordination with other social service agencies in the resident's community and the resident's family.

514.7.10 Non-Emergency Medical Transportation

Nursing facilities must provide non-emergency medical transportation (NEMT) for all residents. If the nursing facility does not provide these services with a facility owned vehicle, the facility must contract with a transportation vendor that provides non-emergency transportation. These contracted services for transportation are not billable to West Virginia Medicaid by the facility or transportation provider.

The cost of all non-emergency medical transportation, provided by a vehicle owned or contracted by the nursing facility, is included in the all-inclusive Medicaid rate.

If a resident meets the criteria stipulated in *Chapter 524, Transportation Services, Section on Basic Life Support-Non-Emergency*, West Virginia Medicaid may be billed by the transportation company. Nursing facilities are not required to contract with transportation providers for Basic Life Support (BLS) non-emergency ambulance services.

Additionally, any nursing facility that may be enrolled as a non-emergency transportation provider with the West Virginia Medicaid NEMT broker, shall not bill for NEMT reimbursement for transportation provided to their residents. The nursing facility must cover the cost of these transportation services and may be counted as an allowable expense on the cost report, under nursing-purchased services.

Upon transfer to another nursing facility, it is the responsibility of the receiving nursing facility to providethe transportation to their facility. The sending facility is not reimbursed for the day of discharge and thereceiving facility is reimbursed for the day of admission.

514.8 RESIDENT RIGHTS

As promulgated in 42 CFR 483.10, the resident has a right to a dignified existence, self-determination,and communication and access to persons and services inside and outside the facility.

514.8.1 Notice of Rights

A facility must protect and promote the rights of each resident, including each of the rights defined below. Written policies and procedures must be implemented to ensure that each resident or his/her representative is fully informed of his/her rights and responsibilities. Notification of resident rights must be provided periodically, no less than annually, during the stay to the resident/representative.

The administrator or designee must encourage and assist the resident throughout the period of stay to exercise rights as a resident and a citizen including the right to vote, formulate advanced directives and meet and organize in resident/representative groups to voice grievances and recommend changes in policies and services to facility staff and/or other representatives of choice free from restraint, interference, coercion, discrimination, or reprisal. The administrator or designee must assure each resident civil and religious liberties, privacy of telephone and written communications, provide services and care consistent with special needs and individual preference, and respond promptly to requests.

In the case of a resident who has been determined by a West Virginia Court to meet the definition of a protected person in need of the assistance of a guardian, conservator, or both under W.Va Code 44 A-1-4, or by a court of competent jurisdiction in a similar proceeding under the laws of another state, the rights of the resident are exercised by the person appointed to act on the resident's behalf. In the case of any other resident, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent permitted by State law.

The administrator or designee must inform each resident and/or his/her representative both orally and in writing, in a language or method of communication that the resident understands of his/her rights and ofall rules and regulations governing patient conduct and responsibilities. Such information must be provided prior to or at the time of admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of resident right's policies. Written acknowledgment of the receipt of resident rights information must be maintained within the facility.

The administrator or designee will keep all personal and medical records private and refuse to allow access to these records without written authorization by the resident/representative unless State and/or Federal regulations regarding release of information supersedes. The resident or his/her representative will have access to all records pertaining to the resident including clinical records. Upon receipt of a written request by the resident or his/her representative, the administrator or designee will provide the records in accordance with WV C Section 16-29-1 et seq.

The resident has the right to receive adequate, appropriate health care and appropriate protection and support services with reasonable accommodation of individual need and preference including, but not limited to, selection of personal physician. The resident or his/her representative has the right to be fully informed in a language that he/she can understand of his/her total health status. The resident or their representative has the right to refuse treatment, and to refuse to participate in experimental research.

The resident or their representative has the right to be present and participate in the formulation of a care plan as well as be consulted in advance about any changes in treatment or care. Self-

administered medication by a resident must be allowed if individual capabilities are assessed and documented by professional staff.

Outside of the formal plan of care, the resident has the right to plan personal daily activities and participate in activities both inside and outside the facility.

Residents who are entitled to Medicaid benefits or become eligible for Medicaid benefits must be informed in writing of the items and services under the State Plan for which the resident may not be charged as well as the items for which the resident may be charged and the amount of the charges, including an explanation of the resident resource amount. This information must also be provided to the resident annually during the resident's stay in the nursing facility.

A resident of a nursing facility must be provided a room as homelike as possible according to individual tastes, desires, and medical necessities. Personal furnishings including furniture must be allowed depending on space. A private storage space within the personal room for clothing and possessions must be provided. The administrator or designee must take reasonable precautions to protect and treat personal possessions with respect, as well as investigate incidents of loss, damage, or misappropriation of property.
The facility must provide a written description of legal rights including:

- The manner of protection of personal funds;
- The names, addresses, and telephone numbers of all pertinent State advocacy groups;
- A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and/or misappropriation of funds or property in the facility;
- The name, specialty and way of contacting the physician responsible for the care of the resident; and
- The procedures for applying for and using Medicare and Medicaid benefits as a resident of a nursing facility.

514.8.2 Transfer and Discharge Policies

According to 42 CFR 483.15, transfer and discharge of an individual includes movement of a resident to a bed outside of the Medicaid-certified portion of the facility, whether that bed is in the same physical plant or not. Transfer and discharge do not refer to movement of a resident to a bed within the Medicaid-certified portion of the facility.

The administrator or designee must permit each resident to remain in the facility, and not be transferredor discharged from the facility unless one of the following conditions is met:

- The transfer or discharge is necessary for the resident's welfare when the needs of the resident cannot be met in the facility; or
- The transfer or discharge is appropriate because the health of the resident has improved sufficiently that the individual no longer meets the medical criteria for nursing facility services; or
- The safety of individuals in the facility is endangered; or
- The health of individuals in the nursing facility would otherwise be endangered; or
- The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicaid) a stay at the nursing facility, including but not limited to, the amount of money

determined by the financial eligibility evaluation as co-payment for the provision of nursing facility services; or
- The facility ceases to operate.

Documentation must be recorded in the resident's medical record by a physician of the specific reason requiring the transfer or discharge. Discharge documentation is required regardless of the reason for discharge.

Before the nursing facility transfers or discharges a resident, the administrator or designee must notify the resident and/or the responsible party verbally and in writing, in an accessible format that is understandable to the parties, of the intent and reason for transfer or discharge. The same information must be recorded in the resident's medical record and a copy of this written notice must be sent to the State Long-Term Care Ombudsman or his/her designee. The notice of transfer or discharge must be provided at least 30 days prior to the anticipated move to ensure a safe and orderly discharge to a setting appropriate to the individual's needs.

Waiver of this 30-day requirement may be appropriate if the safety of individuals in the facility would be endangered, the immediate transfer is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days.

The written notice must include the following:

- The effective date of the transfer or discharge;
- Reason for the discharge;
- The location or person(s) to whom the resident is transferred or discharged;
- A statement that the resident has the right to appeal the action to the State Board of Review, during this time of appeal, the resident/member may choose to stay in the facility;
- The name, address, and telephone number of the State long-term care ombudsman; and
- For nursing facility residents with developmental disabilities, the mailing address and telephonenumber of the agency responsible for the protection and advocacy of developmentally disabledand mentally ill individuals.

It is the responsibility of the nursing facility to notify the local the State office when a Medicaid member is admitted to the facility and when a member discharges from the facility in order for the facility and member to receive the appropriate Medicaid benefit.

514.8.3 Bed Reservation

For rate periods through September 30, 2024, a nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility. This is paid at the facility's established Medicaid baserate.

The facility's occupancy must be 95% or greater as of midnight on the day immediately before the time that the resident leaves and there must be a current waiting list for admission to the nursing facility. The midnight census must be obtained daily and kept either in hard copy or electronic format and must contain, at a minimum, the names and ID numbers for each resident. A waiting list for admission must be maintained either in hard copy or electronic format by day and must contain, at a minimum, the names,

addresses and contact numbers of the individuals on the waiting list and must be available immediately upon request by the State.

A day of leave is defined as a continuous 24-hour period. At the time the resident leaves the facility, the primary payer for services must be Medicaid. Bed reservation days may be for acute care hospitalization or a therapeutic leave.

The resident whose bed is reserved is to be accepted by the facility immediately upon discharge from the hospital or return from therapeutic leave. Placement is to be in the same bed and living space occupied by the resident prior to the hospital or therapeutic leave of absence unless the resident's physical condition upon returning to the facility prohibits access to the bed previously occupied. If the nursing facility discharges a resident and return is not anticipated, as indicated on the MDS, the facility cannot charge the State for a Medicaid bed hold.

When all hospital or therapeutic days have been used by a Medicaid resident, a facility may charge a resident to reserve a bed only when there are no vacancies and there is a current waiting list. Familiesthat are willing and able are free to pay these charges, and the amount paid is not considered as a resource or income for Medicaid purposes.

Personal needs allowance may be used to reserve a bed only with the resident/member or responsible party's written consent. The resident's contribution to the cost of care (resource) may not be used to pay to reserve a bed. After a hospitalization or a leave of absence for which there was no bed hold, a former resident has the right to be re-admitted to the first available bed in a semi-private room in the nursing facility from which he or she came if the resident requires the services provided by the nursing facility and has not been out of the facility for more than 30 days.

For rate periods beginning October 1, 2024, a nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility, for a maximum of 18 days (for all types of leave). This is paid at the facility's non-acuity adjusted reimbursement rate.

A day of leave is defined as a continuous 24-hour period. At the time the resident leaves the facility, the primary payer for services must be Medicaid. Bed reservation days may be for acute care hospitalization or a therapeutic leave.

The resident whose bed is reserved is to be accepted by the facility immediately upon return from leave. Placement is to be in the same bed and living space occupied by the resident prior to the leave of absence unless the resident's physical condition upon returning to the facility prohibits access to the bed previously occupied. If the nursing facility discharges a resident and return is not anticipated, as indicated on the MDS, the facility cannot charge the State for a Medicaid bed hold.

