

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512)
16 DE Admin. Code 20700

PROPOSED

PUBLIC NOTICE

Home and Community-Based Services Waivers

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) intends to amend policies in the Division of Social Services Manual (DSSM) regarding *Home and Community-Based Services Waivers*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by April 30, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposal described below amends policies in the Division of Social Services Manual (DSSM) regarding Home and Community-Based Services Waivers.

Statutory Authority

- 42 U.S.C. §1315, *Demonstration projects*
- Social Security Act §1115, *Demonstration projects*
- 42 CFR §435.217, *Individuals receiving home and community-based services*

Background

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

Under a waiver authority of Section 1115(a) of the Social Security Act, the Diamond State Health Plan (DSHP) implemented a mandatory Medicaid managed care demonstration program statewide on January 1, 1996. Using savings achieved under managed care, Delaware expanded Medicaid health coverage to additional low-income adults in the State with incomes less than 100% of the Federal Poverty Level (FPL).

Effective April 1, 2012, the Division of Medicaid and Medical Assistance (DMMA) implements its 1115 Demonstration Waiver to integrate primary, acute and long-term care (LTC) services for the elderly and persons with physical disabilities into the Diamond State Health Plan (DSHP) statewide program under the name "Diamond State Health Plan Plus."

Summary of Proposal

The proposed policy revisions in the Division of Social Services Manual (DSSM) identify the elimination of some of the 1915(c) home and community-based services waivers and the incorporation of them into Long Term Care Managed Care. In December 2010, three 1915(c) waivers: Elderly/Disabled Waiver, ABI Waiver, Assisted Living Waiver; were consolidated into one Elderly and Disabled Waiver. These changes were never reflected in policy.

As of April 1, 2012, the consolidated Elderly and Disabled Waiver, as well as the AIDS/HIV waiver will be moved to an 1115 Waiver and incorporated into a Managed Care Program.

This regulatory action also proposes to increase the daily living needs allowance of those individuals residing in the community. In supporting community based care, the daily living needs allowance for these individuals increases to be equal to their total income, including income that is deposited into a Miller Trust.

The proposed changes affect the following policy sections:

DSSM 20700, *Home and Community-Based Services*

DSSM 20700.1, *Division of Mental Retardation*

DSSM 20700.2, *Home and Community-Based Waiver for the Elderly and Disabled*

DSSM 20700.3, *Home and Community-Based Waiver for Individuals with AIDS/HIV*

DSSM 20700.4 through DSSM 20700.4.8, *Assisted Living Waiver*

DSSM 20700.5 through DSSM 20700.5.J, *Acquired Brain Injury Medicaid Waiver Program*

ADDED:

DSSM 20710, *Long Term Care Community Services*

DSSM 20720, *Patient Pay Calculation*

DSSM 20720.1, *Daily Living Needs*

DSSM 20720.4, *Patient Pay Amount*

DSSM 20740, *Hospitalization*

DSSM 20760, *Redetermination.*

Fiscal Impact Statement

The proposed regulation imposes no increase in cost on the General Fund.

DMMA PROPOSED REGULATION #12-10

REVISIONS:

20700 Home and Community Based Services

Federal Regulation - 42 CFR 435.217

1115 Social Security Act (42 U.S.C. 1315)

~~Individuals who are eligible to receive home and community based services, under a special waiver granted to the State's Medicaid program by the Centers for Medicare and Medicaid Services (CMS) are also eligible for the increased financial standard that is used for individuals in nursing facilities-~~

~~These are individuals who would need to be in an institution if the special Medicaid community services were not available. They are also individuals who may not be eligible for SSI or SSP while living in the community because of excess income.~~

~~Delaware currently has a waiver for the mentally retarded (effective 7/1/83), the elderly and disabled (effective 7/1/86) and (effective 1/1/91) persons with Acquired Immune Deficiency Syndrome (AIDS) or other HIV Related Disease (HRD). The Assisted Living Waiver which is a program of community-based residential services became effective October 1, 1998.~~

~~Medicaid eligibility under any HCBS waiver is not established until services under the HCBS waiver begin.~~

Effective April 1, 2012, all Home and Community Based Waiver programs, except for the Division of Developmental Disabilities Services Waiver, are incorporated into Diamond State Health Plan Plus, a managed care program. See section DSSM 14900 for additional information regarding this program.

