

H E A L T H M A N A G E M E N T A S S O C I A T E S

**Enhanced Medicaid Nursing Facility Reimbursement
for
Ventilator-Dependent Individuals in Florida**

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Executive Summary

The Department of Health (DOH), Bureau of Emergency Medical Services (EMS) has identified a need for a statewide coordinated care system for individuals who are ventilator-dependent and are transferred from state approved trauma centers to designated skilled nursing facilities (NFs). The Bureau of Emergency Medical Services, the Brain and Spinal Cord Injury Program (BSCIP – also located within the DOH) and the Agency for Health Care Administration (AHCA) have each received requests for assistance in locating NFs willing to accept individuals who are ventilator-dependent and ready for discharge from a hospital or trauma center. In these instances, agency staff has experienced difficulty in locating any NFs willing and/or able to provide the necessary care. In addition, the DOH/EMS has received contacts from numerous trauma centers regarding concerns that individuals on ventilators discharged to NFs were returning to hospitals with serious medical problems including stage IV decubiti (pressure ulcers/skin breakdown with infection and damage to bones, muscles, tendons, or joint capsules) and respiratory infections. Trauma centers reported a number of instances where individuals who are ventilator-dependent have remained hospitalized for years because of an inability to locate a suitable and willing NF to provide services. Moving ventilator-dependent individuals to NFs that specialize in caring for ventilator-dependent patients would improve the individual's quality of life and potentially result in long-term cost savings to the Medicaid program.

Approach

As part of the effort to address the special needs of ventilator-dependent individuals, the DOH gathered professionals with expertise in the care of individuals who are ventilator-dependant and formed a task force to develop standards of care designed to facilitate optimal outcomes for these individuals, including whenever possible, weaning from a ventilator. The DOH envisioned a two-pronged strategy to address the existing need:

- The development and implementation of enhanced payment for Medicaid patients residing in NFs who are ventilator-dependent, and
- The development of standards of care designed to optimize patient outcomes when NFs provide ventilator care.

In addition, the DOH anticipated designation of a select group of NFs that would meet the standards of care and be eligible for an enhanced payment. The DOH contracted with Health Management Associates (HMA) to research and develop viable options to seek increased funding for nursing facilities (NFs) that would be eligible for a special payment to provide care to individuals who are ventilator-dependent and to assist DOH in understanding the best use for the standards to be developed by the task force.

Support for the Project

The DOH has received twenty letters of endorsement from the state's twenty trauma centers and three letters of endorsement from general hospitals expressing the need for both the development of standards of care for individuals who are ventilator-dependent and for an enhanced payment to NFs providing care for these individuals. The AHCA supports the development of a ventilator supplemental payment for NFs, and developed legislative budget requests for submission to the Florida legislature in 1999 and 2001 seeking a specific appropriation to implement an enhanced rate.

Provider groups (FAHA, FHCA and the FHA) expressed support for some form of enhanced reimbursement for NFs serving individuals who are ventilator-dependent, and for requiring that participating NFs meet specific standards in order to be eligible to receive this rate.

Recommendations

Payment

- HMA recommends the use of a supplemental payment for NFs providing care to Medicaid recipients who are ventilator-dependent.

Supplemental payments permit a state to provide additional funding to a provider without having to revise the existing cost-based reimbursement methodology, a process that is generally complex and subject to various pitfalls including legal challenges by providers. In addition, supplemental payments may be paid to a NF even if the NF's per diem rate is limited by existing ceilings. Finally, supplemental payments are relatively easy to implement and administer and are already utilized for two other groups of individuals residing in NFs (individuals with AIDS and medically fragile children). No major revision of the current NF reimbursement plan is required. Only a new Medicaid billing code for a supplemental payment is required. The amount of the supplemental payment must be both sufficient to ensure that NFs can provide the necessary care and must also be cost-effective. The determination of what constitutes an adequate and cost-effective rate must be determined by the State of Florida.

Standards

The DOH believes that a supplemental payment for individuals who are ventilator-dependent should be tied to some specific care standards designed to prevent the types of medical problems currently being reported when these individuals are being readmitted to hospitals from NFs. However, standards must be realistic and readily enforceable if they are to be meaningful.

- HMA recommends that standards for program participation be comprised of a minimum set of basic requirements encompassing staffing levels, staff

knowledge, ongoing training, admission and discharge policies, and access to other services (including specialty care and ancillary services).

Medical Necessity

States have broad discretion in setting requirements for Medicaid services based on objective measures of medical need or “medical necessity”. At the same time, states cannot set limits on a service by requiring that an individual have a certain condition or diagnosis that has no direct relationship to the service being requested or provided. Because a supplemental payment proposed under this project is designed to support significantly increased costs that NF providers incur to meet the needs of individuals who are ventilator-dependent above the costs already covered by Medicaid, medical necessity requirements should be designed to identify those individuals for whom a provider will actually incur significantly higher costs than covered by the NF’s per diem payment. Florida should exercise its authority to set medical necessity criteria in order to ensure that precious public funds are utilized cost-effectively.

- HMA recommends that Florida consider limiting a supplemental payment to individuals who are dependent on a ventilator at least 6 hours a day and who do not rely solely on a CPAP or BiPAP for respiratory support.

Provider Participation

- Finally, HMA recommends that AHCA restrict participation to providers using a formal procurement process.

If the state wishes to limit the number of providers who could participate, procurement would be based on the ability of the state to secure a Medicaid waiver from the federal government. The ability to limit participation to a specified number of NFs will contribute to a number of desired outcomes including:

- ❑ The ability to ensure the uniform and coordinated delivery of specialized services;
- ❑ The ability of NFs to provide care to a sufficient number of ventilator-dependent individuals to achieve economies of scale and acquire the expertise and staff necessary to provide quality care;
- ❑ The opportunity to provide enhanced quality of life for individuals who are ventilator-dependent, including opportunities to develop social connections with other individuals within a NF with similar needs; and
- ❑ The ability to strengthen opportunities to move ventilator-dependent individuals or individuals who have been successfully weaned from ventilators from the NF to a community setting.

Project Background

The Department of Health (DOH), Bureau of Emergency Medical Services (EMS) has identified a need for a statewide coordinated care system for individuals who are ventilator-dependent and are transferred from state approved trauma centers to designated skilled nursing facilities (NFs). The Bureau of Emergency Medical Services, the Brain and Spinal Cord Injury Program (BSCIP – also located within the DOH) and the Agency for Health Care Administration (AHCA) have each received requests for assistance in locating NFs willing to accept individuals who are ventilator-dependent and ready for discharge from a hospital or trauma center. In these instances, agency staff have experienced difficulty in locating any NFs willing and/or able to provide the necessary care. In addition, the DOH/EMS has received contacts from numerous trauma centers regarding concerns that individuals on ventilators discharged to NFs were returning to hospitals with serious medical problems including stage IV decubiti (pressure ulcers/skin breakdown with infection and damage to bones, muscles, tendons, or joint capsules) and respiratory infections. In addition, trauma centers reported a number of instances where individuals who are ventilator-dependent have remained hospitalized for years because of an inability to locate a suitable and willing NF to provide services. It is probable that moving individuals to NFs that specialize in caring for ventilator-dependent patients would improve the individual's quality of life and potentially result in long-term cost savings to the Medicaid program.

As part of the effort to address the special needs of ventilator-dependent individuals, the DOH gathered professionals with expertise in the care of individuals who are ventilator-dependant and formed a task force to develop standards of care designed to facilitate optimal outcomes for these individuals, including whenever possible, weaning from a ventilator. In addition, the DOH identified a need to analyze the existing Medicaid payment structure and the potential for some form of enhanced payment to NFs providing care to these individuals, in order to enable NFs to realistically provide the additional hours of care and the provision of enhanced supplies that are required to ensure the best possible patient outcomes.