When all leave days have been used by a Medicaid resident, a facility may charge a resident to reserve a bed only when there are no vacancies and there is a current waiting list. Families that are willing and able are free to pay these charges, and the amount paid is not considered as a resource or income for Medicaid purposes.

Personal needs allowance may be used to reserve a bed only with the resident/member or responsible

party's written consent. The resident's contribution to the cost of care (resource) may not be used to pay to reserve a bed. After a hospitalization or a leave of absence for which there was no bed hold, a former resident has the right to be re-admitted to the first available bed in a semi-private room in the nursing facility from which he or she came if the resident requires the services provided by the nursing facility and has not been out of the facility for more than 30 days.

514.8.4 Medical Leave of Absence

For rate periods through September 30, 2024, the medical leave of absence is payable for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, who is expected to return to the facility, and whose stay in the acute care facility is 24 hours or greater. The maximum number of medical leave of absence days which may be reimbursed for an individual for a medical leave of absence is 12 days in acalendar year (i.e. January 1 through December 31).

The resident's medical record must contain the physician's order, the date and time the resident is transferred to the hospital, and the date and time the resident returns to the reserved bed in the nursing facility. The day of transfer from the nursing facility to the hospital is counted as **day one** of the leave. If the Medicaid member returns to the nursing facility in less than 24 hours, this is not considered a leave day. If the resident expires in the hospital, is transferred to another facility, or goes home, that day mustbe considered the day of discharge from the nursing facility.

For rate periods beginning October 1, 2024, a nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility, for a maximum of 18 days (for all types of leave). This is paid at the facility's non-acuity adjusted reimbursement rate.

514.8.5 Therapeutic Leave of Absence

For rate periods through September 30, 2024, a therapeutic leave of absence, such as a home visit, to be eligible for payment, the medical recordmust contain a physician's order for therapeutic leave and must be a part of the resident's plan of care.The maximum number of therapeutic leave of absence days which may be reimbursed for an individualresident is six days in a calendar year (i.e. January 1 through December 31).

The medical record of the individual requesting therapeutic leave must contain a physician's order, the date and time of the beginning of the therapeutic leave, and the date and time the resident returns to the reserved bed in the nursing facility. For therapeutic leave, the date the member leaves the nursing facility is counted as a leave day and the day the resident returns to the facility is not counted as a therapeutic leave day.

For rate periods beginning October 1, 2024, a nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility, for a maximum of 18 days (for all types of leave). This is paid at the facility's non-acuity adjusted reimbursement rate.

514.8.6 Resident Personal Funds

The resident has the right to manage his or her own financial affairs and the administrator or designee shall not require residents to deposit their personal funds with the nursing facility, in compliance with the Code of Federal Regulations. Upon written authorization of a resident, the administrator or designee shall hold, safeguard, manage, and account for the personal funds of the resident deposited with the nursing facility as specified in the following sections.

514.8.7 Deposit of Funds

According to 42 CFR 483.10, an administrator or designee must deposit any resident's personal funds in excess of $50.00 in an interest-bearing account (or accounts) that is separate from any of the nursing facility's operating accounts and that credits all interest earned on a resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

An administrator or designee must maintain a resident's personal funds that do not exceed $50.00 in a non-interest-bearing account, interest bearing account, or petty cash fund.

514.8.8 Accounting and Records

The administrator or designee must establish and maintain a system that assures a complete and separate accounting, according to Generally Accepted Accounting Principles (GAAP), of each resident's personal funds entrusted to the nursing facility. The system shall preclude any commingling of a resident's personal funds with nursing facility funds or with the funds of any person other than another resident.

Each resident's financial record shall be provided through quarterly statements and on request of the resident or his/her legal representative. For any transaction from a resident's account, the administrator or designee shall provide the resident with a signed receipt and retain a copy of the receipt.

The administrator or designee shall administer the funds on behalf of the resident in the manner directed by the resident or in the case of the resident's inability to make financial decisions, the appropriate or financial legal representative.

514.8.9 Notice of Certain Balances

An administrator or designee shall notify each resident who receives Medicaid benefits or his/her legal representative when the amount in the resident's personal funds account reaches within $200.00 of the Supplemental Security Income (SSI) limit for one person. Should the amount in the account, in addition to the value of the resident's other non-exempt resources, reach the SSI resource limit for one person, it may result in the individual losing eligibility for Medicaid and SSI.

514.8.10 Conveyance Upon Discharge

Upon the death or discharge of a resident with personal funds deposited with the nursing facility, the administrator or designee shall comply with all applicable State and if appropriate, Federal statutory and regulatory provisions.

514.8.11 Allowable Resident Charge

Allowable resident charges, according to 42 CFR 483.10 (f)(11), are charges by the facility to the resident/financial representative that are amenities/items/services above the "all-inclusive rate" that are requested by the resident or responsible party. Additional charges must be explained to the resident/ responsible party during the admission process. The following may be used as examples of allowable resident charges: telephone, television/radio, personal comfort items, smoking materials, cosmetic items, personal clothing, personal reading materials, flowers and plants, social events and entertainment offered outside the scope of an activities program, and special care services such as privately hired individuals. Commercial laundry/dry cleaning expenses for personal items of clothing will be the responsibility of the resident.

For a Medicaid resident desiring a private room, the administrator or designee may charge the difference between the facility's actual charge for room and board of a semi-private room and the charge for room and board of a private room. For a Medicaid resident's whose medical condition warrants an isolation/private room, the administrator or designee may not charge an additional fee.

Individuals may reserve a bed in a nursing facility as a contractual agreement to pay the nursing facility for a bed hold as long as the amount paid is not considered as a resource or income for Medicaid. However, the resident's contribution of cost of care/resource cannot be used for this purpose.

514.9 ANCILLARY SERVICES

The nursing facility must have formal arrangements for the provision of ancillary services which are necessary to support the primary activities of the nursing facility; however, they are not included in theper-diem rate.

514.9.1 Prosthetics and Orthotics

Prosthetic and Orthotic devices/appliances that are prescribed by an enrolled practitioner to residents in a nursing facility are subject to service limitations and prior authorization requirements noted in *Chapter 506 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).*

514.9.2 Dental Services

Generally, dental care is not a covered service for adults and is not reimbursable as a fee for service. However, in accordance with *Chapter 505, Oral Health Services,* emergent dental care for adults is covered and defined as treatment for pain, infection, fractures, and trauma. Coverage is limited to the Least Expensive Professionally Acceptable Alternative Treatment (LEPAAT). If the resident is under 21 years of age, there may be additional benefits covered. Please refer to the local the State office for further information on non-reimbursable medical expense deductions for dental services not covered by Medicaid.

514.9.3 Vision Care Services

Covered vision services may be found in *Chapter 525, Vision Services*. All covered services MUST be medically necessary and prescribed by an enrolled physician. Vision services covered by Medicaid are

eligible for reimbursement as a direct billing to Medicaid when the Medicaid member is a resident of the nursing facility at the time the vision service is provided.

514.9.4 Podiatry Services

The Medicaid program covers podiatry services, with certain limitations, furnished to a resident when referred by the attending physician.

Routine foot care is not a covered service, except for residents referred by the physician for the treatment of a metabolic disease (such as diabetes). Routine foot care includes, but is not limited to, the cutting or removal of corns or calluses, the trimming of nails, observation and cleaning of the feet, nail care not involving surgery, and other hygienic and maintenance care. Routine foot care is considered a part of the nursing services provided by facility staff.

The regulations detailed in *Chapter 519.13, Podiatry Services* for the Medicaid program apply to nursing facility residents.

514.9.5 Laboratory, X-Ray, and Other Diagnostic Services

Laboratory and x-ray services are covered as ancillary services when provided by a certified and participating hospital or laboratory upon the order of the attending physician as needed to diagnose or treat an illness, accident, or injury.

The resident's initial medical evaluation which is required within 48 hours after admission, may include a chest x-ray and/or routine laboratory work to safeguard against the spread of disease and to ensure adequate medical care.

According to 42 CFR 483.50 (a), the facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

A nursing facility that provides laboratory services must follow Clinical Laboratory Improvements Amendment (CLIA) regulations as applicable. Please refer to *Chapter 529, Laboratory and Pathology Services*.

514.9.6 Emergency Ambulance Transportation Services

West Virginia Medicaid reimburses emergency transportation services rendered to members residing in nursing facilities when the services are medically necessary. Services must be rendered in the nearest hospital or facility that has the appropriate equipment and personnel and is documented in the nursing facility transfer agreement. Please refer to *Chapter 524, Transportation Services* for further emergency guidelines.

Use of an ambulance merely for the member or the nursing facility's convenience is not covered nor is residence in a nursing facility adequate justification for the utilization of transportation via ambulance. The following are not emergency transportation services and will not be reimbursed:

- Transport for services routinely available at the nursing facility;
- Transport for personal services;

- Transport for services that do not meet medical necessity guidelines;
- Transportation for services where the level of transportation does not meet the medical necessity requirements of the member; and
- Transportation to any location that does not render covered medical, diagnostic or therapeutic services.

This list is not intended to be all inclusive.

514.9.7 Hospice/Nursing Facility Resident

West Virginia Medicaid maintains a separate program of Hospice Services for individuals who are residents of a nursing facility. If a member electing hospice care is a resident of a West Virginia Medicaid certified nursing facility, the administrator or designee may contract with a Medicare/Medicaid certified hospice agency to provide hospice services for eligible individuals who qualify medically for both the hospice benefit and Medicaid nursing facility benefits. Medicare certification of a nursing facility is not a requirement of this program. The hospice agency must enroll with the Medicaid agency to be a provider of this benefit in nursing facilities. The hospice agency staff must follow the nursing facilities policies and procedures.

The nursing facility is responsible for the provision of the room and board component for resident who receives hospice services. The room and board component include the provision of a living space, nutrition, and ancillary services normally provided for residents.