20700.1 ~~Division of Mental Retardation Waiver~~ Developmental Disabilities Services Waiver

1. Only clients of the Division of Developmental Disabilities Services (DDDS) are eligible for this Waiver.

2. Individuals must be medically eligible.

Initial medical eligibility is determined by DDDS staff. The DDDS Intake Coordinator makes a preliminary determination for each applicant for initial eligibility. Once an individual is placed in a residential facility, the ~~social~~ DDDS Social Service Benefits Administrator sends all waiver requests to the Medicaid Division of Medicaid & Medical Assistance Medical Review Team (MRT) for review. Based on the information provided on the comprehensive Medical Report (MAP-25), Social Evaluation Form, Cost Projection Data Sheet and the ~~level~~ Level of Care (LOC) form, the MRT will either concur with the initial decision to approve or deny the applicant for an ICF/MR level of care.

~~3.~~ The MRT signs off on all forms sent by the DDDS Social Service Benefits Administrator.

3. Individuals must be financially eligible.

If the client is not already Medicaid eligible as an SSI recipient, DDDS submits an application to the appropriate Long Term Care Unit for financial eligibility determination. Eligibility determination is made by using financial criteria applied to those institutionalized and receiving Medicaid.

20700.2 Home and Community Based Waiver for the Elderly and Disabled

1. ~~The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) determines medical eligibility for this waiver through their Pre Admission Screening unit (PAS).~~
2. ~~DSAAPD PAS must assure that the applicant is in need of nursing home (i.e., skilled nursing facility (SNF), or intermediate care facility (ICF) as defined by DSS/Medicaid.~~
3. ~~The Long Term Care Financial Unit will determine eligibility using criteria in section 20103.~~
Effective April 1, 2012, this waiver program is incorporated into the Diamond State Health Plan Plus and referred to as Long Term Care Community Services. See DSSM 20710.

20700.3 Home and Community Based Waiver for Individuals with AIDS/HIV

1. ~~All cases will be referred to the DSS Pre Admission Screening Unit for initial medical eligibility.~~
2. ~~The DSS PAS Units must assure that the applicant has a diagnosis of AIDS or HIV with at least two or more chronic related medical conditions to HIV/AIDS that would contribute to increased hospitalizations and be in need of institutional care.~~
3. ~~Eligibility Determination~~
~~The Long Term Care Financial Units will determine eligibility by using criteria in section 20103.~~
4. ~~Once the medical and financial eligibility is completed, the financial eligibility worker will notify the Medicaid Waiver Administrator of financial eligibility and send the level of care packet to the case management agency and MRT for processing of a care plan for initial eligibility. Once the care plan information is completed, the case management agency sends documentation to the MRT for review and final approval.~~
~~Once medical and financial eligibility is completed, the financial eligibility worker will call the Medicaid Waiver Administrator to determine if a slot is available in the AIDS Waiver.~~
Effective April 1, 2012 this waiver program is incorporated into the Diamond State Health Plan Plus and referred to as Long Term Care Community Services. See DSSM 20710.

20700.4 Assisted Living Waiver

~~The Assisted Living Medicaid Waiver Program (ALMWP) provides community based residential services. The program is administered by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). The program is funded by Delaware Medicaid and state general funds. It is targeted to older persons and adults with physical disabilities who need assistance with the Activities of Daily Living (ADL) AND meet Medicaid nursing facility admission criteria.~~

Effective April 1, 2012 this waiver program is incorporated into the Diamond State Health Plan Plus and referred to as Long Term Care Community Services. See DSSM 20710.

