Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

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

Long-Term Care Facility Services - Standards for Payment of Reserved Beds During Absence from Long-Term Care Facilities

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Delaware Title XIX Medicaid State Plan and the Division of Social Services Manual (DSSM) regarding Methods and Standards for Payment of Reserved Beds during Absence from Long-Term Care Facilities, specifically, *standards for payment of reserved beds during absence from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Del.C.** §10114 and its authority as prescribed by 31 **Del.C.** §512.

The Department published its notice of proposed regulation changes pursuant to 29 **Del.C.** §10115 in the April 2016 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by May 1, 2016 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services/Division of Medicaid and Medical Assistance is proposing to amend the Title XIX Medicaid State Plan and the Division of Social Services Manual (DSSM) regarding Methods and Standards for Payment of Reserved Beds during Absence from Long-Term Care Facilities, specifically, *standards for payment of reserved beds during absence from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)*.

Statutory Authority

- §1919(c)(2)(D) of the Social Security Act, *Notice of bed hold policy and readmission*
- 42 CFR §447.40, *Payment for reserving beds in institutions*
- 42 CFR §447.205, *Public notice of changes in statewide methods and standards for setting payment rates*
- 42 CFR §483.12, *Admission, transfer and discharge rights*

Background

Under Medicaid payment regulations in 42 CFR §447.40, Federal Financial Participation (FFP) is available if a state plan includes provision for bed-reservation payments during a recipient's temporary absence from an inpatient facility, as follows:

Payments for Reserving Beds in Institutions

(a) The Medicaid agency may make payments to reserve a bed during a beneficiary's temporary absence from an inpatient facility, if-

(1) The state plan provides for such payments and specifies any limitations on the policy; and

(2) Absences for purposes other than required hospitalization (which cannot be anticipated and planned) are included in the patient's plan of care.

(b) An agency that pays for reserved beds in an inpatient facility may pay less for a reserved bed than an occupied bed if there is a cost differential between the two beds (Section 1102 of the Social Security Act).

To satisfy Medicaid nursing facility requirements for participation in §1919(c)(2)(D) (i) - (ii) of the Act and in 42 CFR §483.12(b)(1)-(2), a nursing facility must tell the residents departing for hospitalization or therapeutic leave about the state's bed-reservation payment policy. This information must be in writing and must specify the number of days the state Medicaid covers, if any, and the nursing facility's policies regarding bed-reservation periods.

If a Medicaid eligible resident's absence from the nursing facility exceeds the bed-reservation period in the state plan, §1919(c)(2)(D)(iii) of the Act and 42 CFR §483.12(b)(3) guarantee the resident readmission to the facility immediately upon the first availability of a bed in a semi-private room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

In Delaware, if a Medicaid recipient is hospitalized for a short period of time and is expected to return to the facility,

Medicaid reimbursement is available for no more than seven (7) days within any thirty-day period. The thirty-day count begins with the first day of hospitalization. If payments are suspended because recipient remains hospitalized more than seven (7) days and the thirty-day count expires, a new thirty-day count starts with readmission to the long-term care facility.

Summary of Proposal

Rationale and Justifications

The Medicaid State Plan and the Division of Social Services Manual (DSSM) requires the Delaware Medical Assistance Program (DMAP) to make payments to long-term care (LTC) facilities to ensure a bed is reserved for a Medicaid recipient who is temporarily absent from the LTC facility due to hospitalization or leave of absence. Currently, bed-reservation payments are limited to seven (7) days per hospitalization in any thirty-day period.

DMMA recognizes the unique role that the Mary Campbell Center and Stockley Center, both of which are Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), fulfill in serving a very vulnerable population. Given the distinct challenges faced by these LTC facilities in serving this population, it was determined that the additional protection of an extended bed-reservation payment period of fourteen (14) days is necessary in order to sustain services for this population of recipients.

Purpose

This amendment to the State Plan and DSSM adds a provision that allows DMAP to extend the bed-reservation payments from seven (7) days to fourteen (14) days in any thirty-day period for individuals residing in an ICF/IID long-term care facility.

Summary of Proposed Changes

Effective for services provided on and after July 1, 2016 Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) proposes to amend Attachment 4.19-C of the Medicaid State Plan to add a provision to the long-term care bed-reservation reimbursement policy to make payments for reserving beds in ICF/IID for fourteen (14) days per hospitalization for acute conditions in any thirty-day period.

Also effective for services provided on and after July 1, 2016, DMMA proposes to make changes to policy section 20650, Temporary Absence from Nursing Facility for Hospitalization, and it's sub-sections of the Division of Social Services Manual (DSSM) to reflect the proposed changes to the State Plan.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the *state* public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input to the coverage and payment methodology for reservation of beds in ICF/IID long-term care facilities. Comments were to be received by 4:30 p.m. on Monday May 2, 2016.