The Hospice provider is responsible for specialized services covered by Medicare or Medicaid, including but not limited to, medications associated with the terminal illness and assistance with care planning. The hospice provider becomes an active participant in the interdisciplinary care plan team and the care plan must be immediately updated to reflect these changes. Emotional support for the member and the member's family is also provided. The hospice must bill Medicare and Medicaid for all covered services, including nursing facility room and board. The nursing facility cannot charge Medicaid a bed hold if the resident is under the Hospice benefit. The bed hold is to be contracted between nursing facility and the approved Hospice provider.

A Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains a resident at the nursing facility. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same as or later than the date of the hospice election statement, but not earlier). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing facility is in place.

A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing facility to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing facility remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease the resident is experiencing.

A SCSA is required to be performed when a resident who is receiving hospice services decides to

discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following:

- The effective date of the hospice election revocation (which can be the same as or later than the date of the hospice election revocation statement, but not earlier);
- The expiration date of the certification of terminal illness; or
- The date of the physician's or medical director's order stating the resident is no longer terminallyill.

If a resident elects the Hospice program, it is important that the two separate entities (nursing facility and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing facility and hospice plans of care should reflect the current status of the resident. In addition to coordinating plans of care between the nursing facility and the hospice provider, the two entities must also coordinate billing procedures for these members, which should include but are not limited to, the proration of patient resource amounts. When nursing facility residents are receiving hospice care, the nursing facility cannot bill Medicaid for the days that the member is receiving hospice services. The hospice provider is responsible for billing Medicaid. When a nursing facility resident is receiving hospice services for a partial month, the patient resource amount may need to be prorated. For example, a member is admitted to the nursing facility on January 1st and remains in the facility for the entire month and then on January 11th, the member elects hospice services in the nursing facility and continues to receive the hospice services through January 31st. The nursing facility would prorate the resource amount for the January claim for 10 days. The hospice claim would reflect a prorated resource amount for 21 days. If the nursing facility resident is receiving hospice services for the entire month, the full resource amount will be deducted from the payment made to the hospice provider for room and board.

514.9.8 Documentation Requirements for Hospice/Nursing Facility Authorization

For each individual who applies for hospice coverage in a nursing facility, election of services and physician certification documentation is required. Please refer to *Chapter 509, Hospice Services*. The hospice provider must submit to the State or its designee for review of the following information

- An agreement between the specific nursing facility and the hospice provider that each will provide its appropriate services to residents who qualify;
- Documentation to support the medical necessity for each covered hospice service and the financial eligibility documentation for the specific individual regarding Medicare and Medicaid.

As with hospice services provided in other settings, those hospice services provided in nursing facilities apply only to the terminal condition or disease. For health needs not related to the terminal diagnosis, established West Virginia Medicaid policies and procedures are to be followed.

The authorization information must be submitted with the first claim for payment.

514.10 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

The administrator or designee must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information* and *Chapter 300,*

Provider Participation Requirements. In addition to the documentation requirements described in those chapters, the following requirements also apply to payment for nursing facility services.

514.10.1 Resident Record System

A resident record system must be maintained which assures that the record is available to professional and other staff directly involved with the resident as well as authorized representatives.

Resident records must be safeguarded against destruction, loss, or unauthorized use and must comply with all Health Insurance Portability and Accountability Act (HIPAA) regulations. Records must be retained for a minimum of five years following a resident's discharge. Representatives of the State and the United States Department of Health and Human Services (USDHHS) may have access to the resident records at any time without the consent of the resident or responsible party. A separate clinical record must be maintained for each resident at a location that is accessible to appropriate nursing facility staff with all entries recorded in accordance with current professional standards and practices.

514.10.2 Demographic Information

The clinical record must include at a minimum the following information:

- Name of resident (first, middle, last, and generation if applicable)
- Date and time of admission
- Social Security identification number
- Medicare identification number (where applicable)
- Medicaid identification number and any other payer identification number
- Marital status
- Date of birth
- Gender
- Home address
- Religion
- Name, address, and telephone number of referral agency (including institution from which admitted, where applicable)
- Attending physician
- Next of kin or other responsible person
- Admitting diagnosis
- Final diagnoses (or cause of death)
- Condition on discharge and disposition (where applicable)
- Inventory of personal effects.

514.10.3 Medical Information

For each resident, the clinical record must include at a minimum the following information all of whichmust be signed and dated:

- Physician's certification reflecting the need for nursing facility services upon admission to the nursing facility.
- An overall plan of care based on a comprehensive assessment setting forth goals to be

accomplished, prescribing an integrated program of individually designed activities, therapies and treatments necessary to achieve such goals, and indicating which professional service or individual is responsible for each element of care or service prescribed in the plan.
- Initial medical evaluation including medical history, physical examination, diagnoses, and estimation of restoration potential done on admission.
- Physician's orders including all medications, treatments, diets, therapies and special restorative /medical procedures.
- Medication and treatment administration records including all medications, treatments, andspecial procedures performed.
- Physician's progress reports noted for each visit or consultation describing the residents' health status and/or significant changes in resident's condition.
- Nursing note documentation must reflect the current conditions as well as changes in conditionsof the resident. Monthly documentation which indicates observations, medication changes, progress, regress, any changes in conditions. Physician recertification must include documentation by the physician substantiating the resident's need for continued services in the nursing facility.
- Hospital transfer information (where applicable).
- Discharge summary completed by the physician prior to the resident's discharge for transmittal to the receiving institution at the time the resident is discharged, if applicable.
- A record of the resident's major grievances, if any, and the disposition.
- Laboratory, x-ray and other diagnostic reports.
- A list of medications transferred to the resident or responsible party upon discharge, to include a medication disposition form signed and dated by the receiving individual and the discharging nurse.
- The PAS form.

514.11 PAYMENT AND BILLING PROCEDURES

Nursing facility providers must comply with the payment and billing procedures and requirements asnoted below and found in *Chapter 600, Reimbursement Methodologies.*

514.11.1 Payment and Billing Procedures Non-Hospice

Nursing facilities must bill for services using either the UB04 paper form or the 837i electronic institutional format. The services may not be billed until the following month after which the services were provided.

Nursing facilities will use bill type 21X. The following are the revenue codes and the Health Insurance Prospective Payment System (HIPPS) codes that must be billed in order to receive appropriate payment for services provided:

- **Revenue Code 0190** is the room and board (fixed portion of the rate);
- **Revenue Code 0550** in skilled nursing (nursing portion of the rate) and must have HIPPS/RUG code attached:
    - For claims billed through September 30, 2024:
        - HIPPS/RUG Codes are AAA01-AAA29 to identify the West Virginia specific case mixclass
        - HIPPS/RUG Code AAA00 is to identify there is no MDS available;

- **Revenue Code 0183** is the therapeutic bed hold leave of absence;
- **Revenue Code 0185** is the hospital bed hold leave of absence and
- **Revenue Code 0189** is the non-covered leave of absence.

For non-hospice billing after October 1, 2024, billing procedures can be found on the BMS Website.

514.11.2 Nursing Facility Billing Procedures for Hospice Patients

All services are to be billed under **Revenue Code 0658**. The West Virginia Medicaid program will remit to the hospice provider, who is contracted to provide services in the nursing facility, 95% of the daily rate which would have been paid to the nursing facility forcare of this member had they not elected hospice coverage. The hospice will reimburse the nursing facility for the cost of room and board, as identified in their contract. The amount of reimbursement will bebased on the nursing facility base per diem rate with the Medicaid adjustment for the acuity of the beneficiary. The claim form for billing is the UB04 and cannot be billed electronically. Documentation identifying the specific case mix class of the individual must be attached.

514.11.3 Reimbursement Requirements

The West Virginia nursing facility reimbursement system is prospective with semi-annual rate adjustments. It is designed to treat all parties fairly and equitably, i.e., the resident, taxpayer, agency and facility. To meet these goals, complete and accurate cost data must be maintained by each facility with cost reports accurately prepared and submitted on a timely basis. The basic principles and methodology for the system are described in this chapter.

Federal and state law, the West Virginia State Plan and Medicaid regulations cover reimbursement principles in the following order: when Medicaid regulations are silent and Medicare cost principles and regulations are silent, then generally accepted accounting principles will be applied. None of these secondary applications will serve to reduce the State's ability to apply "reasonable cost" limits under Medicaid.

514.12 COST REPORTING

All facilities are required to maintain cost data and submit cost reports according to the methods and procedures specified in this chapter.

514.12.1 Chart of Accounts

The Medicaid Chart of Accounts (MCOA) is mandated by the State for nursing facility service providers who are required to complete the Financial and Statistical Report for Nursing Homes (Medicaid Cost Report) as part of their participation in the Medicaid program. The MCOA details the account number, account name, file/field specification (FIELD), page and line reference (MAP) and description of items applicable for each account. The file/field specification (FIELD) column contains the file and field layout for submission of the Medicaid Cost Report.

It is not mandatory for providers to use the MCOA for internal reporting purposes; however, the provider's internal chart of accounts MUST contain a sufficient number of accounts to capture data in the level of

detail necessary to correlate to the MCOA. Individual accounts must be used to report separate types of costs, even if the accounts aggregate to one cost report cost center.

The provider must submit a trial balance using the MCOA as part of the automated cost reporting process. This is accomplished in the cost reporting software by assigning the appropriate MCOA number to the provider's internal account number. It is the provider's responsibility to secure and maintain acceptable cost report software. The MCOA is maintained by Rate Setting Unit of the Office of Accountability and Management Reporting (OAMR) and is periodically updated. Cost reports must be submitted in accordance with the MCOA.

The Grouping Report (a trial balance submitted with the cost report through which each provider's internal account has been mapped to the appropriate MCOA number) must reflect the actual balance in each provider's internal account for the semi-annual, or annual, period reported, and the "Per Books" column must agree directly to the balance for each account in the provider's general ledger for that six months or year of activity. All adjustments are to be posted through the "Net Adjustments" column of the Grouping Report.

514.12.2 Financial and Statistical Report

Facility costs must be reported on the Financial and Statistical Report for Nursing Homes, which must be completed in accordance with Generally Accepted Accounting Principles (GAAP) and the accrual method of accounting. The reports must be submitted to the State OAMR; Attention: Division of Audit and Rate Setting, as an electronic submission in a format as required by the State.