The DOH envisioned a two-pronged strategy to address the existing need:

- The development and implementation of enhanced payment for Medicaid patients residing in NFs who are ventilator-dependent, and
- The development of standards of care designed to optimize patient outcomes when NFs provide ventilator care.

In addition, the DOH anticipated designation of a select group of NFs that would meet the standards of care and be eligible for an enhanced payment.

The DOH contracted with Health Management Associates (HMA) to research and develop viable options to seek increased funding for nursing facilities (NFs) that would be eligible for a special payment to provide care to individuals who are ventilator-dependent and to assist DOH in understanding the best use for the standards to be developed by the task force.

In order to understand the existing system of NF care for individuals who are ventilator-dependent, develop an appropriate reimbursement methodology, and garner broad support for this methodology, HMA:

- Conducted telephone interviews and/or meetings with key stakeholders including the Bureau of EMS, the BSCIP and the AHCA (and the Bureaus of Health Systems Development and Health Quality Assurance including the Office of Plans and Construction, within AHCA), the Florida Health Care Association (FHCA), the Florida Association of Homes for the Aging (FAHA), and the Florida Hospital Association (FHA);
- Analyzed federal and state laws and regulations concerning nursing home reimbursement;
- Conducted telephone interviews with staff from four states currently providing enhanced payments to NF through the Medicaid program for individuals who are ventilator-dependent; and
- Analyzed potentially relevant reimbursement methodologies and programs that can meet the desired objectives.

Support for the Project

The DOH has received twenty letters of endorsement from the state's twenty trauma centers and three letters of endorsement from general hospitals expressing the need for both the development of standards of care for individuals who are ventilator-dependent and for an enhanced payment to NFs providing care for these individuals. The AHCA supports the development of a ventilator supplemental payment for NFs, and developed legislative budget requests for submission to the Florida legislature in 1999 and 2001 seeking a specific appropriation to implement an enhanced rate.

Provider groups (FAHA, FHCA and the FHA) expressed support for some form of enhanced reimbursement for NFs serving individuals who are ventilator-dependent, and for requiring that participating NFs meet specific standards in order to be eligible to receive this rate. Standards that were mentioned as particularly important included access

to a ventilator-trained RN twenty-four hours a day, mandatory continuing education for nurses and respiratory therapists, and admission standards that require that an individual be medically stable, but do not preclude NF admissions if the individual has a chronic infection or condition. Each of these provider groups stated they are aware that the number of nursing homes willing to serve individuals on ventilators is declining and that a special program to support enhanced payment for ventilator care is needed. The FHA expressed concern, however, regarding the lack of reimbursement available to hospitals to cover the cost of care for ventilator-dependent individuals who have exhausted the 45 days of Medicaid coverage and for whom no NF placement (or alternative placement) is available. One trauma center reported they have been providing care to a ventilator-dependent individual for over two years as a result of a lack of suitable and available NF placements.

In the past, the AHCA has encouraged hospitals to develop transfer agreements with NF that include payment arrangements. Under this arrangement, the hospital pays the NF a negotiated per diem payment that is less than the costs the hospital would have incurred had they continued to care for the individual in the hospital setting. However, while this approach may mitigate uncompensated care costs, it does not address the hospital's concern regarding an overall accumulation of uncompensated care costs. The State of Illinois has addressed this concern by permitting the Illinois Medicaid program to authorize payment to a hospital in which a ventilator-dependent patient is receiving services at a rate not to exceed the average statewide long-term care provider (i.e. nursing facility) per diem Exceptional Care (EC)¹ Program rate, in the event a suitable NF or other non-hospital placement cannot be located.

HMA discussed two different approaches to making an enhanced rate available to NFs with the provider groups. The first approach would permit any willing provider who meets a set of specified requirements to be eligible for the enhanced rate. The second approach limits eligibility for the enhanced rate to a specified group of NFs. Concerns regarding these options are discussed in the section entitled "Recommendations".

¹ The Illinois Exceptional Care (EC) Program provides for enhanced payment for NF care provided to individuals with exceptional care needs, including individuals who are ventilator-dependent.

Florida Nursing Facility Services Background

The Florida Agency for Health Care Administration (AHCA), Medicaid program reimburses for nursing facility (NF) services for individuals who are determined to meet nursing facility level of care (LOC) requirements² based on a determination by staff of the Department of Elder Affairs (DOEA). The DOEA Comprehensive Assessment, Review, and Evaluation Services (CARES) team makes a determination regarding whether an individual over the age of 21 meets NF LOC requirements. For individuals under the age of 21, this determination is made by the Department of Health (DOH), Children's Medical Services (CMS), Children's Multidisciplinary Assessment Team (CMAT).

Determinations regarding NF LOC are conducted for individuals seeking NF services or seeking alternatives to NF services, primarily enrollment in a Home and Community-Based Services (HCBS) waiver. The DOEA CARES team currently conducts LOC determinations for:

- The NF Program;
- The Aged/Disabled Adult Waiver Program;
- The Assisted Living for the Elderly Waiver Program;
- The Adult Cystic Fibrosis Waiver Program;
- The Channeling Waiver Program;
- The Nursing Home Diversion Waiver Program;
- The Project AIDS Care Waiver Program; and
- The Traumatic Brain Injury/Spinal Cord Injury Waiver Program.

The NF LOC assessment is conducted by either a CARES nurse or social worker, with medical review by a physician prior to approval. Objectives of the CARES program include the following:

- Prevention of unnecessary or premature admission to a nursing home;
- More effective coordination of an individual's medical, social and psychological needs and resulting level of care;
- Referral and assistance in obtaining in-home and community services to avoid nursing home care; and
- Education of the public, particularly health-care providers, about less costly alternatives to long-term care.

² Individuals must also meet Medicaid financial eligibility requirements, as determined by the Office of Economic Self Sufficiency (Department of Children and Families).

In order for an individual to be authorized for admission to a NF, they must meet NF LOC requirements. In Florida, there are currently three levels of care for NF services – Intermediate I and II, and Skilled.

All NF services must be ordered by and remain under the supervision of a physician. Intermediate NF services are indicated for individuals who require nursing management, periodic assessment, planning or intervention by a licensed nurse or other health professional on a daily or intermittent basis. Intermediate I services are indicated for individuals who require extensive health related care and service and who are incapacitated physically or mentally. Examples of Intermediate I services include the administration of routine medications, oral suctioning, incontinence care, bowel and bladder training, and assistance or supervision with dressing, eating and toileting. Intermediate II services are indicated for individuals who require limited health related care and service and who are mildly incapacitated or ill to a degree to require medical supervision. Individuals must be:

- ❑ Ambulatory (with or without assistive devices),
- ❑ Independent in activities of daily living (ADLs) and not require administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision.

Skilled nursing facility services are indicated for individuals who require nursing supervision, assessment, planning or intervention by a registered nurse (RN) on a daily basis, medical services or rehabilitation services (and in the case of rehabilitation services, services provided by a PT, OT or RT at least 5 days a week).³ Examples of skilled services include the administration of intravenous medication, colostomy care, rehabilitation care following surgery, and ventilator care. Individuals who are ventilator-dependent, who require either continuous or intermittent use of a ventilator and/or are engaged in a ventilator weaning program, would receive skilled nursing facility services.

According to the AHCA, Florida had 670 licensed nursing homes in 2001 with 81,218 beds. Of these 670 licensed nursing homes, 642 provided care to Medicaid recipients.⁴ Thirty-five NFs in Florida reported serving one or more individuals who were ventilator-dependent during 2002.⁵ The actual number of individuals residing in Florida NFs who are ventilator-dependent is not currently collected by the AHCA.

