DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

FINAL

FINAL ORDER

REVISION OF THE REGULATION OF DELAWARE'S DIVISION OF SOCIAL SERVICES MANUAL (DSSM) 20800

Nature of the Proceedings:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend existing rules in the Division of Social Services Manual (DSSM) used to determine eligibility related to Long Term Care, specifically, the Acute Care Program. 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 August 2008 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by August 31, 2008 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary of Proposal

As a reminder, the proposed provides notice to the public that the Division of Medicaid and Medical Assistance (DMMA) intends to amend existing rules in the Division of Social Services Manual (DSSM) used to determine eligibility related to Long Term Care, specifically, the Acute Care Program.

Statutory Authority

- 42 CFR §435.211, Individuals who would be eligible for cash assistance if they were not in medical institutions;
- 42 CFR §435.236, Individuals in institutions who are eligible under a special income level; and,
- 42 CFR §435.622, Individuals in institutions who are eligible under a special income level.

Summary of Proposal

DSSM 20800, ~~*Long Term Acute Care Program (SSI)*~~ *Determining Eligibility for the Acute Care Program*: First, the rule title has been renamed to reflect the revised content of the rule regarding medical eligibility rules for 30-day hospitalization/rehabilitation and out-of-state rehabilitation. Individuals who are inpatients of an acute care hospital for 30 days or more may be eligible for Long Term Care Medicaid.

Second, to simplify the policy format, Section 20800 is substantially revised, renumbered, and reorganized for greater clarity and ease of reading. Individuals requiring out-of-state placement in a rehabilitation center may also be eligible for Long Term Care Medicaid. Specific medical policy clarifications have been added to assist DMMA staff in obtaining the necessary information when determining medical eligibility.

Summary of Comments Received with Agency Response

The Delaware Developmental Disabilities Council (DDDC) and 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.

As background, under the regulations, an individual may be eligible for Medicaid coverage in an acute care hospital or rehabilitation facility if both medical and financial criteria are met. Financially, there is a $2,000 countable resource limit. In general, income cannot exceed 100% of the Federal SSI standard. If an applicant is expected to enter a nursing home directly from the hospital or rehabilitation facility, countable income can be higher (250% of the Federal SSI standard). The medical eligibility standards are more detailed. Moreover, the medical eligibility standards for out-of-state rehabilitation are stricter than for in-state rehabilitation. We have the following observations and recommendations.

First, in the "Income Guidelines" section, it is anomalous to adopt a more liberal income test for persons opting for nursing home placement directly from the hospital. Consistent with Olmstead and similar precedents, the State Medicaid program is expected to encourage alternatives to institutionalization. See attached January 14, 2000 CMS letter to State Medicaid Directors. It would therefore be preferable to authorize the higher income cap if an applicant were expected to enter a Medicaid waiver program. The superseded regulation (Section 20800.1) contemplated patients being discharged to the community with HCBS services. For example, a patient could be discharged to an assisted living facility and benefit from Medicaid assisted living waiver services. Eligibility for such waiver requires the applicant to meet a nursing level of care. See 16 DE Admin Code 20700.

Agency Response: There is no change to current policy. This section was only reformatted. Therefore, no changes have been made to the proposed amendment text as a result of this comment.

Second, the Councils question the categorical requirement that a participant in an out-of-state rehabilitation facility participate in "at least 3 hours of physical and/or occupational therapy per day". The preceding standards are more flexible in justifying eligibility based on intensive speech therapy, psychological services, or prosthetic-orthotic services. Someone recovering from a traumatic brain injury could conceivably focus on speech language therapy, cognitive retraining, and other sophisticated supports apart from OT and PT. We recommend deletion of the categorical eligibility requirement that the individual participate in 3 hours of OT and PT. It would be preferable to simply condense the standard as follows: "The individual must be able to tolerate and participate in required therapies and services." Since eligibility is reviewed on a "bi-weekly basis", there is ample scrutiny of active treatment.

Agency Response: The Division believes that the proposed regulation fails to clearly articulate medical eligibility requirements. The intent was to ensure that individuals could, in fact, participate in the required services. The final order regulation has been amended to read, "The individual must be able to tolerate and participate in all required therapies or services."

Findings of Fact:

The Department finds that the proposed changes as set forth in the August 2008 Register of Regulations should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual (DSSM) related to Long Term Care, specifically, the Acute Care Program, is adopted and shall be final effective August 10, 2009.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #09-26
REVISION:

~~**20800 Long Term Acute Care Program (SSI)**~~

~~Until 12/31/95, Medicaid coverage was available to individuals in acute care hospitals for more than 30 days, who would be eligible for SSI (aged, blind, or disabled) except that their income is between 100% and 250% of the SSI standard. Effective 1/1/96, individuals with income exceeding 100% of the SSI standard are not eligible. Individuals who would be eligible for TANF if not hospitalized may also qualify. This section will focus on applicants who would be eligible for SSI. These individuals will be determined eligible only after the patient has been in the hospital for 30 consecutive days. For example, if an individual enters the hospital on April 24th, Medicaid units need not consider eligibility unless the individual is still hospitalized on May 23rd (and has been continuously hospitalized since April 24th).~~