The report must also be accompanied by the Medicaid Grouping Report trial balance that matches the costs on the report. These reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be rejected and returned to the facility for correction.

514.12.3 Cost Reporting and Filing Periods

For cost report periods ending through December 31, 2023, facility costs are reported semi-annually with the two reporting periods being January 1 through June 30 with a deadline of August 29, and July 1 through December 31 with a deadline of March 1 (February 29 on leap years). Cost reports must be filed with the State within 60 days following the end of the reportingperiod. The December 31, 2023 cost report period ended will be the last semi-annual filing period.

For cost report periods ending on or after January 1, 2024, facility costs are to be reported annually with the reporting period being January 1 through December 31 with a submission deadline of the following March 31. Cost reports must be filed with the State within 90 days following the end of the reporting period, or as required by the State. The January 1, 2024 through December 31, 2024 cost report period will represent the first required annual filing period.

For new providers, providers with changes of ownership, or those who have undergone a temporary closure a cost report must be filed for any fiscal period as determined necessary by the State, with a minimum filing period of six months.

514.12.4 Extension Requests

An extension of time for filing cost reports may be granted by the State for extenuating circumstances when requested and justified by the facility in writing by the close of business on the due date. For cost report periods ending through December 31 2023, extension requests will be limited to a maximum of 30 calendar days. For cost report periods ending on or after January 1, 2024, extension requests may be approved by the department for extenuating circumstances. The procedure for requesting extensions shall be communicated by the State in advance of the filing deadline.

514.12.5 Penalty for Delinquent Reporting

Failure to submit cost reports by the due date, where no extension has been granted to the facility or within the time constraints of an extension will result in penalties to that facility in accordance with the State Plan. If incomplete cost reports are not corrected and resubmitted within 10 calendar days, the facility may be subject to these penalty provisions at the discretion of the State.

514.12.6 Correction of Errors

Errors in cost report or rate setting data identified by the facility must be corrected and resubmitted to the State. If submitted within 30 days after the original rate notification, those corrections will be considered for rate revision. The State will make rate revisions resulting from computational errors in the rate determinationprocess.

An instance where a rate is revised for correction of an error, whether identified by the facility or the State for computational or other errors, shall not prohibit the State from making additional rate revisionsas needed upon subsequent discovery of additional errors.

514.12.7 Changes in Bed Size

A cost adjustment may be made during a rate period where there has been a change in the facility bed size if the change affects the appraisal value of the facility. When a bed change occurs it is recognized effectively in the month in which the change occurs. In this instance, an appraisal of the facility willbe completed after the bed size change has been certified. If the annual appraisal has been completed, the facility will be responsible for the cost of the additional appraisal.

514.12.8 Projected Rates and Rates After Change of Ownership

For changes of ownership occurring through September 30, 2024, a projected rate may be established where there has been a change of ownership and control of the operating entity, and the new owners have no previous management experience in the facility. When a stock purchase occurs, a projected rate is not established. If a change of ownership and control has occurred because there has been a complete purchase of assets, a projected rate is established.

A projected rate will be established for new facilities with no previous operating experience for rate periods through September 30, 2024. A change of location with the same ownership does not constitute a new facility. A projected rate will last no longer than 18 months from the opening date of the facility. The facility may choose to go off the projected rate at any time after a full twelve months of operating experience in a cost reporting period. Each facility on a projected rate must submit the calendar year cost reports during the projected rate period even if the first report is a partial report (less than twelve months).

At the end of the projected rate period, the audited cost report of the facility will be reconciled with the projected cost reimbursement using actual occupancy and tested for reasonableness against the cost standard established for the bed groups (0-90 beds and 91+ beds). Overpayment identified in the reconciliation process will be recovered by the State.

A projected rate for a new facility or a facility with a recognized change of ownership and control will be established as follows:

- Standard Services: The cost standard Cost Average Point (CAP) established for the bed group.
- Mandated Services: The cost standard CAP established for the bed group.
- Nursing Services: The average of the cost established for the bed group.
- Cost of Capital: The Standard Appraised Value (SAV) methodology is applied to a new facility or the SAV established for the facility if a change of ownership occurs.

For changes of ownership on or after October 1, 2024, a change of ownership shall result in the new operator of a facility receiving the prior operators' reimbursement rate until such a time that the new operators' costs are fully incorporated into a rate calculation period. New operator costs will be considered for rate setting beginning with the July 1 rate period following the filing of the new operator's first cost report which is 6-months or greater and has been reviewed by the State.

For new providers operating on or after October 1, 2024, the reimbursement rate shall be the statewide average reimbursement rate per component for their bed group except for cost of capital and quality. For the quality per diem, the provider will receive the points for new providers as described in the Quality Scoring Metrics and Special Population Determination file published to the BMS website. Any days utilized in determining the Quality Per Diem shall utilize the minimum occupancy standard as shown in §514.12.12.

Full disclosure of ownership is required on the cost report. As a condition of the change of ownership, the new operator agrees to assume the liabilities owed to the State by any predecessor provider, whether the provider is purchased through an asset purchase, stock purchase, or another arrangement.

514.12.9 Maintenance of Records

A desk review of the cost report may be done prior to rate setting and an on-site audit of facility records willbe conducted periodically. Financial and statistical records must be maintained by the facility to support and verify the information submitted on the cost reports. Such records must be maintained for a minimumof five years from the ending date of the report. Upon request by the State, all records will be made available within 10 working days. If not produced within that time frame, the records will be considered non-existent. The State reserves the right to determine the site where the records are to be made available. Cost or census data reported that is found to be unsubstantiated or related to records requested but not produced will be disallowed.

514.12.10 Census Data

Upon request for desk review or audit, source documentation for census as reported on the cost report must include at a minimum a midnight census (by payer class with bed reservations specifically identified) that agrees in aggregate to a monthly census (by payer class with bed reservations specifically identified),

which agrees (or has an accompanying reconciliation) to each month as reported on the cost report, with bed reservations specifically identified.

514.12.11 Rate Determination and Allowable Costs for Cost Centers

Allowable Costs: For rate periods through September 30, 2024, reimbursement rates shall be calculated as follows:

Reimbursement for nursing facility services is limited to those costs required to deliver care to residents. These are costs related to inpatient care, i.e., facility operating costs and the cost of direct services to residents, which are considered for reimbursement. Allowed costs are subject to the regulations prescribing the treatment of specific items in this manual.

A cost standard is developed for each of four cost center which becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following four methodologies:

1. Standard services,
2. Mandated services,
3. Nursing services, and
4. Cost of capital.

Standard Services: The cost standard for standard services is comprised of four departmental cost centers:

1. Dietary;
2. Laundry and housekeeping;
3. Medical records; and
4. Administration.

A separate cost standard is calculated for each of these cost centers by bed group based on bed size (0-90 beds and 91+ beds). Within each cost center, the Per Patient Day (PPD) allowable costs are arrayed assuming 100% occupancy on a facility specific basis. Extremes are eliminated by including only those values falling within plus or minus one standard deviation; this is then adjusted to a 90% occupancy level. The cost standard for standard services is the sum of the cost center CAP for dietary, laundry and housekeeping, medical records and administration. The cost standard then establishes the maximum allowable cost by bed group for standard services.

Mandated Services: The mandated services component is comprised of four departmental cost centers:

1. Activities;
2. Maintenance;
3. Utilities; and
4. Taxes and insurance.

A separate cost standard is calculated for each of these cost centers by bed group. Within each cost center the PPD allowable costs are arrayed from highest to lowest. The 90th percentile value of each costcenter is then selected as the CAP. The mandated services cost standard is the sum of the cost center CAP for activities, maintenance, utilities, and taxes and insurance. The cost standard then

establishes the maximum allowable cost by bed group for mandated services.

Nursing Services: The cost standard for nursing services is shown as the Resident Assessment calculation on the rate sheet. This calculation provides for professional staffing levels and supply costs that are recognized as representative of those necessary for delivery of the core level of resident needs. It incorporates all minimum federal and state mandates for licensure and certification of nursing facilities.

The professional staffing hours on the Resident Assessment calculation serve as a benchmark and areheld constant over time. A factor of 0.35 hours PPD is included in the licensed practical nurse (LPN) hours for 0-90 beds and 0.30 hours PPD for 91+ beds to account for restorative services. Additionally, 0.05-hours PPD is included in the standard Aides hours for restorative services.

The standard hours PPD, by bed group, for each of the professional levels of nursing staff are as follows:

Staff	1-90 Beds	91+ Beds
Registered Nurse (RN)	0.20	0.20
LPN	0.85	0.80
Aides	1.85	1.85
Total Hours PPD	2.90	2.85

The cost standard for nursing wage rates uses total compensation and is calculated by bed group. Hourly wage rates, by professional level, are derived from the cost reports of each facility and arrayed from highest to lowest in each bed group. The 70th percentile value is then selected as the bed group CAP. The CAP is multiplied by the hour benchmark to yield the salary component of the nursing services cost standard. Nursing and restorative supply costs are summed for each facility and converted to a PPD cost. These PPD costs are then arranged, by bed group, from highest to lowest, and the 70th percentile is selected as the nursing supplies CAP.

The DON salary is selected at the 70th percentile, by bed group, as derived from thesubmitted cost reports. An additional factor is added for the DON by dividing the DON salary by each facility's beds at 100% occupancy.