³ Intermediate I and II requirements are described more fully in Florida Administrative Code (F.A.C.) Section 59G-4.180, and skilled services in F.A.C. Section 59G-4.290. The F.A.C. is available online at: <http://fac.dos.state.fl.us/>

⁴ From: Presentation to the Senate Appropriations Subcommittee on Health and Human Services, January 15, 2003 by Bob Sharpe, Deputy Director of AHCA. Available online at: http://www.fdhc.state.fl.us/Medicaid/deputy_secretary/recent_presentations/long%20term_care_system_011503.pdf

⁵ Information from the AHCA State Center for Health Statistics – special data run.

Florida Medicaid Reimbursement of Nursing Facility Services

The Florida Medicaid program pays nursing facilities (NFs) on the basis of facility-specific rates. These rates are established bi-annually and are based on each NF's costs from the prior year multiplied by an inflation factor. This type of reimbursement is "cost-based reimbursement" because the rate is derived from the facility's cost to provide the agreed upon services. The NF reimbursement (per diem) rate is determined every January 1 and July 1 based on cost reports received by September 30 and March 31, respectively. The AHCA sets limits on what a facility can claim as a legitimate cost and places a ceiling (or limit) on these legitimate costs. The specific requirements for reimbursement of NF services provided to Medicaid recipients are contained in a written reimbursement plan, authorized by the Florida legislature and approved by the federal Centers for Medicare and Medicaid Services (CMS).

For the purposes of reimbursement, nursing facilities are divided into one of six classes, based upon size (1-100 beds, or 100+ beds) and location (North, South, or Central) of the facility within the state. These classes have different ceilings (limits) on reimbursement because:

- Regional variations in cost of living impact the cost of providing NF services; and
- The size of a facility also impacts costs. For example, all facilities are required to employ or retain the services of a Director of Nursing and a Medical Director. In a larger facility, the cost for these positions is spread among more residents.

The Medicaid reimbursement plan for NFs classifies a NF's costs as being comprised of four components: operating costs (i.e. administrative, maintenance, laundry, housekeeping costs, etc.), direct patient care costs (i.e. the salaries of nurses, nurses aides, physical therapists, etc.), indirect patient care costs (i.e. dietary services, nursing supervision, medical records, etc.) and property costs. Each of these cost components is subject to a reimbursement ceiling that limits the maximum amount a NF provider can receive for the component, regardless of the actual legitimate costs. In addition, there is a class-specific ceiling and a provider-specific ceiling for costs. In short, cost-based reimbursement for NFs is quite complex. (Some states use even more complex reimbursement methodologies for NFs based on diagnosis or complexity of care, called case mix adjusted reimbursement. In these states, reimbursement varies not only by facility but potentially by each resident within the facility).

Florida presently provides a supplemental payment to NFs caring for individuals with AIDS and "medically fragile" patients under the age of 21, and provided a special payment for individuals on ventilators for two years (1985 and 1986). Florida implemented a special payment for NFs serving individuals with AIDS or on ventilators in 1985, revised the payment to a flat rate (a specified supplemental payment) in 1986 but also froze participation specific to individuals dependent on ventilators in 1986 to the

existing ventilator patients. By 1987, the special payment for ventilator patients in NFs was ended, although payments for individuals with AIDS continued. In 1990, the “Medically Fragile under 21 Years of Age” payment was established.

The payment for medically fragile children is limited to children who require an intense level of nursing supervision on a continual basis. Many such children are ventilator or technology-dependent. This supplemental payment is an additional dollar amount above the established per diem rate for the facility and is provided to compensate the NF for the additional costs incurred to provide extra staffing and/or supplies.

The existing supplemental payments must be prior-authorized by the AHCA, Medicaid program. In addition, children who may be eligible for the medically fragile supplemental payment must be assessed and determined to meet the medically fragile criteria by the CMAT.

Due to various quality of care concerns, the Florida legislature has made several changes to NF reimbursement during the last three years, including increased reimbursement to support the cost of meeting increased staffing requirements.⁶ In 1999, the legislature added a case mix add-on to permit increased payment to NFs caring for individuals with more complex medical needs, but subsequently eliminated this adjustor in 2001. In 2000, the legislature authorized an adjustment to the direct care component of NF reimbursement plan permitting increased reimbursement for nursing costs.

Nursing Facility Requirements Related to Supplemental Payments

Nursing facilities are required, as a condition of licensure, to be able to meet the needs of the individuals they agree to serve. At present, there are no facility-specific requirements that a NF must meet in order to receive the AIDS or medically fragile supplemental payment. However, all NFs are required to restrict admission to individuals whose needs they can meet. Therefore, facilities are expected to have the staff, supplies and specialized knowledge required to serve an individual with AIDS or a medically fragile child upon admission. A NFs ability to meet these needs is determined during the annual inspection conducted by AHCA or during an inspection conducted on the basis of a response to a complaint. The annual inspection includes a facility tour; interviews with residents, families, staff, visitors and volunteers; assessments of resident rights, protections and activities; and medical record reviews. If, during the annual inspection or during a complaint visit, AHCA determines that a facility cannot meet the needs of a specific individual, action is taken to remedy the situation or locate an alternate and appropriate NF placement for the individual. NFs that fail to meet the needs of the individuals they admit can face serious sanctions, up to and including loss of licensure and Medicaid certification. Some NFs will continue to decline to serve ventilator-

⁶ For example, legislation passed in 2001 requires an increase in the CNA minimum staffing from 1.7 CNAs per patient day to 2.3 ppd by January 1, 2002; 2.6 in January 2003 and to 2.9 by January 2004 and requires a daily posting of the staffing in each facility.

dependent individuals as a result of concerns that they will be unable to respond adequately to the special needs of these individuals, especially without the availability of enhanced funding.

Florida Experiences

The AHCA and the DOH report ongoing contact by individuals, families and case managers unable to locate a NF willing to provide care to individuals who are ventilator-dependent. A neurosurgeon in Jacksonville stated he has four or five ventilator-dependent individuals residing in the hospital because the hospital has been unable to locate a NF willing to admit them for care. The neurosurgeon expressed concern for the individuals' quality of life and noted that movement to a NF can offer opportunities for socialization not available in a hospital setting.

A case manager recently contacted the BSCIP regarding a Florida resident who has been ventilator-dependent for eighteen years as a result of a spinal cord injury. This individual had received care at home provided by his wife until two years ago, at which time he sought admission to a NF. His wife wanted to continue to provide care but was unable to continue to meet his needs and maintain her employment and income. In a period of two years, the individual has resided in five different nursing homes and at the time of the call to the BSCIP was residing in a VA facility. The most recent NF he resided in closed their ventilator unit and the VA facility does not provide long-term ventilator care. The BSCIP has received other calls from individuals in similar circumstances, and is presently providing a \$200 a day supplement to a NF in order to serve a ventilator-dependent BSCIP client who was unable to locate a NF willing to provide services at the standard rate.

The AHCA reported that a Florida resident was traveling through another state last year and was involved in a catastrophic car accident. He was severely injured and placed on a ventilator. The hospital was unable to wean him and unable to locate a nursing home or hospital in Florida willing to accept him for admission. The hospital reported that Florida providers stated this was a result of the current Medicaid reimbursement rates. The man remained in the out-of-state hospital for about six months until the AHCA, with assistance from a member of Congress, was able to locate an in-patient hospice willing to accept him. He passed away within days of returning to Florida. Most of the staff involved with his care felt that he was just hanging on long enough to see his family again. The AHCA reports that the inability to locate a NF willing to accept him for admission resulted in extreme anguish for the family (who were unable to travel to see him), high un-reimbursed costs for the treating hospital (which had to keep him in a trauma bed for several months), and unnecessary suffering for the patient.