CMS Review and Approval

The provisions of this draft state plan amendment (SPA) are subject to the Centers for Medicare and Medicaid Services (CMS) review and approval. The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

Provider Manual Update

Also, upon CMS approval, the applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates.

Cost/Budgetary Impact

The following represents the potential increase in expenditures if bed-reservation payments for individuals residing in an ICF/IID are increased from seven (7) days to fourteen (14) days in any thirty-day period effective July 1, 2016.

The following fiscal impact is projected:

	Federal Fiscal Year 2016[1]	Federal Fiscal Year 2017
General (State) Funds	$6,250	$25,000
Federal Funds	$7,587	$29,585

1. Represents July - September 2016

Summary of Comments Received with Agency Response

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

As background, a CMS regulation (42 CFR §447.40) allows states at state option, to make "bed hold" payments to a long-term care facility during a resident's temporary absence hospitalization or other specified reasons. DMMA currently implements this option but plans to modify it for residencts of an ICF/IID. In a nutshell, the normally paid 7-day bed-hold period per hospitalization would be extended to 14 days for Delaware's only ICF/IIDs - Stockley Center and Mary Campbell Center. The expected fiscal impact for FFY 17 is $25,000 in state funds and $29,585 in federal funds.

GACEC and SCPD endorse the extended paid "bed-hold" period for ICF/IIDs but has the following observations and recommendations.

Agency Response: DMMA thanks the Council for its endorsement and offers the following responses to your observations and recommendations.

First, on p. 889, the reference to 42 CFR §440.40 is incorrect. The reference should be to 42 CFR §447.40.

Agency Response: DMMA agrees that the reference citation was entered incorrectly under the Statutory Authority listing in the Summary of Proposal, despite being listed correctly in the Background. The correct citation will be listed in both places when the final regulation is published.

Second, consistent with 42 CFR §447.40, DMMA reaffirms the current policy of allowing up to 18 days per calendar year of "bed-hold" payments if included in the resident's plan of care. It would be informative to include the following clarifying sentence after Par. "2" on p. 891: "This may include absences included in a plan of care due to transfers to a 'specialized treatment facility' consistent with Title 16 **Del.C.** §1121(18)." This would be instructive to providers and residents seeking to reconcile Medicaid payment standards and the overlapping State "bed -hold" statute. For similar reasons, the same sentence could be added to §20650.2.1 on p. 892.

Agency Response: DMMA thanks the Council for its comment. However, no change was made as a result of this comment.

Third, waiver of the 18 day paid leave of absence limit can be obtained if the LTC facility applies and its medical director confirms medical necessity. This may be unduly limiting. It would be preferable to allow either the LTC facility or the resident [supported by his personal attending physician [16 **Del.C.** §1121(21)] to apply for a waiver since a resident's view may be different than the facility's view. CMS recognizes the divergence of interest in the context of transfers and discharges. See 42 C.F.R. §483.12(a)(3)(i); attached CMS Surveyor Guidance F201-203; and attached CMS proposed regulations, 80 Fed Reg. 42247-42249, 42254-42255. For example, the facility may prefer that the resident or resident's family "private pay" for the period in excess of 18 days since that results in higher payment.

Agency Response: DMMA thanks the Council for its comment. However, no change was made as a result of this comment.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the April 2016 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Delaware Title XIX Medicaid State Plan and the Division of Social Services Manual (DSSM) regarding Methods and Standards for Payment of Reserved Beds during Absence from Long-Term Care Facilities, specifically, *standards for payment of reserved beds during absence from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)*, is adopted and shall be final effective June 11, 2016.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER #16-012a
REVISIONS:

ATTACHMENT 4.19-C

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Standards for Payment of Reserved Beds During Absence from Long-Term Care Facilities

42 CFR 447.40

Payment will be made for reserving beds in long-term care (LTC) facilities for recipients during their temporary absence for the following purposes:

~~4. For periods of hospitalization for acute conditions up to 7 days per hospitalization in a 30-day period.~~

1. Hospitalization for acute conditions:
   a. For periods of hospitalization for acute conditions up to fourteen (14) days per hospitalization in any thirty-day period for individuals residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
   b. For periods of hospitalization for acute conditions up to seven (7) days per hospitalization in a thirty-day period for individuals residing in all other LTC facilities.

~~5.~~ 2. For leaves of absence up to ~~18~~ eighteen (18) days per calendar year as provided for in the recipient's plan of care.

~~6. The 18-day leave of absence may be waived as follows:~~

3. If a recipient's physical condition is being negatively impacted by ~~their~~ his or her emotional need to be in a family setting, prior approval may be obtained for a waiver of the ~~18-day~~ eighteen-day leave of absence limitation (for other than acute care hospitalization) from the Title XIX Medical Consultant in order to allow the patient more time to visit with his or her family, as long as such absences are provided for in the recipient's written plan of care.

