DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

DSSM 20700.5 Acquired Brain Injury Medicaid Waiver Program

Nature of the Proceedings:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend the Division of Social Services Manual (DSSM) regarding the Acquired Brain Injury Medicaid Waiver Program (ABIMWP). The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the December 2007 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 31, 2007 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary of Proposal

Statutory Authority

- Legal basis of the Medicaid home and community-based services (HCBS) waiver: Section 1915(c) of the Social Security Act
- Purpose and intent of a Medicaid HCBS: Section 1902(c) of the Social Security Act
- Allows states to create the HCBS waiver program: Omnibus Budget Reconciliation Act of 1981, Section 2176
- The Code of Federal Regulations (CFR) specifically dealing with HCBS services are in Title 42, Parts: 431.50, 435.3, 435.217, 435.726, 435.735, 440.1, 440.180, 440.250, 441.300 through 441.306, and 441.310.

Summary of Proposal

The Acquired Brain Injury Medicaid Waiver Program (ABIMWP) is a community-based services program funded by the Division of Medicaid and Medical Assistance and operated by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). It is targeted to individuals with acquired brain injury who meet Medicaid nursing facility admission criteria.

The proposed revises the rules and regulations governing the administration of the ABIWP, and describes the types of services available under the program. The regulations being amended, also, define the eligibility criteria that must be met by applicants for the services and the scope of services available to eligible applicants.

And, to simplify the policy format, Section 20700.5 is substantially revised, renumbered, and reorganized for greater clarity and ease of reading.

Summary of Comments Received with Agency Response and Explanation of Changes

The State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows.

The regulations basically "track" the waiver document and other regulations adopted this month [11 DE Reg. 786 (December 1, 2007)]. However, SCPD has two (2) observations.

First, the reference to the Division of Long Term Care Residents Protection (DLTCRP) Regulation 5.9 at the end of the regulation is ostensibly an inaccurate citation. The DLTCRP assisted living regulation is codified at 16 **DE Admin. Code** 3225.

Agency Response: We agree. The regulation's correct citation is reflected by **[Bracketed Bold Type]**.

Second, DMMA POL-20700.5.1 ABI Program Absences Due To Hospitalization recites that "ABI waiver services will terminate upon the 31st day of hospitalization." It is unclear if DMMA intends this reference to mean that services are suspended/cease or that the participant is actually terminated from the waiver program. This provision is obtuse and may merit clarification. If the provision is retained, the following could be substituted to conform to the advance notice requirement of 16 DE Admin Code 5301:

1. In the event of an extended hospitalization, DMMA will send advance notice to the participant that all waiver services will terminate upon the 31st day of hospitalization.

This is a more consumer-oriented approach which alerts the participant that he/she may wish to promote discharge from the hospital before the 31st day. Otherwise, the regulation literally contemplates more draconian termination of all services with no advance warning.

If DMMA does intend to terminate waiver eligibility on the 31st day, the consequences to the participant could be severe. The participant would have to reapply for eligibility and be placed at the end of any waiting list [Appendix B:3:3]. The participant may lose the supports necessary for discharge, thus extending the hospital stay even further. It would therefore be preferable to suspend waiver services upon the 31st day of hospitalization rather than terminating the participant's enrollment in the waiver.

Agency Response: This provision refers to the actual waiver services, not to Medicaid. The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) will be responsible for notifying the participant that waiver services will be terminated. DMMA will provide adequate notification if Medicaid will be terminated.

Further analysis and review by staff corrects the policy number designation from "DMMA" to DSSM" indicated in the Final Order Regulation by **[Bracketed Bold Type]**.

Findings of Fact:

The Department finds that the proposed changes as set forth in the December 2007 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation related to the Acquired Brain Injury Medicaid Waiver Program is adopted and shall be final effective February 10, 2008.

Vincent P. Meconi, Secretary, DHSS, January 11, 2008

DMMA FINAL ORDER REGULATION #08-02
REVISION:

~~**20700.5 ACQUIRED BRAIN INJURY MEDICAID WAIVER PROGRAM**~~

~~The Acquired Brain Injury Medicaid Waiver Program (ABIMWP) is a home and community based services program funded by the Division of Social Services (DSS), Delaware Medical Assistance Program (DMAP) and operated by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). It is targeted to individuals with acquired brain injury who meet Medicaid nursing facility admission criteria.~~

~~The earliest implementation date for the ABIMWP is October 10, 2004.~~

~~**20700.5.1 ELIGIBILITY CRITERIA**~~

To be eligible for the ABIMWP, an individual must:

1. be a Delaware resident
2. be between 18 and 64 years of age (persons who enter the waiver before age 65 may remain in the waiver after age 65)
3. meet the financial and medical criteria for the DSS Long Term Care Medicaid Program and meet nursing facility admission criteria.