A social worker at a Florida hospital shared the story of a woman who became a quadriplegic in the 1970s as a result of injuries sustained during an accident caused by a drunk driver. For more than twenty-five years, the woman was able to advocate on her

own behalf while residing in a NF and remain free of the complications commonly experienced by quadriplegics such as decubitus ulcers. Her family visited her daily. She reported satisfaction with the quality of her life, much of which was due to her positive outlook and family support. Last year, this woman suffered a medical incident that resulted in her becoming ventilator-dependent. When she was ready for discharge to a NF, not a single facility (NF, rehabilitation center or specialty hospital) could be located within the state of Florida that was willing to accept Medicaid reimbursement once Medicare would no longer provide coverage (which can be available for up to ninety days following discharge from the hospital). The social worker contacted at least twenty-three NFs (and possibly as many as thirty). The social worker reported that NFs stated they would not take an individual who had no potential to be weaned from the ventilator. One NF would provide care only if the hospital agreed to pay a supplement of \$190 daily as long as this woman remained on Medicaid and for the entirety of her life (given she continued to reside in the NF). Her family expressed a desire to care for her at home but did not have the resources to expand their home to accommodate the necessary equipment and complete other required modifications. In addition, home health agencies indicated they did not have the skilled staff available to provide the necessary coverage while the family was away from the home working.

Ultimately, the woman was placed in a NF in another state. She continues to have a very positive outlook, despite having to relocate far from her family. Her family members make periodic trips out-of-state to visit her but continue to be concerned for her well-being especially now that they are unable to continue their daily visits.

Selected States and Special Payments for Ventilator-Dependent Individuals Residing in Nursing Facilities

HMA obtained information from five states identified as providing enhanced Medicaid reimbursement for ventilator-dependent individuals residing in nursing facilities: Colorado, Illinois, Michigan, Oklahoma, and Wisconsin.

Colorado

Colorado pays each NF a per diem amount based on the facility's costs modified by a case mix adjustor.⁷ The case mix adjustor is designed to modify the payment based on the acuity (or "case mix") of the population the NF serves. The use of case mix adjustment provides the basis for the provision of higher per diem payments to facilities serving individuals with more complex conditions, including individuals who are ventilator-dependent. In addition, Colorado created a Quality Care Incentive Payment (QCIP) program in 1994, designed to provide financial incentives to NFs for delivering high quality care. These incentives are paid in two parts – one part that reflects the

⁷ Information obtained from "Report of the State Auditor – Nursing Facility Quality of Care", State of Colorado, September 2000.

outcomes of facility surveys, and one part that rewards NFs that develop resident-centered programs designed to enhance quality of life. The survey-related incentives are weighted so that facilities with the least deficiencies and the most Medicaid patient days receive the highest payments. In fiscal year 2000, Colorado paid \$4.4 million in QCIPs, of which \$1.3 million was for the survey portion and \$3.1 million was for the resident-centered programs. Colorado served 10,263 Medicaid residents in NFs in 2000. The QCIP program is currently under revision following recommendations by the state auditor that the requirements necessary to receive QCIPs be strengthened.

In 2002, Colorado produced a report entitled “Long-Term Care Best Practices: Moving Beyond Basics” profiling NF resident-centered programs recognized by the state in 2002. The report was sponsored by the Colorado Department of Public Health and Environmental Health, the Long Term Care Advisory Committee, the Colorado Association of Homes and Services for the Aging, the Colorado Health Care Association, the Colorado Medical Directors Association and the Colorado State Ombudsman. Westwind Village nursing facility was recognized for their ventilator-dependent unit, which has been in operation for over 10 years. The facility reports that their unit serves clients from all over Colorado and surrounding states and provides care to individuals with tracheostomies, ventilators, severe wound care needs, long-term infusion needs and other complex physical ailments. The unit is staffed with one nurse to four or five patients. In addition, respiratory therapy staff are available in-house 24 hours a day and provide assessment and safety checks every two hours. The unit has a high-tech low-pressure alarm system along with flow sheets and forms required for extensive care documentation. A team of professionals provides total body range of motion twice a day. Physical therapists, occupational therapists and speech pathologists assist with the process of weaning as well as motivating. The report continues:

“The unit has filled a need in our state and our community to provide quality care with a good amount of dignity to these clients. They are no longer bed numbers in hospital gowns staring at four walls and listening to alarms sounding. They are dressed in their normal attire; make-up, nail polish and hair done; out to the movies or to a concert; on a fishing trip; visiting family; communicating and making decisions about the kind of life they want. You may think that individuals having to be suctioned every two hours to maintain an airway and connected to machines would say that they have little quality of life. This is not the case when we have questioned our clients. All have said they enjoyed good quality of life and would make the same decision to be placed on life support. It is hard for any of us not in this situation to imagine. A tremendous cost savings occurs when these clients can be moved away from the sterile intensive care unit at the hospital into the homelike setting of long-term care. Additionally, the pressures of getting the patient weaned during the DRG period⁸ are gone. Clients can wean at a pace that they can tolerate. The unit has been able to wean 95 percent of those clients

⁸ Refers to a shortened time-period within a hospital during which the hospital may receive reimbursement for a specific diagnosis related group (DRG).

determined to be unweanable in the hospital. This is partly due to the ability to allow the clients to regain their strength before weaning begins.”⁹

Westwind Village established a partnership with a local hospital to develop the unit. Respiratory therapists who are employees of the hospital provide twenty-four hour support to the nursing staff. The NF rents ventilators and uses piped in oxygen to meet the demands of ventilator operation. The NF also maintains a bulk storage tank for liquid oxygen and pipes with connections in each room. An alarm system alerts staff when a ventilator becomes disconnected from the patient. The facility developed an education program that provides for the initial and continuing educational needs of the staff working in the unit. Topics include ventilator and respiratory management, wound care, cardiac issues, tube feeding issues and management of bowel programs. A generator located outside the facility provides supplemental power in the event of a power failure. The Colorado Nursing Home Census Report for September 2002 reported that Westwind Village had a total of 72 residents, 61 or 85% of whom were Medicaid recipients.¹⁰

Illinois

In 1985, Illinois implemented the Quality Incentive Program (QUIP) that provided additional reimbursement for targeting at-risk populations for pressure ulcer prevention, such as residents who were immobile or nutritionally compromised. An Exceptional Care (EC) program was subsequently developed to support the costs of providing enhanced care to individuals in NFs with conditions such as head trauma, AIDS, and complex respiratory problems, and individuals who are ventilator-dependent. Section 140.569 of Illinois Administrative Code¹¹ specifies requirements for the program.

Illinois negotiates rates with facilities requesting payment for exceptional care services and includes data collected from EC program providers during prior fiscal years, rate adjustments (including any updates for inflation) and the average cost of each service category for the geographic area in which the facility is located in the development of the new rate. After approval of negotiated rates, a facility's rates are adjusted for inflation. At the end of fiscal year 2001, there were 202 facilities serving 462 EC residents with a statewide average reimbursement rate of \$192.51 per day. Average reimbursement for NFs inclusive of payments for EC residents was approximately \$91.49 per day.

Illinois specifies minimum staffing requirements for this program, including a minimum of one RN on duty on the day shift, seven days per week. Additional RN staff may be determined necessary by the Department of Public Aid, based on the a review of the exceptional care services needs. In addition, providers of complex respiratory or

⁹ Excerpted from “2002 Long-Term Care Best Practices: Moving Beyond Basics” published by the Colorado Department of Public Health and Environmental Health. Available online at: <http://www.cdphe.state.co.us/hf/download/LTCBP2002.PDF>.

¹⁰ Report available online at: <http://www.cdphe.state.co.us/hf/static/census1.htm>

¹¹ The Administrative Code is available online at: http://www.state.il.us/dpa/html/title_89_illinois_adminstrativ.htm

ventilator services under the EC program are required to employ or contract with a certified respiratory therapy technician or registered respiratory therapist.