   To obtain approval, a written request must be submitted by the ~~nursing home~~ long-term care facility to the ~~Nursing Home~~ Long-Term Care Coordinator and must include:

   ~~1.~~ a. ~~reason~~ Reason for the request;
   ~~2.~~ b. ~~medical~~ Medical summary;
   ~~3.~~ c. ~~statement~~ Statement from the ~~nursing home's~~ LTC facility's medical director regarding the medical necessity of the patient being absent from the ~~home~~ facility in excess of ~~18~~ eighteen (18) days per year;
   ~~4.~~ d. ~~anticipated~~ Anticipated frequency of absence~~.~~; and
   e. Number of days the recipient was absent from the LTC facility during the previous six-month period.

The number of days waived must fall within a six-month period.
Any request for a waiver after the six-month limit must be resubmitted and approved for payment to be continued.

DMMA FINAL ORDER #16-012b
REVISION:

20650 Temporary Absence from ~~Nursing~~ a Long-Term Care Facility
42 CFR §447.40

~~If a recipient is hospitalized for a short period of time and is expected to return to the facility, payment to the facility may continue for a period of not more than 7 days provided the nursing facility agrees to hold the bed for the resident. Medicaid reimbursement is available for no more than seven (7) days within any 30-day period. The 30-day count begins with the first day of hospitalization. If payments are suspended because recipient remains hospitalized more than seven (7) days and the 30 day count expires, a new 30 day count starts with readmission to the nursing facility. In other words DMMA will not pay 7 days out of every 30 days for people who remain in the hospital for weeks at a time.~~

Payment will be made for reserving beds in long-term care (LTC) facilities for Medicaid recipients during their temporary absence for the following purposes:

20650.1 Temporary Absence from a Long-Term Care Facility for Acute Hospitalization
20650.2 Temporary Absence from a Long-Term Care Facility for Reasons Other Than Hospitalization
7 DE Reg. 781 (12/1/03)

20650.1 Temporary Absence from a Long-Term Care Facility for Acute Hospitalization
20650.1.1 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

If a recipient is hospitalized for a short period of time and is expected to return to the facility, payment to the facility may continue for a period of not more than fourteen (14) days provided the ICF/IID agrees to hold the bed for the resident. Medicaid reimbursement is available for no more than fourteen (14) days within any thirty-day period. The thirty-day count begins with the first day of hospitalization. If payments are suspended because recipient remains hospitalized more than fourteen (14) days and the thirty-day count expires, a new thirty-day count starts with readmission to the ICF/IID. In other words DMMA will not pay fourteen (14) days out of every thirty (30) days for people who remain in the hospital for weeks at a time.

20650.1.2 Other Long-Term Care Facilities

If a recipient is hospitalized for a short period of time and is expected to return to the facility, payment to the facility may continue for a period of not more than seven (7) days provided the LTC facility agrees to hold the bed for the resident. Medicaid reimbursement is available for no more than seven (7) days within any thirty-day period. The thirty-day count begins with the first day of hospitalization. If payments are suspended because recipient remains hospitalized more than seven (7) days and the thirty-day count expires, a new thirty-day count starts with readmission to the LTC facility. In other words DMMA will not pay seven (7) days out of every thirty (30) days for people who remain in the hospital for weeks at a time.

~~20650.1~~ 20650.2 Temporary Absence from ~~Nursing~~ a Long-Term Care Facility for Reasons Other Than Hospitalization

20650.2.1 A recipient may be absent from ~~the nursing~~ a long-term care facility for reasons other than hospitalization for a period of ~~18~~ eighteen (18) days per year without interruption of payment to the ~~nursing~~ long-term care facility, as long as such absences are provided for in the recipient's plan of care.

20650.2.2 If a recipient's physical condition is being negatively impacted by his or her emotional need to be in a family setting, prior approval may be obtained for a waiver of the ~~18-day~~ eighteen-day leave of absence limitation (for other than acute care hospitalization) from the Title XIX Medical Consultant in order to allow the patient more time to visit with his or her family.

To obtain approval, a written request must be submitted by the ~~nursing~~ long-term care facility to the Long-Term Care Coordinator and must include:

20650.2.2.1 ~~reason~~ Reason for the request;

20650.2.2.2 ~~medical~~ Medical summary;

20650.2.2.3 ~~statement~~ Statement from the ~~nursing~~ LTC facility's medical director regarding the medical necessity of the patient being absent from the ~~nursing~~ LTC facility in excess of ~~18~~ eighteen (18) days per year;

20650.2.2.4 ~~anticipated~~ Anticipated frequency of absence; and

20650.2.2.5 ~~number~~ Number of days the recipient was absent from the ~~nursing~~ LTC facility during the previous ~~six month~~ six-month period.

If the approval is given, the ~~18-day~~ eighteen-day restriction will be waived for six (6) months from the date of approval. Any request for a waiver after the ~~six month~~ six-month limit must be resubmitted and approved for payments to be continued.

19 DE Reg. 1092 (06/01/16) (Final)