The cost standard for nursing services is derived as the sum of the above factors (RN, LPN, Aide, Supplies, and DON). The CAP is then adjusted to a facility specific CAP based on the facility's average Medicaid MDS score from the six-month reporting period. The average Medicaid MDS score (including the Medicaid Hospice resident) is divided by 2.5 and then multiplied by the base constant to arrive at an adjusted nursing services CAP for each facility. The adjusted nursing services CAP cannot exceed 112% (MDS average of 2.8) or be less than 80% (MDS average of 2.0) of the base constant. The facility actual allowable PPD nursing costs are reimbursed up to the level of the nursing services CAP.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the rate period when the case mix score derived from the MDS, as determined at the time of monthly billing, indicates a higher level of need and care delivered to a specific resident. A base case mix score of 2.9 is established as a threshold. For residents with a monthly case mix score of 2.9 or less, there is no add-on factor. If the monthly case mix score exceeds 2.9, then an add-on factor is determined by dividing the excess of the case mix score over 2.9 by the threshold factor of 2.25. The resulting factor is then

multiplied by the nursing rate to derive a PPD nursing services add-on.

Rate Determination: For rate period begin dates through October 1, 2023, individual facility rates are established on a prospective basis, considering costs to be expected during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors of omissions of data or reconciliation of audit findings related to falsification or misreporting of costs or census. The basic vehicle for arriving at each facility's rate is the uniform financial and statistical report for nursing homes.

The reported costs are subject to desk review and then converted to cost per patient day. Rates will be issued for six-month periods beginning April 1 and October 1 based on each facility's reported costs and adjustments for the applicable reporting period. The October 1, 2023 rate period will be in effect through September 30, 2024.

Cost Adjustment: Reported facility costs are subject to review and analysis through document/desk review process. Adjustments are made to exclude non-allowable costs and by application of the agency's established cost standards using the following methodologies: Standard services, mandated services, and nursing services (described below):

- **Standard Services:** Total reported allowable costs in the standard services area are compared against the total cost standard for these cost centers using the appropriate bed group for the facility. If the total reported allowable exceeds the total cost standard, then the facility rate is limited to the standard services CAP.
- **Mandated Services:** Total reported allowable costs in the mandated services area are fully recognized for these cost centers, providing they do not exceed the 90th percentile of total reported costs by bed group.
- **Nursing Services:** Allowable costs and reimbursement for nursing services will be determined on a facility-by-facility basis by the kind and amount of services needed and being delivered to the resident. The staffing required to deliver the care and the restorative and rehabilitative programs offered by the facility will be based on the application of a minimum staffing pattern and adjustments to reflect needs determined by the case mix characteristics.

Monthly billing information for services rendered to nursing facility residents will include data derived directly from the computerized assessment instrument for each resident, which may be used to determine case mix scores for each resident and a composite score for the facility. These case mix scores will measure the relative intensity establish a SAV). This value includes the necessary real property and equipment associated with the actual use of the property as a nursing facility. The SAV uses the cost approach to value modified by the Model Nursing Facility Standard. This valuation is the basis for capitalization to determine a PPD cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest and return onequity in the traditional approach to capital cost allowance.

Cost of Capital: Reimbursement for cost of capital is determined using an appraisal technique to establish a SAV). This value includes the necessary real property and equipment associated with the actual use of the property as a nursing facility. The SAV uses the cost approach to value modified by the Model Nursing Facility Standard. This valuation is the basis for capitalization to determine a PPD cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest and return on equity in the traditional approach to capital cost allowance.

Cost Approach to Value: The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting from them the estimated accrued depreciation and adding the market value of the land (actually used if required for use as if vacant and available for development of such use). Established sources of cost information are used to supply costs to reproduce the structure. Construction indexes used are Marshall & Swift Valuation Services and Boeckh Building Valuation Manual.

Accrued Depreciation: Accrued depreciation in a cost approach is the difference between the value of a building or other improvement at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the "breakdown" method which involves an analysis of loss in value from the following sources:

- Physical deterioration; curable and incurable
- Functional obsolescence; curable and incurable
- Economic obsolescence

The nursing facility appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plant valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciations, curable and incurable, as well as functional obsolescence, curable and incurable. The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

Model Nursing Facility Standard: The model nursing facility standard is a composite of current regulations and criteria derived from several sources and WV Legislative Rule 64 CSR 13 (Nursing Home Licensure Rule).

These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes which foster improved resident care or cost-effective measures which do not compromise resident care.

The model nursing facility standard also sets an upper reasonable cost limit for constructing a nursing facility. This effectively discourages the creation of unnecessarily costly facilities. Currently, land is being appraised at its "highest and best" use. This occasionally results in land values in excess of the building and equipment appraisal.

Appraisal Technique: A complete appraisal of each new facility will be performed after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the State. Updates of the initial appraisal may be performed annually and used in the October 1st rate setting period, in addition to the following April 1st rate setting period. Updates may be performed at any time during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate setting purposes. Initial and annual appraisals must include on-site inspections. Prior to rate setting, the updated appraisals will be indexed to June 30, as a common point valuation, based on the Consumer Price Index. All appraisals will include an on-site evaluation.

A copy of the facility appraisal report is furnished to the facility for its records.

514.12.12 PDPM Rate Determination

Effective for rate periods beginning October 1, 2024 and after, reimbursement for nursing facility services is limited to those costs required to deliver care to residents.These are costs related to inpatient care, i.e., facility operating costs and the cost of direct services to residents, which are considered for reimbursement. Allowed costs are subject to the regulations prescribing the treatment of specific items in this manual.

Effective October 1, 2024, a rate is comprised of the following rate components which are updated annually, save for the Quality component which is updated semi-annually. The base year used for October 1, 2024 rates will be the desk reviewed July 1, 2022 to December 31, 2022 cost reports.

1. Direct Care
2. Care Related
3. Operational
4. Pass-Through
5. Liability Insurance
6. Cost of Capital
7. Quality (Semi-Annual Update)
8. Phase-in Adjustment

After October 1, 2024, these rate components will be rebased at a minimum of every two years. The State, at their discretion, may choose to rebase more frequently than every two years. An inflationary index factor as discussed in this section below will be applied each July 1 for a non-rebase year.

1. Direct Care: The direct care component is comprised of the following departmental cost centers:

1. Registered Nurses;
2. Licensed Practical Nurses;
3. Nurse Aides;
4. Restorative and;
5. Contracted Nurses.

The per diem direct care cost for each NF is determined by dividing the facility's direct care cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period or 70% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed within this section below.

The per diem normalized direct care cost is calculated by dividing each NF provider's inflated direct care cost per diem by the NF provider's NF cost report period case mix index.

The price for the direct care component is established by peer group. The direct care normalized per

patient day allowable costs are arrayed from highest to lowest. The statewide direct care prices are established at one hundred and twelve and a half percent (112.50%) of the 90th percentile for each peer group. This price is then reduced for each facility by the direct care spending floor adjustment, to set the final direct care per diem. This final direct care per diem will be case mix adjusted through the billing process as discussed in section 514.11.1.

The direct care spending floor adjustment is calculated as follows:

- The sum of the NF provider's direct care cost component calculated above is multiplied by the spending floor percentage to determine the direct care spending floor threshold.
- The direct care spending floor percentage is 80% of the direct care price for the facility.
- The direct care spending floor adjustment is calculated as the lesser of the normalized direct care cost per diem minus the direct care spending floor threshold, or zero.

2. Care Related: The care related component is comprised of the following departmental costcenters:

1. Director of Nursing
2. Supplies
3. Non-Prescription Drugs
4. Oxygen
5. Other Nursing
6. Therapy
7. Medical Records
8. Activities

The per diem care related cost for each NF is determined by dividing the facility's care related cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period, or 75% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed in this section below.

The price for the care related component is established by peer group. The care related per patient day allowable costs are arrayed from highest to lowest. The statewide care related prices are established at one hundred and twelve and a half percent (112.50%) of the 80th percentile for each peer group. This price is then reduced for each facility by the care related spending floor adjustment, to set the final care related per diem.

The care related spending floor adjustment is calculated as follows:

- The sum of the NF provider's care related cost component calculated above is multiplied by the spending floor percentage to determine the care related spending floor threshold.
- The care related spending floor percentage is 75% of the care related price for the facility.
- The care related spending floor adjustment is calculated as the lesser of the care related cost per

diem minus the care related spending floor threshold, or zero.

3. Operational: The operational component is comprised of the following departmental costcenters:

1. Dietary
2. Laundry and Housekeeping
3. Administration
4. Maintenance

The per diem operational cost for each NF is determined by dividing the facility's operational cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period, or 85% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed in this section below.

The price for the operational component is established by peer group. The operational per patient day allowable costs are arrayed from highest to lowest. The statewide operational prices are established at one hundred and five percent (105.00%) of the 75th percentile for each peer group. This price is then reduced for each facility by the operational spending floor adjustment, to set the final operational per diem.

The operational spending floor adjustment is calculated as follows:

- The sum of the NF provider's operational cost component calculated above is multiplied bythe spending floor percentage to determine the operational spending floor threshold.
- The operational spending floor percentage is 75% of the operational price for the facility.
- The operational spending floor adjustment is calculated as the lesser of the operational cost per diem minus the operational spending floor threshold, or zero.

4. Pass-Through: The pass-through services component is comprised of the following departmental costcenters:

1. Utilities
2. Taxes and Insurance

The per diem pass-through cost for each NF is determined by dividing the facility's pass-through cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period, or 85% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base

year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed in this section below.

From October 1, 2024 until the next rebase which incorporates cost reports with a year end in calendar year 2025, or later, an additional $4.21 will be included in the pass-through per diem for each provider.

5. Liability Insurance: The per diem for liability insurance is determined for each NF by dividing the facility's liability insurance cost from the base year cost reporting period by the greater of the NF's actual total resident days during the cost reporting period, or 80% of the bed days available for the cost reporting period. For the October 1, 2024 rates, the December 31, 2022 base period costs shall be inflated using the Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit as of 2022 Q2 (inflation applied from Q2 2022 to Q1 2023). Each non-rebase July 1, these costs shall be trended forward from December 31, 2024 to the midpoint of the current state fiscal year. Beginning for rebase years and non-rebase years July 1, 2026 and after, these costs shall be trended forward from the midpoint of the NF provider's base year cost reporting period to the midpoint of the current state fiscal year using the inflation factor as discussed in this section below.