Illinois has also developed special training requirements for EC program providers serving ventilator-dependent residents. At least one of the full-time professional nursing staff members must have successfully completed a course in the care of ventilator-dependent individuals and the use of ventilators, conducted and documented by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one year experience in the care of ventilator-dependent persons. All staff caring for ventilator-dependent residents must have documented in-service training in ventilator care prior to providing such care. In-service training must be conducted at least annually by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one year of experience in the care of ventilator-dependent persons.

Providers serving ventilator-dependent individuals are also required to have written agreements with specialists and medical equipment providers, including:

- ❑ A medical equipment and supply provider who includes a service contract for ventilator equipment;
- ❑ A local emergency transportation provider;
- ❑ A local hospital capable of providing the necessary care for equipment dependent residents, when appropriate; and
- ❑ A certified respiratory therapy technician or registered respiratory therapist (unless a respiratory therapist is on staff within the facility).

In order for a NF to receive the EC program rate for an individual, the cost of the person's care must be at least 50% more than the proposed admitting provider's Medicaid per diem rate. Eligible items used in computing the cost of the resident's care include nursing services costs, therapy services costs, and medical equipment and supply costs.

In the event placement for a patient in need of exceptional care services cannot be located, the Illinois Medicaid program can authorize payment to the hospital in which the patient is receiving services at a rate not to exceed the average statewide long-term care provider per diem EC program rate. The state reviews exceptional care residents' utilization of services every 90 days, although patients who are considered "stabilized" may be reviewed less frequently.

Michigan

Michigan calculates special rates for each NF that provides care to ventilator-dependent individuals based on the NFs request for payment to cover costs in excess of the NF's

established per diem payment. These additional costs include the provision of additional nursing services, equipment and supplies. The per diem payment in 2002 for NFs providing care to Medicaid recipients who are ventilator-dependent ranged from \$217 to \$333 a day. Five nursing facility's were receiving enhanced payments as of January, 2003. Michigan state staff report an increase in demand for NFs that can provide care to ventilator-dependent individuals along with the use of an aggressive weaning program for individuals residing in NF ventilator units.

Michigan measures the cost-effectiveness of their program by determining the difference in cost between continued care in a hospital inpatient unit versus a NF ventilator unit and considers the NF ventilator-dependent program cost-effective because care is less expensive in the NF.

Michigan has established medical necessity criteria for individuals residing in NFs for whom the NF may request special payment. The individual must:

- ❑ Be on the ventilator at least six hours per day;
- ❑ Have met the High Day Outlier Threshold for the DRG 475 (41 days in acute care prior to the move to the NF); and
- ❑ Not be on a CPAP or BiPAP only¹².

There are no facility-specific standards other than a general requirement that the NF be able to meet the needs of each individual they admit.

Oklahoma

Oklahoma implemented a special payment in 1995 and currently provides a supplemental payment of \$128.24 per day for Medicaid recipients residing in NFs who are ventilator-dependent. The average rate for NFs as of July 2002 was \$94.61, for an average rate paid to NFs for care provided to ventilator-dependent individuals of \$219.70 (or \$128.24 plus the base NF per diem of \$91.46). Ventilator supplies and equipment are not included in the NF per diem payment but are billed separately to Medicaid (or any other available source of coverage).

Oklahoma developed their rate based on a number of criteria including:

- ❑ The estimated costs for direct care staff for tasks specific to ventilator care, including specialized staff such as RNs and respiratory therapists.
- ❑ The hours of care related to these tasks in excess of standard NF care.

¹² CPAP:Continuous positive airway pressure. BiPAP:Bilevel Positive Airway Pressure.

- ❑ A 5% allowance for the cost of medical supplies not reimbursable by Medicare and a \$4 per day add-on for nutritional therapy.
- ❑ The application of an inflation factor for the specific reporting period.

Facilities providing ventilator care are required to provide a separate cost report to the state for ventilator care.

In 2001-2002, three facilities in Oklahoma were providing care to nine Medicaid recipients on ventilators and receiving Medicaid supplemental payments. The number of NFs receiving the supplemental payment, and the number of individuals for whom the supplemental payment was received, has steadily and sharply declined since 1999, with an overall decrease of over 50%. Oklahoma Medicaid staff report this is primarily the result of increased opportunities to serve individuals on ventilators in community settings utilizing services available from their Home and Community-Based Services (HCBS) Waiver programs.

Oklahoma: Medicaid Supplemental Payments to NFs for Ventilator-Dependent Patients

	1999-2000	2000-2001	Change from prior year	2001-2002	Change from prior year
Facilities	6	4	-33%	3	-25%
Patient Days	2,989	3,184	7%	1,783	-44%
Patients	22	14	-36%	9	-36%

Wisconsin

Wisconsin established a separate rate (rather than a supplemental payment) for NF care for individuals who are ventilator-dependent in 1982. This rate is currently \$375 per day and is applied on a statewide basis. This compares with an average NF per diem payment of \$106 in 2001.¹³ Most ventilator supplies and the ventilator rental are billed separately. Three facilities currently qualify for the special rate and were serving twelve Medicaid recipients as of December 2002. According to Wisconsin Medicaid staff, the number of participating NFs has been declining consistent with a decrease in demand for services. Wisconsin has undertaken an aggressive weaning program and has been able to serve individuals who might otherwise have needed NF care in their Community Options Program (COP), a Home and Community-Based Services (HCBS) waiver for individuals with disabilities.

¹³ From “Wisconsin Nursing Homes and Residents, 2001” published by the Wisconsin Department of Health and Family Services, and available online at: <http://www.dhfs.state.wi.us/provider/pdf/01nr&r.pdf>

In order for nursing facilities to be eligible for the special payment, the NF must meet special physical plant and personnel training requirements. Wisconsin implemented both requirements and recommendations for NFs providing care to ventilator-dependent individuals in 1984. The requirements are specific to the availability of a suitable power supply for ventilators (and other life support systems), which includes at a minimum, an alternate power source to prevent interruption of the system in the event of a power outage. Recommendations focus on patient care and include:

- ❑ Clear admission criteria limiting admission to individuals who are medically stable, have been ventilator-dependent a minimum number of days and who have been approved by a screening committee for admission;
- ❑ Written agreements with acute care facilities for transfer, and on-call availability of specialists (including pulmonary, surgical, gastroenterological, neurological, psychological, dietary, respiratory and R.N. clinical specialists);
- ❑ A program of initial training and ongoing, in-service training for direct care staff and the minimum scope of that training; and
- ❑ The availability of ancillary services (including pharmacy and laboratory services).

Interested NFs call the State of Wisconsin Medicaid program to receive prior-authorization to accept a ventilator-dependent individual. The state helps the NF initiate the program and provides authorization for the special payment.

Texas

HMA was not able to obtain detailed information regarding Texas' program, but did learn that Texas provides a supplemental payment to NFs for residents who are ventilator-dependent. Effective September 1, 2002, Texas paid an additional \$79.98 a day for individuals who require the continuous use of a ventilator and \$31.99 a day for individuals who require six to twenty-three hours use of a ventilator a day. This information is included because Florida may have an interest in differential payments for individuals who require continuous versus intermittent ventilator use.

Conclusions from the Review of Five States

Reimbursement mechanisms for NFs providing care to Medicaid recipients who are ventilator-dependent range from a more administratively simple supplemental payment, to a set per diem payment, to the more complex facility-based rate developed using case mix adjustors. While the use of case mix adjustment is attractive for its potential to ensure that NFs providing care to individuals with a wide-range of more complex

conditions are compensated in accordance with the complexity of this care, the implementation of case mix adjustors is complex and not recommended at present for the Florida NF program.