Medical eligibility is determined by the Pre-Admission Screening Unit of DSAAPD.

Financial eligibility is determined by DSS.

Program eligibility is determined by DSAAPD. An individual must meet all of the following criteria:

a have an injury to the brain which is not hereditary or congenital (Acquired Brain Injury)

b have a need of one waiver service, in addition to case management, on a monthly basis

c have a physical, cognitive and/or behavioral symptom of an acquired brain injury and currently reside in a nursing facility or is at risk for placement in a nursing facility

d have completed or would no longer benefit from intensive, inpatient, post-trauma or rehabilitation programs

e accept and maintain case management services

20700.5.2 NUMBER OF RECIPIENTS

There is a maximum number of recipients who may be served under the ABIMWP each fiscal year. The total unduplicated number of recipients served under the program cannot exceed the maximum number approved by the Centers for Medicare and Medicaid Services (CMS). DSAAPD will monitor the number of individuals receiving ABIMWP services so the maximum number will not be exceeded.

20700.5.3 COST EFFECTIVE REQUIREMENT

In order for an applicant to be eligible for the ABIMWP, the applicant's cost of care cannot exceed the cost of their care if the same applicant were institutionalized. This determination is made on an aggregate basis which considers all ABIMWP recipients. An average monthly cost for institutionalized individuals is used to determine the amount that may be spent on ABIMWP recipients. A DSAAPD worker determines cost effectiveness.

20700.5.4 APPROVAL

Upon approval, DSS will send a notice of approval to the applicant or the applicant's representative and the ABIMWP provider. The notice to the provider will include the effective date of Medicaid coverage, the patient pay amount, and the Medicaid identification number.

20700.5.5 POST ELIGIBILITY BUDGETING

See DSSM 20720 and 20995.1 for patient pay calculation.

For recipients residing in Assisted Living facilities, the personal needs allowance is equal to the current Adult Foster Care rate. Collection of the patient pay amount from the recipient or the recipient's representative is the responsibility of the assisted living provider.

For recipients residing in community based settings, the personal needs allowance is equal to 250% of the Federal SSI Benefit Rate. Collection of the patient pay amount from the recipient or the recipient's representative is the responsibility of the provider who is providing the most costly service.

20700.5.6 DAYS APPROPRIATE FOR BILLING

The waiver provider may not bill for any day that the recipient is absent from the program or facility for the

~~entire day. The waiver provider may bill for services for any day that the recipient is present in the facility or program for any part of the day.~~

~~If the recipient resides in an assisted living facility, the waiver provider may not bill Medicaid for room and board.~~

~~20700.5.7 HOSPITALIZATION OR ILLNESS~~

~~Waiver services will terminate upon hospitalization. There are no Medicaid bed hold days for hospitalization. DSS will redetermine eligibility for continued Medicaid coverage. Waiver services may restart after hospital discharge as determined by DSAAPD staff.~~

~~If the recipient is a resident of an assisted living facility, the waiver provider shall not provide services to a recipient in accordance with the Delaware Regulations for Assisted Living Facilities outlined in section 63.409.~~

~~20700.5.8 ABIMWP SERVICES~~

~~Acquired brain injury waiver services will include the following:~~

~~Case Management~~
~~Personal Care~~
~~Respite Care~~
~~Adult Day Expanded Services~~
~~Specialized Medical Equipment and Supplies~~
~~Personal Emergency Response Systems (PERS)~~
~~Assisted Living Program~~
~~Behavioral and/or Cognitive Services~~

8 DE Reg. 557 (10/01/04) (Section 20700.5 added)

[~~DMMA~~ DSSM] POL-20700.5 ACQUIRED BRAIN INJURY MEDICAID WAIVER

[~~DMMA~~ DSSM] POL-20700.5.A ABI MEDICAID WAIVER DEFINED

1. The Acquired Brain Injury (ABI) waiver program is a home and community based services program funded by the Division of Medicaid and Medical Assistance (DMMA).
2. The ABI waiver is operated by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD).
3. This waiver is targeted to individuals with an acquired brain injury aged 18 years of age and above.
4. The individual must meet Medicaid criteria for nursing home admission.
5. The earliest implementation for the ABI waiver is December 1, 2007.