The cost standard CAP for the liability insurance component is established by bed group. The liability insurance per patient day allowable costs are arrayed from highest to lowest. One hundred and five percent (105.00%) of the 75th percentile for each bed group is then selected as the CAP or maximum rate. The cost standard then establishes the maximum allowable cost by bed group for the liability insurance component. For each facility the lesser of the facility-specific cost per diem or the CAP will be utilized for their final per diem.

6. Cost of Capital: On October 1, 2024 the SAV will be frozen from the values established on October 1, 2022. Inflation will be applied thereafter at each July 1 rate setting period, trended from midpoint of state-fiscal year 2025 to the midpoint of the current state-fiscal year using the inflation factor as discussed in the section below. The SAV determination from October 1, 2022 will follow the methodology as described in § 514.12.11.

Implementation of a new Cost of Capital methodology is not to occur prior to October 1, 2025.

7. Quality: Facilities are eligible for quality-based reimbursement via a per diem in the reimbursement rate. The total combined projected pool of dollars for quality shall start at $60,000,000. On an annual basis this pool shall be inflated using the most recently published Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit or a comparable index, if this index ceases to be produced. The inflation factor, once set for a given rate period, is not adjusted as it represents what is a reasonable expectation for cost increases. The inflation factor will be applied from the mid-point of the prior state fiscal year rate period, to the mid-point of the state fiscal year rate period. This annual pool of dollars will then be split between the Quality Scoring Metrics and the Special Populations as shown below, with scores and related per-diems updated semi-annually:

Effective Date	Percent of Quality/Special Populations Budget
Quality Scoring Metrics	90.00%
Special Populations	10.00%

a. Quality Measure Reimbursement: Quality outcome measures and associated measure cut points shall be established and contained in the policy document, “Quality Scoring Metrics and Special Population Determination”. These measures shall be weighted out of 100 total available points per facility per semi-annual rate period. Changes to the “Quality Scoring Metrics and Special Population Determination” document shall be determined by the State. These changes shall be published to the BMS website.

   Quality scores shall be calculated each semi-annual rate period using the most recently available source data information available for the quality measures calculated in accordance with the published policy document “Quality Scoring Metrics and Special Population Determination”.

b. Special Populations Reimbursement: The rate component is meant to offset additional costs associated with certain members with behavioral conditions as established and contained in the policy document, “Quality Scoring Metrics and Special Population Determination”. Changes to the “Quality Scoring Metrics and Special Population Determination” document shall be determined by the State. These changes shall be published to the BMS website.

   The rate component will be based on the most recently available semi-annual MDS assessment data prior to each semi-annual rate calculation and paid claims from the same time period.

   These payments will be calculated as follows:

   i. Quality Measure Reimbursement:
      1. The facility’s percentage of the projected annual payment pool
         a. Quality score adjusted Medicaid days / Total statewide quality adjusted Medicaid days
            i. Quality adjusted Medicaid days
               1. Facility’s semi-annual quality score / 100 points possible multiplied by Medicaid days
                  a. Medicaid days from the most recently reviewed cost report at the time of payment calculation or Medicaid days from the state MMIS data at the discretion of the State.
                  b. For new providers, should no days be available at the time of calculation, the Medicaid days shall be set at the statewide average occupancy percentage, as of the date of the calculation, of the available bed days for one calendar year.
      2. Multiplied by the total projected annual quality measures payment pool

   ii. Special Populations Reimbursement

1. The facility's allocation of the projected annual payment pool
    a. Semi-Annual Special Population adjusted Medicaid days / Total statewide Semi-Annual Special Population adjusted Medicaid days
        i. Special Population Adjusted Medicaid Days
            1. Number of Qualifying Medicaid Assessments / Total Statewide Number of Qualifying Medicaid Assessments from the same period multiplied by Medicaid days
                a. Medicaid days shall come from the most recently reviewed cost report at the time of payment calculation or Medicaid days from the state MMIS data at the discretion of the State.
                b. For new providers, should no days be available at the time of calculation, the Medicaid days shall be set at the statewide average occupancy percentage, as of the date of the calculation, of the available bed days for one calendar year.
            2. Multiplied by the total projected annual special populations payment pool

iii. Per Diem Determination: The total semi-annual quality per diem is calculated by summing the quality measure allocation, and the allocation of the special population's reimbursement. This amount will then be divided by total annualized Medicaid days from the most recently reviewed cost report available at the time of rate determination to set the semi-annual quality per diem.

8. Phase-in Adjustment: To aid in the transition of rate setting methodologies, a blended rate approach will be utilized to phase-in the new reimbursement rate from the estimated acuity adjusted prior system reimbursement rate. This phase-in will be in effect until June 30, 2027. The phase-in process will be calculated as follows:

a) A NF provider's base reimbursement rate under RUGs will be established as the October 1, 2023 imputed NF RUG reimbursement rate at the time of rate calculation. Projected provider reimbursement rates will be calculated using all applicable reimbursement provisions specified within this chapter as of October 1, 2023. These base rates will be inflated utilizing trended CPI IHS Market Basket from December 31, 2022 to June 30, 2024. Projected calculated rates will utilize Medicaid billed CMI information from January 1, 2023 through June 30, 2023 to impute an expected CMI adjusted prospective rate.
    i) Beginning with the October 1, 2024 rate period, a phase-in adjustment factor of 100.940% will be applied to each provider's base reimbursement rate. The final adjusted base rate will be the base rate, which will be inflated at the beginning of each current state fiscal year

utilizing the inflation factor as discussed in the section below from the midpoint of state fiscal year 2025 to the midpoint of the current state fiscal year until the phase-in expires.

b) The providers' current PDPM-based reimbursement rate will be determined according to the rate calculation procedures identified in this chapter as of October 1, 2024. Rate components considered include Direct Care, Care Related, Operational, Pass Through, Liability Insurance, Cost of Capital, and Quality. Projected calculated rates will utilize the most recent semi-annual period of Medicaid billed CMI information to impute an expected CMI adjusted prospective rate. If Medicaid billed PDPM CMI information is not available, the most recent semi-annual MDS assessment information will be utilized in its place. On January 1, 2025, January 1, 2026, and January 1, 2027, the projected rates for use in blending will utilize all the same components as October 1, 2024, July 1, 2025, and July 1, 2026, respectively, with the exception of the semi-annual update to the quality component.

c) The blended rate shall be calculated using the following percentages:

Rate Effective Date	Percentage of Base Reimbursement Rate	Percentage of Current PDPM-based Reimbursement Rate
October 1, 2024	75%	25%
January 1, 2025	75%	25%
July 1, 2025	50%	50%
January 1, 2026	50%	50%
July 1, 2026	25%	75%
January 1, 2027	25%	75%
July 1, 2027	0%	100%

d) Once the blended rate has been determined, the difference between the blended rate and the providers' current PDPM-based reimbursement rate shall be calculated. This difference shall be the phase-in blended adjustment, which shall be its own rate component.

10. Cost Adjustment: Reported facility costs are subject to review and analysis through document/ desk review process. Adjustments are made to exclude non-allowable costs

Monthly billing information for services rendered to nursing facility residents will include data derived directly from the computerized assessment instrument for each resident, which may be used to determine case mix scores for each resident and a composite score for the facility. These case mix scores will measure the relative intensity and service needs of the facility's residents and will comprise the basis for determining allowable adjustments to per diem staffing and nursing costs required to deliver the kind and amount of services needed.

11. Authoritative Guidance: West Virginia nursing facility costs are reported on the Financial and Statistical Report for Long-Term Care Facilities, which should be completed in accordance with generally accepted accounting principles (GAAP) and the accrual basis of accounting. The rules and regulations governing cost allowability for WV Medicaid Nursing Provider rate methodology are determined by the West Virginia Medicaid State Plan and the West Virginia Bureau for Medical Services (or BMS) Provider Manual, Chapter 514; where these are silent as to a situation, the Federal Medicare rules and regulations

provide guidance. If all are silent as to a situation, then the GAAP rules should be followed.

514.12.13 Capitalized Assets

Reported capitalized assets shall align with Medicare cost reporting principles, as described in CMS publication 15-1 §108, Guidelines for Capitalization of Historical Costs and Improvement Costs of Depreciable Assets.

514.12.14 Working Capital Interest

Working Capital Interest (WCI) is limited to short-term loans (term of one year or less) taken out to meet immediate needs of daily operations. To be allowable, there must be a genuine effort by the provider to repay these notes. If no evidence of repayment is apparent and if no justification can be made for nonpayment of the note and these notes are merely renewed throughout the year, the program will not consider these to be bona fide working capital notes and the interest incurred will not be allowed.

514.12.15 Vehicle Expenses

Allowable vehicles include the cost of ownership, as well as reimbursement for use of personal vehicles. Providers must maintain appropriate records and invoices related to vehicle related expenditures.

514.12.16 Allocated Costs

Hospital-based nursing facilities and nursing facilities associated with assisted living facilities or other related parties that use allocated costs must maintain detailed documentation to support any costs allocated on the cost report (either allocated to the facility or allocated among individual cost centers) and the allocation calculation(s) must be made available upon request for desk review or audit. All costs must show reasonableness and be comparable to other facilities in the industry.

Should direct identification of costs not be possible, allocation of costs is allowable. The standard allocation methodology utilizes resident days. Should a provider allocate on another basis, approval from the State must be given prior to the filing of the cost report, and the alternative methodology must be reasonable and accurate.

514.12.17 Home Office Costs

Certain home office costs may be included in the provider's cost report and considered for reimbursement as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain. The administrator or designee must prove the home office costs are related to patient care. The administrator or designee must maintain documentation to establish the benefit to patient care realized as a result of any home office costs included in the cost report. Please reference Section 514.12.12 Allowable Costs for Cost Centers for additional guidance. Management fees charged between related organizations are not allowable costs, and such fees must be reported as non-allowable on the provider's cost report. Any cost report received with related party management fees and home office costs will be rejected and returned to the facility for correction. Home office costs must be appropriately reported by individual line item on the home office schedules of the cost report and should

not be aggregated as management fees. Thus, allowable cost is limited to the lesser of:

1. Allowable costs properly allocated to the provider, and
2. The price for comparable services, facilities, or supplies that could be purchased elsewhere, taking into account the benefits of effective purchasing that would accrue to each member or provider because of aggregate purchasing on a chain wide basis.