None of the reviewed states specifically limit the number of participating NFs. Three of the five states reviewed in detail have set minimum standards specific to NFs that must be met in order to be eligible to receive an enhanced payment for providing care to Medicaid recipients who are ventilator-dependent. In addition, the NF in Colorado, with over ten years of experience serving ventilator-dependent individuals, has developed a specific program of minimum staffing requirements, staffing competencies and physical plant requirements that they believe permits the NF to provide high-quality care to individuals who are ventilator-dependent. The utilization of a set of minimum standards for NFs receiving enhanced payment for the care of ventilator-dependent individuals is included in the following recommendations for Florida.

Recommendations

Payment

The use of a supplemental payment for NFs providing care to Medicaid recipients who are ventilator-dependent is the preferred and recommended reimbursement method for this project. Supplemental payments permit a state to provide additional funding to a provider without having to revise the existing cost-based reimbursement methodology, a process that is generally complex and subject to various pitfalls including legal challenges by providers. In addition, supplemental payments may be paid to a NF even if the NF's per diem rate is limited by existing ceilings. Finally, supplemental payments are relatively easy to implement and administer and are already utilized for two other groups of individuals residing in NFs (individuals with AIDS and medically fragile children). No major revision of the current NF reimbursement plan is required. Only a new Medicaid billing code for a supplemental payment is required.

The amount of the supplemental payment must be both sufficient to ensure that NFs can provide the necessary care and must also be cost-effective. The determination of what constitutes an adequate and cost-effective rate must be determined by the State of Florida. Exhibit 1 contains several tables which provide a comparison of what several other states pay to NFs for a regular NF per diem payment and the enhanced payment made for NF services provided to ventilator-dependent Medicaid recipients. The sufficiency and cost-effectiveness of these payments are subject to various interpretations beyond the scope of this report. However, in 2001 the AHCA proposed a supplemental rate of \$160 per day for ventilator-dependent individuals residing in NFs. The AHCA identified 13 Medicaid eligible individuals ages 21 through 35 who were ventilator-dependent and estimated there were at least an additional 15-25 additional individuals over the age of 35. At that time the estimated annual cost for the proposed supplemental payment was \$1,728,000 of which \$749,606 would be funded by the state and \$978,394 would be the Federal share. HMA recommends that the state implement a supplemental rate as proposed by the AHCA and conduct a rate review process similar to that conducted in Illinois for their Exceptional Care Program – this includes collection of data from participating NF providers following the first year of implementation in order to identify the average cost of each service category for the geographic area in which the facility is located. This information could then be considered in reviewing the sufficiency of the supplemental rate.

Note that the information gathered from the various states reflects a variety of payment and reporting mechanisms. For example, some average per diem rates are based on paid claims while others are based on the average approved range for NF per diem payments. This information is provided for illustrative purposes only. Likewise, the table comparing existing and proposed supplemental payments in Florida compares varying years. Proposed rates have not been adjusted for inflation or other factors that impact NF rates (such as legislatively mandated changes to NF staffing patterns).

Exhibit 1

Sample NF Rate Comparisons

State	Average NF Per Diem Rate	Special NF Per Diem Rate ¹⁴	Difference (“supplement” ¹⁵)	Supplement Compared to Average NF Per Diem
IL	\$91.49	\$192.51	\$101.02	110%
OK	\$94.61	\$219.70	\$125.09	132%
WI	\$106.00	\$375.00	\$269.00	254%
TX - continuous vent	\$103.79	\$183.77	\$79.98	77%
Average				143%

Florida NF Supplemental Per Diem Rates Compared to 2003 Average NF Per Diem (\$146.16)¹⁶

NF Supplemental Payments	Supplemental Payment Amount	Example of Total Per Diem Using Statewide Average Per Diem Plus Supplemental Per Diem
2002 - AIDS	\$111.74	\$257.90
2002 - Medically Fragile	\$201.40	\$347.56
1999 - Proposed (Ventilator-Dependent)	\$201.40	\$347.56
2001 - Proposed (Ventilator-Dependent)	\$160.00	\$306.16

Comparison of various state special payments¹⁷ to Florida’s 2002 Medically Fragile Supplemental Payment and AIDS Supplemental Payment

State	Average NF Per Diem Payment	Special NF Per Diem Payment	Supplemental Amount	Difference Between Florida Medically Fragile Supplement and State’s Ventilator Supplement	Difference Between Florida AIDS Supplement and State’s Ventilator Supplement
IL	\$91.49	\$192.51	\$101.02	\$100.38	\$10.72
OK	\$94.61	\$219.70	\$125.09	\$76.31	(\$13.35)
WI	\$106.00	\$375.00	\$269.00	(\$67.60)	(\$157.26)
TX - continuous vent	\$103.79	\$183.77	\$79.98	\$121.42	\$31.76

¹⁴ The special NF payments are either specific to individuals who are ventilator-dependent or are provided to individuals who require "exceptional care" (inclusive of ventilator-dependent recipients).

¹⁵ Equals the difference between the average NF per diem and special per diem payment or rate.

¹⁶ From “Florida Nursing Homes January 2003 Rate Semester Initial Per Diems” obtained from staff of the AHCA, Bureau of Program Analysis.

¹⁷ May be in the form of a supplement or equals the difference between the average NF per diem and special per diem payment or rate. See state-specific information for actual form of special payment.

Florida could establish a differential supplemental payment specific to continuous and less than continuous ventilator use. Texas utilizes a two-tier system for their ventilator supplemental payment to NFs. However, a differential rate should only be considered if the reduction in payment is reflective of an actual decrease in costs for the NF provider. For example, there is unlikely to be a reduction in costs for an individual who is dependent 24 hours daily compared to an individual who is dependent 22 hours daily. The cost reductions associated with decreasing reliance on a ventilator are likely to vary by facility and to be impacted by factors such as the number of other individuals residing in the facility who are ventilator-dependent.

Texas NF Payment Comparison

Ventilator Status	Supplemental Per Diem Payment	Texas Statewide NF Average Per Diem¹⁸	Total NF Per Diem Payment (using an average NF per diem)	Supplement as a % of Statewide NF Per Diem Payment
Continuous	\$79.98	\$103.79	\$183.77	77%
6 to 23 hrs/day	\$31.99	\$103.79	\$135.78	31%

Standards

The DOH believes that a supplemental payment for individuals who are ventilator-dependent should be tied to some specific care standards designed to prevent the types of medical problems currently being reported when these individuals are being readmitted to hospitals from NFs. However, standards must be realistic and readily enforceable if they are to be meaningful. Therefore, HMA recommends that standards for program participation be comprised of a minimum set of basic requirements encompassing staffing levels, staff knowledge, ongoing training, admission and discharge policies, and access to other services (including specialty care and ancillary services). Some specific recommendations are provided in Attachment 1. Clinical care standards developed by the task force that exceed the minimum payment-related standards should be provided to the NF in the form of provider training. The clinical care standards could be further supplemented by consultation from AHCA, Health Quality Assurance resource staff and trauma center specialists. Standards that were mentioned by reviewers of the draft report as particularly important, included access to a ventilator-trained RN twenty-four hours a day, mandatory continuing education for nurses and respiratory therapists, and admission

¹⁸ Texas uses a case-mix reimbursement system - nursing home residents covered by Medicaid are classified by nursing facility staff according to an index of 11 categories plus a default. This index is called the Texas Index for Level of Effort (TILE). TILE assessments reflect the residents' service and care needs, and also determine the daily reimbursement rates paid by Medicaid. Nursing facilities are paid higher per diems for patients with more intensive care needs.

standards that require that an individual be medically stable, but that do not preclude NF admissions if the individual has a chronic infection or condition.