20700.4.1 ELIGIBILITY CRITERIA

~~To be eligible for this program, individuals must:~~

- ~~◆ Be a resident of the State of Delaware~~
- ~~◆ Be eighteen years of age or older;~~
- ~~◆ Meet the Financial and Medical criteria for DSS Long Term Care Institutionalized Services~~
- ~~◆ Meet Assisted Living Program criteria as determined by DSAAPD~~

~~Medical eligibility is determined by Pre Admission Screening Units of either DSS or DSAAPD.~~

~~Financial eligibility is determined by the DSS Long Term Care Financial Units.~~

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

~~Have need of an assisted living services on a regular weekly basis; AND~~

~~Be able to be maintained safely in the assisted living agency with the provision of the ALMWP services. Safety concerns must be brought to resolution through a mutually agreed upon Managed Risk Agreement.~~

~~If the financial eligibility determination period has expired, and the individual has been unable to obtain placement in a suitable and acceptable assisted living facility, the application will be denied.~~

20700.4.2 NUMBER OF RECIPIENTS

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

20700.4.3 COST EFFECTIVE REQUIREMENT

In order for an individual to be eligible for the Assisted Living Program, the individual's cost of care cannot exceed the cost of their care if the same individual was institutionalized. An average monthly cost for institutionalized individuals is used to determine the amount that may be spent on Assisted Living eligibles. A DSAAPD worker determines the cost effectiveness.

20700.4.4 DAYS APPROPRIATE FOR BILLING

The assisted living provider may NOT bill MEDICAID for room and board. The assisted living provider may bill for services for any day that the recipient is present in the facility for any part of the day. The assisted living provider may NOT bill for any day that the consumer is absent from the facility for the entire day.

20700.4.5 ILLNESS OR HOSPITALIZATION

The assisted living provider shall NOT provide services for an individual that has been bedridden for 14 consecutive days unless a physician certifies that the consumer's needs may be safely met by the service agreement.

There are no Medicaid bed hold days for hospitalization.

20700.4.6 APPROVAL

Upon approval the Medicaid Financial Unit will send a notice of acceptance to the applicant or his representative, and ALMWP provider. The notice to the provider will include patient pay amount, amount to be protected for medical insurance and personal needs, effective date of Medicaid coverage, and Medicaid recipient's billing ID number.

20700.4.7 POST ELIGIBILITY BUDGETING

See DSSM section 20720 for Patient Pay Calculation policy. If the consumer has income under the Adult Foster Care standard, there will be no patient pay amount.

Collection of the patient pay amount from the consumer or his representative is the responsibility of the assisted living provider.

20700.4.8 ASSISTED LIVING SERVICES

Assisted living services include the following:

- Personal services assistance with the activities of daily living (ADL)
- Nursing services
- Meal services
- Social/emotional services
- Assistance with instrumental activities of daily living (IADL)

20700.5 Acquired Brain Injury Medicaid Waiver Program

DSSM POL-20700.5 ACQUIRED BRAIN INJURY MEDICAID WAIVER

20700.5.A Acquired Brain Injury (ABI) Medicaid Waiver Defined

20700.5.B ABI Eligibility Criteria

20700.5.C ABI Program Eligibility

20700.5.D ABI Number of Participants

20700.5.E ABI Cost Effectiveness Requirement

20700.5.F ABI Notification of Approval

20700.5.G ABI Post Eligibility Budgeting

20700.5.H ABI Billing of Appropriate Days

20700.5.I ABI Program Absences Due to Hospitalization

20700.5.J ABI Medicaid Waiver Program Services

Effective April 1, 2012 this waiver program is incorporated into the Diamond State Health Plan Plus and referred to as Long Term Care Community Services. See DSSM 20710.

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.

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).

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.

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 cannot exceed the maximum number approved by the Centers for Medicare and Medicaid Services (CMS).

3. The DSAAPD will monitor the number of participants.

DSSM POL-20700.5.E ABI COST EFFECTIVENESS REQUIREMENT

1. The cost of care for an ABI waiver recipient cannot 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.

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.