Home office costs must be reported at cost and net of any inter-company profit, and the home office must be disclosed as a related party on the cost report. Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. Costs related to nonmedical enterprises are not considered allowable home office costs. All allocated central office costs are considered administrative in nature and, therefore, must comply with regulations governing allowable costs at individual facility locations.

Starting with its total costs, including those costs paid on behalf of providers (or components in the chain), the home office must delete all costs which are not specifically allowable in accordance with this manual.

Where the home office incurs costs for activities not related to patient care in the chain's participating providers, the allocation basis used must provide for the appropriate allocation of costs such as rent, administrative salaries, organization costs, and other general overhead costs which are attributable to nonresident care activities, as well as to patient care activities. All activities and functions in the home office must bear their allocable share of home office overhead and general administrative costs.

The basis for allocation of allowed costs among long-term care facilities should be patient days. However, another basis may be considered appropriate and more accurate. The home office must make written request, with its justification, to the State for approval of the change.

The written request must be received no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The State's approval of a home office request will be furnished to the home office in writing. Where the Medicare intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approved a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

514.12.18 Non-Reimbursed Prescription Costs

Prescription drugs are not allowable on the cost report and are not included in the per diem rate. See Section 514.6.2 Pharmacy Services and Section 514.7.3, Non-Prescription Items of this chapter and *Chapter 518, Pharmacy Services* for information regarding covered prescription drug services.

514.12.19 Transportation Services Costs

The cost of emergency and non-emergency ambulance services is not allowed on the cost report. However, the cost of the transportation contract between the nursing facility and the NEMT provider and the transportation provided by a vehicle owned by the facility, is included in the all-inclusive Medicaid rate

and is allowable on the cost report.

514.12.20 Compensation

Allowable compensation is compensation that is reasonable for services that are necessary, related to patient care and pertinent to the operation of the facility. The services must be performed and paid in full less any withholding required by law. The hours worked must be documented as well as the compensation received. This information must be reported to all appropriate State and Federal authorities for income tax, Social Security and unemployment compensation purposes.

“Reasonable” means that the compensation must be comparable for the same services provided by facilities in the bed group. The method used to calculate “reasonable” will be as follows: The ninetieth 90th percentile of the hourly wage of the employee classification for each bed group. No owners, operators, and relatives will be included in the calculation. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 2,080 hours per cost report period worked (1,040 hours for semi-annual cost report periods) in resident related duties and includes documented vacation and sick time.

Compensation must include the total benefits paid for the services rendered, i.e., fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to or for the benefit of those providing the services.

A bonus plan must be clearly established in writing and given to employees prior to the beginning of the cost reporting period. To be considered allowable, any bonuses (including performance-based bonuses) must be paid in accordance with the plan, accrued in the period earned, and be nondiscretionary, (i.e. payable to all eligible employee classifications as set forth in the written plan, including owners and related parties of owners,) so as not to be misconstrued as a discretionary distribution of excess earnings exclusively to owners and related parties of owners.

514.12.21 Administrators

No owners, operators or relatives will be included in the calculation. Full time is considered at least 2,080 documented hours (1,040 hours for semi-annual cost report periods) which include vacation and sick time, per cost reporting period for resident related duties. If the services are provided less than full time, the compensation must reflect this fact. Theadministrator cannot act as director of nursing.

514.12.22 Owners

Administrators/owners will be compensated for administrative duties performed. Where the costs of administrative services are allowed, additional services performed by the administrator who is also an owner are considered rendered primarily to protect their investment and are not allowed.

Owners that do not serve as administrators will be compensated for duties performed, excluding services rendered primarily to protect their investment. To be included on the cost report, the facility must be able to document that the services provided by the owner are not duplicated by other positions.

Compensation is not allowed for owners, operators or their relatives who claim to provide some

administrative or other function required to operate the facility, but who do not actually provide said service. Where functions claimed to be provided by owners, operators or their relatives are merely a duplication of services already provided by other employees or are functions which should reasonably be expected to be performed by other employees, such services are not reimbursable. For example: if a facility has a full-time administrator or other full-time or part-time staff position filled and compensated, the facility's owner, operator, or their relative claiming compensation for the same or similar functions are not allowed by the program.

514.12.23 Non-Allowable Costs

Non-allowable costs are those costs which are not related to patient care or for which a separate charge is made. This includes, but is not limited to, bad debts, charity and courtesy allowances, Medicare Part B chargeable items, personal resident property that has been reported as lost or stolen, flowers and retirement gifts for employees. Refer to the State Long-Term Care webpage MCOA for other non-allowable costs. Other items not referred to in the Chart of Accounts may be specified in State or Federal regulations as non-allowable costs. All undocumented expenses shall be considered non-allowable. Additional non-allowable costs include but are not limited to:

- Travel and associated expenses outside the State for conventions, meetings, trainings, assemblies, conferences or any related activities. However, the costs for training and educational purposes that are held out of the state for employees, may be allowable with proof of attendance.
- Automobiles used by central/home office personnel.
- Legal fees on failed appeals against the State.

514.12.24 Fines and Penalties

In an effort to contain costs, it is expected that providers will pay obligations on time as well as take advantage of any early payment discounts that are offered by vendors. Costs related to fines, penalties, late charges or any other cost increase imposed by vendors for not paying obligations in a timely manner are not allowed. Similarly, any financial penalties or cost increases resulting from violations of regulations or from non-fulfillment of stipulations are disallowed.

514.12.25 Damage Awards and Negotiated Settlements

Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the limits of the provider's policy, as well as the associated legal deductibles or legal costs is non-allowable.

514.12.26 Reorganization/Refinancing Costs

Organization and reorganization costs are the costs incurred in the creation or restructuring of an entity. These costs are considered to be non-allowable for cost reporting and reimbursement purposes.

514.12.27 Purchases from Related Companies or Organizations

All related companies or organizations involved in any business transactions with the facility must be

identified on the cost report. Detailed data must be available in the facility records which describe the kind and extent of such business transactions. Costs for purchase of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable services purchased elsewhere, whichever is less. The facility must maintain and make available, upon request for desk review or audit, detailed documentation that the related party purchase has been included in the cost report at the related party's cost and any calculations to demonstrate that any inter-company profit that would have passed to the related party from the transaction has been eliminated in the cost report preparation.

514.12.28 Filing Reports – Requests for Assistance

Financial and statistical reports and questions regarding cost reporting are to be addressed to the State as communicated prior to the filing deadline.

514.12.29 Minimum Occupancy Standard

For rate periods through September 30, 2024, cost adjustments will be made by applying a minimum occupancy standard of 90% to all cost centers. Actual facility occupancy is used to determine allowable costs per patient day if equal to or greater than 90%. However, if the actual occupancy level is less than 90%, the per patient day, allowable cost will be adjusted to assume a 90% occupancy level.

Beginning October 1, 2024, minimum occupancy shall be applied as described in the PDPM Rate Methodology section of this provider manual.

514.12.30 Efficiency Incentive

For rate periods through September 30, 2024 an efficiency incentive will be allowed where the standard services area allowable costs are less than thetotal of the cost standard. The 50% of the difference between the total allowable cost and the total cost standard will be applied to the prospective rate for the standard services area. The total of the calculatedefficiency incentive may not exceed $2.00 per patient day.
A facility qualifying for efficiency incentive shall not have any deficiencies related to standard services or substandard care, quality of life, and/or quality of care, during the reporting period. Statements of deficiencies generated by OHFLAC for non-compliance found during licensure inspections and/or certification surveys are reviewed to determine compliance with licensure, certification and agency standards.

If it has been determined that a facility has significant deficiencies (defined as one or more deficiencies cited at a severity level of actual harm or immediate jeopardy and/or constituting substandard quality of care on the survey and licensure agency reports), the facility may be denied efficiency incentive for that period. When an audit adjustment results in a change in the allowable costs in the standard services component, no increase or decrease in the efficiency incentive will be made.

Effective October 1, 2024, this section shall no longer be applicable to provider reimbursement.

514.12.31 Inflation Factor

For rate periods through September 30, 2024, after combining the various components, a factor is assigned to costs as a projection of inflation during the next rate-setting cycle. The amount of change in the Consumer Price Index (CPI) experienced duringthe six-month reporting period becomes the inflation factor applied to the next six-month period. The inflation factor, once set for a given rate period, is not adjusted as it represents what is a reasonable expectation for cost increases.

Regulatory costs, such as minimum wage increases, tax changes, Federal Insurance Contributions Act (FICA) increase, Worker's Compensation changes, etc., will be considered an inclusive component of the inflation factor.

For rate periods beginning on or after October 1, 2024, the allowable rate component costs have an inflation factor applied to project costs for the forthcoming rate setting period. The annual inflation factor is applied each July 1 and shall be established for the most recently published Skilled Nursing Facility without Capital Market Basket Index published by IHS Markit or a comparable index, if this index ceases to be produced. The inflation factor, once set for a given rate period, is not adjusted as it represents what is a reasonable expectation for cost increases. The inflation factor will be applied as described in each rate component methodology section.

514.12.32 Audits

The OAMR staff may perform a desk audit of cost reports prior to rate setting and will conduct on-site audits of facility records periodically.

- **Desk Audit:** Financial and statistical reports submitted by the participating facilities will be subjected to a desk review and analysis for rate setting within 60 days of receipt. Incomplete and inaccurate cost reports are not accepted.
- **Field Audit:** Periodic on-site audits of the financial and statistical records of participating facilities will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report and all data to support payroll and census reports. These records must be maintained at the facility or be made available at the facility for review by OAMR staff (or their representatives) for audit purposes upon notice. Records found to be incomplete or missing at the time of the scheduled onsite visit must be delivered to the OAMR within 48 hours or an amount of time agreed upon with audit staff at the exit conference. Costs found to be unsubstantiated will be disallowed and considered as an overpayment.
- **Record Retention:** Audit reports will be maintained by the OAMR for five years following date of completion.
- **Credits and Adjustments:** The State will account for the return of the federal portion of all overpayments to the CMS in accordance with the applicable federal laws and regulations.