Medical Necessity

States have broad discretion in setting requirements for Medicaid services based on objective measures of medical need or “medical necessity”. At the same time, states cannot set limits on a service by requiring that an individual have a certain condition or diagnosis that has no direct relationship to the service being requested or provided. For example, states may require that an individual be unable to walk unaided as a condition of receiving a walker. But they cannot limit the provision of walkers to individuals who cannot walk unaided because of a stroke. In this case, an individual who cannot walk unaided because of multiple sclerosis clearly has as much need for a walker as does the individual with a stroke. Medical necessity standards are used by public and private insurers in order to ensure that services covered under a health plan (such as Medicaid) are reasonable, cost-effective and not in excess of the individual’s need.

Because a supplemental payment proposed under this project is designed to support significantly increased costs that NF providers incur to meet the needs of individuals who are ventilator-dependent above the costs already covered by Medicaid, medical necessity requirements should be designed to identify those individuals for whom a provider will actually incur significantly higher costs than covered by the NF’s per diem payment.

Michigan has determined that individuals who require more than 6 hours a day of ventilator use are individuals for whom additional payment should be made. Colorado and Illinois make this determination on a case-by-case basis. Texas has determined that providers incur additional costs when an individual is dependent on a ventilator at least 6 hours a day, and that this cost is substantially higher still for individuals who are dependent 24-hours a day. While the DOH has a specific interest in addressing the needs of individuals with brain and spinal cord injuries who are ventilator-dependent, a supplemental payment cannot be limited to this group on the basis of “medical necessity”. It is possible that Florida could use a Section 1115 Waiver to limit the provision of a supplemental or special NF payment to individuals within a specified target population, such as individuals with a brain or spinal cord injury who are also ventilator-dependent. It is also possible that such a waiver would not be approved on the grounds that it discriminated against individuals without a brain or spinal cord injury who nevertheless required ventilator support. However, Florida should exercise its authority to set medical necessity criteria in order to ensure that precious public funds are utilized cost-effectively. HMA recommends that Florida consider limiting a supplemental payment to individuals who are dependent on a ventilator at least 6 hours a day and who do not rely solely on a CPAP or BiPAP for respiratory support.

Provider Participation

Finally, HMA recommends that AHCA restrict participation to providers using a formal procurement process. If the state wishes to limit the number of providers who could participate, procurement would be based on the ability of the state to secure a Medicaid waiver from the federal government. The ability to limit participation to a specified number of NFs will contribute to a number of desired outcomes including:

- ❑ The ability to ensure the uniform and coordinated delivery of specialized services;
- ❑ The ability of NFs to provide care to a sufficient number of ventilator-dependent individuals to achieve economies of scale and acquire the expertise and staff necessary to provide quality care;
- ❑ The opportunity to provide enhanced quality of life for individuals who are ventilator-dependent, including opportunities to develop social connections with other individuals within a NF with similar needs; and
- ❑ The ability to strengthen opportunities to move ventilator-dependent individuals or individuals who have been successfully weaned from ventilators from the NF to a community setting.

The primary concerns associated with permitting any willing and qualified provider to participate is the likely inability of some or all participating NFs to admit a sufficient number of ventilator-dependent individuals to support the expenses incurred to develop and maintain a staff of qualified and trained professionals and other direct care staff. In addition, quality of life for ventilator-dependent individuals is likely to decline in direct relationship to the degree of isolation experienced by the individual. A single individual on a ventilator is less likely to have opportunities to socialize and connect with other individuals in the NF who have very different needs.

The NF and hospital provider groups were supportive of limited provider participation and concurred that such a limitation would enhance a NFs ability to achieve financial efficiencies, to develop or enhance expertise in providing care to individuals who are ventilator-dependent, and to develop relationships with facilities seeking placements into NFs and public programs able to assist in developing community options for individuals who could be safely served in the community (either on a ventilator or following weaning from a ventilator). The FAHA representative also expressed support for participation by any willing (and qualified) provider. A hospital trauma program manager expressed concern that a lack of competition could result in poor customer service, poor patient care and/or liberal interpretation regarding NF admission criteria, and recommended that there be at least two or three participating NFs per region.

In order to set a limit on the number of NFs that could be eligible for the supplemental payment, the AHCA would need to seek approval for this limitation from the CMS under the authority of Section 1915(b)(4) of the Social Security Act. Waivers authorized by Section 1915(b)(4) are used for selective contracting – that is for contracting with a select number of providers that meet specified requirements and agree to provide specified services in a manner that complies with access, quality, and cost-effectiveness requirements for Medicaid.¹⁹

The ability to contract with a limited number of NFs that agree to provide care to individuals who are ventilator-dependent consistent with a set of clinical care standards, affords the best opportunity to develop a comprehensive, coordinated and high-quality service continuum for individuals in need of these services. This ability will also enhance the ability of NF providers to develop expertise in the care of such individuals (to the extent they do not currently possess this expertise), and to develop long-term relationships with trauma centers and hospitals seeking to discharge individuals to NFs, and with state programs that can assist in developing community-options when such individuals can reside safely outside a NF. Selective contracting waiver applications must address issues related to provider access. Generally, the availability of geographically diverse facilities representative of a state’s major regions is likely to meet Medicaid access requirements. For example, Florida is comprised of five distinct geographic areas – south (Miami/Dade), southwest (Tampa/Ft. Myers), central (Orlando), northwest (Pensacola) and northeast (Jacksonville).

Selective contracting waivers are relatively easy to develop. Florida has used this type of waiver to limit the providers of specialized Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services and transportation services. If Florida chose to permit any willing provider to participate, the number of NFs would be limited to those facilities willing to undertake the provision of care to individuals who are ventilator-dependent for an agreed to additional reimbursement amount beyond their standard NF per diem amount, and to meet specified minimum standards. It is not known how many NFs would seek to participate under this scenario.

One reviewer expressed concern regarding selective contracting due to workload issues and the potential for litigation. They stated that the use of a reasonable supplemental rate

¹⁹ Section 1915(b)(4) of the Social Security Act permits a state “to restrict the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall be consistent with the requirements of section [1923](#) and are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section [1902\(a\)\(37\)\(A\)](#).”

and establishment of “Centers of Excellence”, as well as the possible certification of participating NFs would best meet the needs of ventilator-dependent individuals.

Cost Effectiveness

Florida covers up to 45 days of inpatient hospital services for adult Medicaid recipients²⁰ annually and up to 365 days of NF services annually. The cost-effectiveness of an enhanced payment to NFs depends on a number of factors. Hospital and NF costs are highly variable. For example, the NF per diem rates for January 2003 range from a low of \$105 to a high of \$180, with a statewide average of \$146.16. The 2003 hospital per diem rates vary tremendously. It is exceedingly difficult to determine potential cost-savings that might accrue to Medicaid by making a supplemental payment available to NFs willing to provide high-quality care to individuals who are ventilator-dependent. Each individual, hospital and nursing facility is unique.

Hospital costs reflect the mix of services a hospital provides, the complexity of individuals served, the costs for labor and other variables. This variability is reflected in the hospital reimbursement table on the following page. Rates for a sample of hospitals that are not designated as Trauma Centers are provided since not all ventilator-dependent individuals are treated initially at trauma centers. Rates for each designated trauma center are also provided. The cost for 45 days of inpatient services (the maximum amount Medicaid reimburses for adult Medicaid recipients) is also provided.

It is likely that a large portion of individuals who are ventilator-dependent are treated in higher-cost hospitals and NFs that are better able to provide the specialized staff and equipment necessary to provide care. Many costs are not captured by Medicaid expenditures. For example, individuals who have private insurance will frequently exhaust their private insurance benefit cap (for example a lifetime maximum of \$1 million) before becoming Medicaid eligible. Once an individual becomes Medicaid eligible, coverage for inpatient hospital services is available for only forty-five days. In addition, a portion of individuals cannot qualify for Medicaid, including low-income, employed individuals without access to employer-sponsored health insurance. When individuals exhaust their private insurance benefits and exhaust their Medicaid inpatient hospital benefits, or are uninsured, hospitals continue to incur costs and seek ways to receive some form of compensation to offset these costs.