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.

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.

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.

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

(Break in Continuity of Sections)

20710 Long Term Care Community Services

1. Individuals must be medically eligible.

The Division of Medicaid & Medical Assistance (DMMA) Pre-Admission Screening (PAS) Unit determines medical eligibility.

The applicant must be in need of nursing facility level of care as defined by DMMA.

See DSSM 20102 for additional information on Medical eligibility.

2. Individuals must be technically and financially eligible

The DMMA Long Term Care Financial Unit determines eligibility using criteria in DSSM 20103.

3. Individuals must choose a managed care organization once eligibility has been determined.

20720 Patient Pay Calculation

~~There are allowable deductions from the monthly income. These are deducted to determine the recipient's share of his/her cost of care.~~

This policy applies to all individuals receiving Medicaid through the Division of Developmental Disabilities Services (DDDS) Waiver and the Long Term Care Community Services Program.

1. The Medicaid recipient's total income will be used in the post eligibility treatment of income.

This includes income that is counted for eligibility and income that is excluded for eligibility.

2. Allowable deductions are given based on an individual's circumstance.

Not all deductions will apply to all individuals.

3. Any amount of income remaining after allowable deductions is the patient pay amount.

This amount must be paid on a monthly basis as indicated below:

For DDDS Waiver recipients, the patient pay amount is paid to the Division of Developmental Disabilities.

Individuals residing in an Assisted Living Facility will make their patient pay amount directly to the Assisted Living Facility.

The following deductions from the Medicaid recipient's total gross income should be taken in the following order:

20720.1 Daily Living Needs

~~Effective 4/1/94 an allowance of 150% of the Federal Poverty Level will be protected for the Elderly and Disabled (E/D) Waiver. Effective 5/1/95 the E/D Waiver personal needs allowance was changed from the Adult Foster Care limit to the special income level for institutionalized individuals. The special income level is the current income standard.~~

~~Effective 8/1/95, the personal needs amount for the HIV/AIDS Waiver will be the current income standard (250% of the SSI income level).~~

~~An amount equal to the current Adult Foster Care (AFC) rate is protected for the DDDS Waivers. The AFC rates are based on the current SSI income level plus \$140.00.~~

Individuals receiving Medicaid under the Division of Developmentally Disabled Services (DDDS) Waiver are allowed a deduction equal to the current Adult Foster Care (AFC) rate. The AFC rate is based on the current SSI income level plus \$140.00.

Individuals receiving Medicaid under the Long Term Care Community Services program and are residing in an Assisted Living Facility are given a deduction based on the Adult Foster Care rate less an amount payable for room and board.

Individuals receiving Medicaid under the Long Term Care Community Services program are allowed an amount equal to their total income including income that is placed in a Miller Trust.

20720.4 Patient Pay Amount

~~Any amount remaining after the above calculations will be paid to the provider by the Waiver recipient.~~

~~Patient pay amount will be included on the HCBS referral form forwarded to the HCBS Case Manager. The Case Manager notifies the recipient of the patient pay amount.~~

~~For DDDS Waiver recipients, any amount remaining will be paid to DDDS. Patient pay amount will be included on the budget sheet forwarded to the DDDS Waiver Administrator.~~

20740 Hospitalization

~~Hospitalization exceeding 30 consecutive days for the Elderly and Disabled Waiver and the AIDS Waiver and 14 consecutive days for the MR Waiver.~~

~~HCBS Case Manager notifies the Financial Unit that Waiver services are terminated. Medicaid case remains open while the patient is hospitalized and no patient pay to hospital is required for the month of admission to the Hospital.~~

20760 Redetermination

A redetermination of eligibility must be performed annually.

Medical eligibility is redetermined by the Managed Care Organization.

Financial eligibility is redetermined by the Division of Medicaid & Medical Assistance (DMMA).

15 DE Reg. 1414 (04/01/12) (Prop.)