[~~DMMA~~ DSSM] POL-20700.5.B ABI ELIGIBILITY CRITERIA

1. The individual must be a Delaware Resident.
2. The individual must meet the financial and medical criteria for the DMMA Long Term Care Medicaid Program.
3. Medical eligibility is determined by the DSAAPD Pre-Admission Screening Unit. DSAAPD also accepts Long Term Care medical eligibility determinations performed by the DMMA Pre-Admission Screening

Unit.

4. Financial eligibility is determined by the DMMA.
5. The individual must meet program eligibility guidelines (see DSSM 20700.5.C).

[~~DMMA~~ DSSM] POL-20700.5.C ABI PROGRAM ELIGIBILITY

1. The individual must have an injury to the brain which is not hereditary or congenital, degenerative, or induced by birth trauma.
2. The individual must have a need of at least one enhanced ABI waiver service in addition to case management.
3. The individual must have a physical, cognitive, and/or behavioral symptom of an ABI, which requires supervised and/or supportive care.
4. The individual must be at risk of placement or currently residing in a nursing facility.
5. The individual must have completed or no longer benefit from intensive inpatient, post-trauma or rehabilitation program(s).
6. The individual must accept and maintain case management services.

[~~DMMA~~ DSSM] POL-20700.5.D ABI NUMBER OF PARTICIPANTS

1. There is a maximum number of participants who may be served under the ABI waiver program each year.
2. The total unduplicated number can not exceed the maximum number approved by the Centers for Medicare and Medicaid Services (CMS).
3. The DSAAPD will monitor the number of participants.

[~~DMMA~~ DSSM] POL-20700.5.E ABI COST EFFECTIVENESS REQUIREMENT

1. The cost of care for an ABI waiver recipient can not exceed the cost of care if institutionalized.
2. The cost of care is determined on an aggregate basis which considers all ABI waiver recipients.
3. An average monthly cost for institutionalization is used to determine the amount that may be spent on an ABI waiver recipient's care.
4. The DSAAPD determines cost effectiveness.

[~~DMMA~~ DSSM] POL-20700.5.F ABI NOTIFICATION OF APPROVAL

1. The DMMA will send a notice of Medicaid approval.
2. The notice will be sent to the applicant or representative.
3. If the recipient is in an Assisted Living facility a notice of approval will also be sent to the provider.
4. The notice to the provider will include the effective date of Medicaid coverage,the patient pay amount, and the Medicaid identification number.

[~~DMMA~~ DSSM] POL-20700.5.G ABI POST ELIGIBILITY BUDGETING

1. DSSM policies 20720 and 20995.1 will be followed to calculate patient pay amount.
2. Persons residing in an Assisted Living facility will have a personal needs allowance equal to the current Adult Foster Care Rate.
3. Persons who are in a community based setting will have an income needs allowance equal to 250% of the Federal Benefit Rate.
4. Collection of the patient pay amount is the responsibility of the provider.

[~~DMMA~~ DSSM] POL-20700.5.H ABI BILLING OF APPROPRIATE DAYS

1. The waiver provider may not bill for any day the individual is absent from the program, excluding case management services. (Case management services are billed monthly, and are still utilized up to 30 days of hospitalization.)
2. The waiver provider may bill for services rendered to the individual.
3. Assisted Living providers may not bill Medicaid for room and board.

[~~DMMA~~ DSSM] POL-20700.5.I ABI PROGRAM ABSENCES DUE TO HOSPITALIZATION

1. ABI waiver services will terminate upon the 31st day of hospitalization.
2. There are no Medicaid bed hold days for hospitalization.
3. The DMMA will redetermine financial eligibility for continued Medicaid coverage.

[~~DMMA~~ DSSM] POL-20700.5.J ABI MEDICAID WAIVER PROGRAM SERVICES

1. ABI waiver services will include:
   - Case Management
   - Assisted Living and Enhanced Assisted Living
   - Day Habilitation
   - Cognitive Services
   - Adult Day Services (Level I - Basic & Level II – Enhanced)
   - Personal Care
   - Respite Care
   - Personal Emergency Response System
2. Residents of an Assisted Living facility will receive services in accordance with the Division of Long Term Care Residents Protection regulation **[~~5.9~~ codified at 16 DE Admin. Code 3225]**.

11 DE Reg. 1054 (02/01/08) (Final)