Costs savings might accrue to the Medicaid program if the state pursued the implementation of a formal aggressive weaning program that offers opportunities to enable individuals to regain respiratory function. Such an effort offers not only the potential for improved quality of life for individuals but potential cost savings as individuals require less intensive care.

²⁰ There is no limit on days of coverage for children who are Medicaid eligible, provided inpatient hospital services are medically necessary.

**January 2003 Medicaid Per Diems for Trauma Centers and Selected Hospitals
(not designated as Trauma Centers)²¹**

Selected Hospitals (Not designated as Trauma Centers)	1/2003 Inpatient Per Diem	45 Day Reimbursement
Columbia West Florida Regional Medical Center	\$656.02	\$29,521
Genesis Rehabilitation Hospital	\$705.25	\$31,736
Vencor Hospital (Tampa)	\$708.46	\$31,881
Lower Florida Keys Hospital	\$750.60	\$33,777
Vencor Hospital - Coral Gables	\$784.46	\$35,301
Pan American Hospital	\$796.16	\$35,827
Jackson Hospital	\$824.08	\$37,084
Tallahassee Community Hospital	\$847.59	\$38,142
Volusia Medical Center	\$874.02	\$39,331
Columbia Medical Center-Sanford	\$905.09	\$40,729
Good Samaritan Hospital	\$949.61	\$42,732
Tallahassee Memorial Regional Medical Center	\$1,135.27	\$51,087
Trauma Centers		
West Florida Community Care	\$218.16	\$9,817
Lakeland Regional Medical Center	\$806.81	\$36,306
Delray Comm. Hospital	\$862.81	\$38,826
Lee Memorial Hospital	\$877.77	\$39,500
Baptist Hospital (Pensacola)	\$925.14	\$41,631
Holmes Regional Medical Center	\$931.97	\$41,939
St. Mary's Hospital	\$966.92	\$43,511
Bayfront Medical Center	\$1,000.96	\$45,043
Sacred Heart Hospital	\$1,020.21	\$45,909
North Broward Medical Center	\$1,054.10	\$47,435
St. Joseph's Hospital	\$1,071.41	\$48,213
Broward General Hospital	\$1,085.18	\$48,833
Halifax Medical Center	\$1,156.04	\$52,022
Orlando Regional Medical Center	\$1,156.96	\$52,063
Shands Jacksonville Medical Center	\$1,239.84	\$55,793
Memorial Hospital	\$1,271.71	\$57,227
Tampa General Hospital	\$1,338.53	\$60,234
Jackson Memorial Hospital	\$1,599.28	\$71,968
All Children's Hospital	\$1,733.42	NA ²²
Miami Childrens Hospital	\$1,813.37	NA

²¹Hospitals designated as trauma centers by the Florida DOH and listed on the DOH Internet site at: <http://www.doh.state.fl.us/workforce/ems1/Trauma/verification.html>. Rates obtained from the AHCA, Medicaid Program Analysis.

²² Medicaid reimbursement for inpatient services provided to children is not limited to 45 days annually.

Because an estimate of costs for a supplemental payment for NFs providing care to ventilator-dependent individuals is exceedingly difficult to determine based on existing information, HMA provided the AHCA with a data request designed to examine actual hospital and NF costs for individuals who were ventilator-dependent during a two-year period. However, the request could not be completed prior to the finalization of this report due to workload issues. The completion of a data analysis at a later time would enable the state to develop a cost profile and refine the estimate of the number of individuals likely to be eligible for a supplemental payment specific to ventilator use.

Final Tasks

The following tasks require completion in order to implement a supplemental payment to a limited number of NFs that agree to provide specified services and meet specified requirements for Medicaid recipients who are ventilator-dependent:

- ❑ The development of a cost analysis for a ventilator supplemental payment using data available from the State Center for Health Statistics and the Florida Medicaid Management Information System (FMMIS).
- ❑ A review of Attachment 1 (Recommended Standards for Nursing Facilities Eligible to Receive a Supplemental Payment for Providing Care to Ventilator-Dependent Medicaid Recipients) by the DOH/EMS Task Force and the development of algorithms of care by a cross-section of appropriate health care professionals, including nursing facility RNs, respiratory therapists, physical therapists, dietitians, social workers and other professionals, as well as trauma center staff. The algorithms of care may then serve as resource materials for NFs authorized to receive enhanced payments from Medicaid for caring for ventilator-dependent Medicaid recipients.
- ❑ A decision by the AHCA regarding the submission of a 2004-2005 legislative budget request (LBR) seeking budget authority to implement a supplemental payment and to seek a Medicaid waiver (if determined necessary), with input from the Secretary of the DOH.
- ❑ A determination regarding the need and desire for use of a selective contracting waiver authorized under Section 1915(b)(4) of the Social Security Act, subsequent submission to CMS and development of an RFP seeking qualified NF providers, as appropriate.
- ❑ Revision of the Medicaid NF Reimbursement Plan and/or Medicaid State Plan, the NF Services Medicaid Coverage and Limitations Handbook (including provider requirements, admission and discharge requirements, and payment

provisions), and the Medicaid Provider Reimbursement Handbook (prior-authorization standards).

Attachment 1

Recommended Standards for Nursing Facilities Eligible to Receive a Supplemental Payment for Providing Care to Ventilator-Dependent Medicaid Recipients

Staffing

- ❑ Respiratory therapy staff available in-house 24 hours a day (either as an employee or by contractual arrangement).
- ❑ At least one full-time professional nursing staff member who has completed a course in the care of ventilator-dependent individuals, documented by a respiratory therapist or physician.

Additional Services and Supplies

- ❑ A written agreement with a medical equipment and supply provider which includes a service contract for ventilator equipment.
- ❑ A written agreement with a laboratory and pharmaceutical supply provider (and other ancillary service providers as appropriate).
- ❑ A written agreement with a local emergency transportation provider capable of transporting ventilator-dependent individuals.
- ❑ A written agreement with a local hospital capable of providing care for ventilator-dependent individuals and providing on-call availability of specialists such as pulmonary, surgical, neurological, gastroenterological, psychological, dietary, respiratory and clinical nurse specialists.

Documentation Requirements

- ❑ Written admission and discharge criteria specifying the medical requirements individuals must meet. These include at a minimum, a requirement that the individual be medically stable prior to admission and that a multi-disciplinary screening has been completed with a finding that the individual can be safely admitted or discharged from the facility prior to admission or discharge.
- ❑ A written weaning program.
- ❑ A written policy regarding the process the facility will utilize to maximize the individual's ability to live in a community setting (at the individual's option). This policy shall specify the method in which the NF shall locate and coordinate access to community-based services, including contact information for CARES and for local HCBS waiver specialists.

Education/Training Requirements

In addition to the requirement that at least one full-time professional nursing staff member has completed a course in the care of ventilator-dependent individuals, documented by a respiratory therapist or physician, the following:

- ❑ All staff providing care to ventilator-dependent individuals must receive training in the provision of ventilator care conducted by a respiratory therapist or qualified registered nurse with at least one year of experience in the care of ventilator-dependent individuals. This training must be completed prior to the provision of care.
- ❑ Annual in-service training specific to the needs of ventilator-dependent individuals conducted by qualified professionals.

Physical Plant Requirements

- ❑ The presence of an alarm system appropriate to ventilators and associated equipment within the facility.
- ❑ A suitable power supply for ventilators including an alternate power source (generator).²³

In addition, HMA recommends that AHCA utilize the final task force recommended clinical care guidelines as educational materials for NFs receiving the supplemental payment.

²³ The AHCA Office of Plans and Construction has drafted electrical standards to address alternate power supplies.