514.13 NURSE AIDE TRAINING AND REIMBURSEMENT

In accordance with 42 CFR 483.154 (c)(3), reimbursement is available for nursing facilities that are eligible and approved by OHFLAC to conduct nurse aide training classes in their facility. The educational costs for nurse aide training may be reimbursed to the facility where the training and evaluation was held at a maximum of $400 for training and $100 for competency evaluation to equal $500. Reimbursement is only available to the nursing facility after the individual has successfully passed the complete competency

evaluation and the training nursing facility verifies the nurse aide has been hired as a nurse aide either at the training facility or another nursing facility. The documentation of employment must be attached to the reimbursement form (see Appendix C, Invoice for Reimbursement of Nurse Aide Training and Competency Evaluation) and it must consist of a letter from the administrator at the hiring nursing facility stating the individual has been hired as a nurse aide, along with dates of hire. This reimbursement is only available for an individual nurse aide once in a lifetime.

514.14 HOW TO OBTAIN INFORMATION

For Nursing Facility Services program contact information, please refer to the Long-Term Care Program website.

514.15 NURSING FACILITY FORMS

Additional information on the forms required for Nursing Facility services is found in the following Appendices:

- Appendix A: Agreement for Nursing Facility Participation in the Title XIX Medicaid Program
- Appendix B: Pre-Admission Screening (PAS) 2000
- Appendix C: Invoice for Reimbursement of Nurse Aide Training and Competency Evaluation

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Administrator: A person licensed by the West Virginia Nursing Home Administrators Licensing Board as a “Nursing Home Administrator” who is responsible and accountable for the day-to-day operations of the nursing facility.

Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resultingphysical harm, pain, or mental anguish.

Ancillary Service: A required service necessary to support the primary activities of the nursing facility to meet the resident’s needs. However, these services are not included in the per diem rate.

Base Period Cost Report: A cost report that is six months or longer which is utilized for setting statewide prices and overall reimbursement rates.

Base Reimbursement Rate: The rate set under reimbursement methodology prior to October 1, 2024.

Capacity: The ability to comprehend and retain information which is material to a decision, especially asto the likely consequences; the person can use the information and weigh it in the balance as part of the process of arriving at a decision and is able to communicate the decision in an unambiguous manner.

Case Mix Reimbursement System: A payment system that measures the intensity of care and services required for each resident. This translates into the amount of reimbursement given to the facility for care

provided to each resident.

Care Area Assessment (CAA): A problem-oriented framework for organizing MDS information and additional clinically relevant information about an individual's health problems or functional status.

Care Plan: A document based on a comprehensive assessment prepared by the interdisciplinary team in the nursing facility. This is coordinated with the resident/representative and identifies measurable objectives for attaining the highest level of physical, mental and psychosocial functioning.

Certificate of Need (CON): A process often associated with cost containment measures. Additionally, the Legislative findings in the CON law declare the need for health services to be provided in an orderly, economical manner that discourages unnecessary duplication. The CON is to be submitted to the Health Care Authority. West Virginia issues a CON to indicate a health service's compliance with W.Va. Code §16-2D-1 *et seq.*

Change of Ownership: Any transaction that results in change of control over the capital assets of a nursing facility including, but not limited to, a conditional sale, a sale, a lease or a transfer of title or controlling stock. The two most common types of change of ownership are asset purchase and stock transfer.

Civil Monetary Penalty (CMP): A punitive fine imposed on a nursing facility when the nursing facility has demonstrated deficient practices.

Cost Average Point (CAP): A calculation used in the reimbursement methodology for establishing rates in nursing facilities.

Cost Report: The instrument used in the reimbursement system for nursing facilities with rebasing rate adjustments. It is designed to treat all parties fairly and equitably, i.e., the resident, taxpayer, agency and facility. In order to be equitable, complete and accurate, cost data must be maintained by each facilitywith cost reports accurately prepared and submitted on a timely basis and in an approved format.

Deficiency: An entry on the federally mandated form provided by the State survey agency, the OHFLAC, which describes the specific requirements of the regulations with which the nursing facility failed to comply, an explicit statement that the requirement was not met, and the evidence to support the determination of noncompliance.

Denial of Payment for New Admissions (DPNA): The denial of Medicaid payment for new admissions when the nursing facility no longer meets the standards of facility certification.

Direct-Access Personnel: An individual who has direct access by virtue of ownership, employment, engagement or agreement with a covered provider or covered contractor. Direct access personnel do not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations or similar services for the covered provider.

Discharge: The termination of a resident's affiliation with the nursing facility, achieved through the permanent move of a resident to another facility or setting that operates independently from the nursing facility.

Discharge Planning: The organized process of identifying the approximate length of stay and the criteria for exit of a resident from the current service to an appropriate setting to meet the individual's needs. Discharge planning begins upon the day of admission to the nursing facility and includes provision for appropriate follow-up services.

Dually Certified Facility: A facility which is certified to participate in both the Medicare and Medicaidprograms.

Facility Certification: The official designation by the State, based on recommendation from the OHFLAC,that the nursing facility meets Medicaid standards and regulations.

Governing Body: The person or group of persons with the ultimate responsibility and authority for the operation of the nursing facility.

Health Care Authority (HCA): An organization which administers programs that help contain the rising cost of health care and assure reasonable access to necessary health care services. The HCA assures public access to the information compiled under the Rural Health Systems program, the Planning Division, and Certificate of Need program**.**

Immediate Jeopardy (IJ): A situation in which the nursing facility's noncompliance with one or more certification requirements has caused, or is likely to cause, serious injury, harm, impairment or death of a resident.

Interdisciplinary Team (IDT): A group of professionals, paraprofessionals, non-professionals and the resident who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the resident's needs and who design specialized programs responsive to the needs of the resident which are to be documented in the care plan.

Licensed Nursing Home: Any institution, residence, place or any part or unit thereof, licensed in accordance with the requirements specified in W. Va. 16-5c et al, in which an accommodation of four or more beds is maintained for the purpose of providing accommodations and care for a period of more than twenty-four hours, to persons who are ill or otherwise incapacitated and in need of extensive, ongoing nursing care due to physical or mental impairment, or provides services for the rehabilitation of persons who are convalescing from illness or incapacitation.

Minimum Data Set (MDS): A core set of screening, clinical, and functional status elements completed by an IDT of which the resident is the principal member. It also includes common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid.

Misappropriation of Property: The deliberate misplacement, exploitation, or wrongful misuse of a resident's belongings or money.

Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, ormental illness.

Non-Acuity Adjusted Reimbursement Rate: All current rate components, including Direct Care, Care

Related, Operational, Pass Through, Liability Insurance, Cost of Capital, Quality, and Phase-In Adjustment. No acuity adjustment is applied to this total rate for leave payment purposes.

Nursing Facility Cost Report Period Case Mix Index: The calendar day weighted average of all applicable all-payer case mix indices, carried to four (4) decimal places. The case mix index periods used in this weighted average will be the calendar day weighted assessments for the active cost reporting year.

Patient Driven Payment Model (PDPM) Resident Classification System: The resource utilization group used to classify residents. The nursing-only weights PDPM Grouper, or its successor, will be utilized for rate determination purposes beginning October 1, 2024.

Patient Resource (or Resident Resource) Amount: The amount calculated by the State that represents the portion of a resident's income, as determined by the State, which the resident must remit directly to the nursing facility each month as the contribution to the cost of care. Medicaid's monthly payment to the nursing facility is reduced by this amount.

Per-diem Normalized Direct Care Cost: The outcome of removing cost variations associated with case mix. Normalized cost is determined by dividing a provider's inflated per diem direct care case mix adjusted costs by its cost report period average case mix index (CMI).

Personal Needs Allowance: The amount deducted from the member's monthly income which allows for personal needs of the nursing facility member.

Pre-Admission Screen (PAS): The preliminary screen conducted on all persons seeking admission to a nursing facility in order to identify persons with major mental illness or developmental disability**.**

RAI Manual: Long-Term Care Facility Resident Assessment Instrument User's Manual.

Rebase: The process of reestablishing cost component prices, caps, and reimbursement rates by incorporating the most recently audited or reviewed qualifying cost reports.

Representative: The spokesperson acting in the best interest of the resident. Representatives may be designated by the residents themselves, court appointed, or physician appointed, in accordance with state law.

Resident: Any individual residing in a nursing facility, skilled nursing facility, or dually certified skillednursing facility/nursing facility. For the purpose of Medicaid reimbursement only, the resident may beidentified as a member of the Medicaid program.

Resident Council: A group of residents residing in the nursing facility having the right to meet to express grievances in relation to the residents' general well-being and to make recommendations concerning nursing facility policies and procedures.

Substantial Compliance: A level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

The State: The West Virginia Department of Health and Human Resources, Bureau for Medical Services

REFERENCES

The West Virginia State Plan references nursing facilities in the following sections:

- 3.1-A 24(d) Nursing Facility Services for Patients Under 21 Years of Age
- 4.19 D Methods and Standards for Determining Payment Rates for State-owned Long-Term Care Facilities (SNF, ICF, and ICF/MR Facilities)
- 4.19 D-1 Methods and Standards for Determining Payment Rates for non-State-Owned Nursing Facilities - Excludes State-Owned Facilities
- Enforcement of Compliance for Nursing Facilities
- Nurse Aide Training and Competency Evaluation for Nursing Facilities
- Preadmission Screening and Annual Resident Review in Nursing Facilities
- 4.41 Resident Assessment for Nursing Facilities

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Nursing Facility Services	July 1, 2020
Entire Chapter	Changes were made throughout to address the transition of the historical West Virginia-specific nursing facility acuity-based reimbursement system to one based on the Patient-Driven Payment Model (PDPM). Changes also include updates to other rate components and their methodology, and the addition of a quality-based component.	October 1, 2024