~~Financial eligibility for this program is always handled by the Financial Eligibility Units. Medical eligibility can be determined by PAS or by the Medicaid Review Team. To be medically eligible, the applicant must have required the level of care provided by a hospital during the time of his/her hospitalization. The individual may also be found eligible based on age alone (age 65 or older) or if the individual is statutorily blind and in the need of acute care services. Anyone 65 or statutorily blind and hospitalized for 30 consecutive days, and in need of acute care services would be medically eligible.~~

~~20800.1 Referral Procedures~~

~~1. The referral is taken by PAS if the applicant is seeking Nursing Home placement or Home and Community Based Services, in addition to this program. PAS will determine medical eligibility and will refer the case to the Financial Eligibility Unit. If Home and Community Based Services are needed, the Financial Unit will refer the case to the HCBS Unit.~~

~~2. If the applicant is planning to be discharged to his home or to an out of state hospital or has already been discharged and does not require Home and Community Based Services or long term care placement, the referral is taken by the Financial Eligibility Unit. The eligibility process begins only when the applicant has reached his 30th day of hospitalization. The Financial Eligibility Unit obtains a FORM 408 from the hospital and forwards it with any pertinent medical information to the Medical Review Team. If the applicant is under the age of 19 and does not require long term care or HCBS, the Financial Eligibility Unit refers the case to the Family and Community Medicaid Unit.~~

~~3. If, in either of the above two situations the referral is an emergency, i.e., the applicant requires a heart transplant, bone marrow transplant, etc., the appropriate referral unit will begin the eligibility process without waiting for the 30 days to elapse or for the FORM 408 Form to be completed.~~

~~In emergency situations, the worker handling the referral will notify her supervisor. The supervisor will inform the Long Term Care Coordinator of the applicant's medical situation. The Long Term Care Coordinator will determine medical eligibility with the assistance of a staff nurse.~~

~~20800.2 Financial Determination~~

~~1. Applicant or representative must complete the application process~~

~~2. Eligibility will be determined using all nursing home technical and financial standards.~~

~~3. If applicant is eligible, the Medicaid case must be opened on DCIS retroactive from the hospital admission date. For example, if an individual enters the hospital April 24th and is continuously hospitalized at least until May 23rd. The Medicaid coverage would begin effective April 24th. In no case shall the effective date of eligibility be earlier than the first day of hospitalization.~~

~~4. There is a patient pay requirement for these individuals and the patient pay amount is determined in accordance with policy section 20600 (Post Eligibility Definitions/Procedures). Notification of patient pay amount and approval must be sent to the appropriate hospital social worker.~~

~~Complete data entry functions to update DCIS and templates.~~

~~5. Redeterminations of eligibility must be completed at six month intervals, but biweekly contacts must be made with the hospital to determine that the recipient is still institutionalized.~~

LTC POL-20800 Determining Eligibility for the Acute Care Program

This policy applies to all applications received for Medicaid payment of Inpatient hospitalization or rehabilitation.

Thirty Consecutive Days of Hospitalization

Eligibility for this program will only be determined once the individual has been hospitalized for 30 consecutive days, unless:

- the discharge plan is for nursing home placement; or
- the individual is seeking out of state inpatient rehabilitation placement.

Licensed and Certified Hospital or Rehabilitation Facility

The medical facility must be licensed and certified as a Title XIX Acute Care or Rehabilitation Medical Facility.

The Acute Care facility must be engaged in providing diagnostic and therapeutic services for medical diagnosis, treatments, and care of injured, disabled, or sick persons. These services must be provided by or under the supervision of physicians. Continuous twenty–four (24) hour nursing services are provided.

The Rehabilitation facility may be a freestanding rehabilitation hospital or a rehabilitation unit in an Acute Care hospital.

Medical Eligibility Requirements For In State Hospitalization and/or Rehabilitation

Medical eligibility for Inpatient hospitalization/rehabilitation services received within the state is determined by the Division of Medicaid and Medical Assistance Pre-Admission Screening (PAS) units. The individual must have required the level of care provided by a hospital during the time of his/her hospitalization, as determined by the PAS units.

Anyone 65 years of age or older, or statutorily blind would meet the medical eligibility criteria if they were in need of acute care services during the time of their hospitalization.

Medical Eligibility Requirements For Out of State Rehabilitation

Medical eligibility for Inpatient Rehabilitation services to be received out of state is determined by the Division of Medicaid and Medical Assistance Medical Director. The individual must require:

- close medical supervision by a rehabilitation physician;
- twenty-four (24) hour nursing supervision;
- an intensive level of physical, occupational or speech therapy; or
- psychological services; or
- prosthetic-orthotic services.

The individual must be able to tolerate and participate in **[all required therapies or services.**~~:~~

- ~~**at least 3 hours of physical and/or occupational therapy per day;**~~
- ~~**and any other required therapies or services.]**~~

Medical eligibility must be reviewed on a bi-weekly basis.

Prior authorization must be requested and approved before out of state placement is made.

Financial Eligibility Requirements

Financial eligibility is determined by the Division of Medicaid and Medical Assistance Financial units. An individual must meet income and resource guidelines.

Income Guidelines

The income limit is equal to 100% of the Federal SSI Standard. However, if the individual is going to a nursing home directly from a hospital or rehabilitation facility, the higher income limit of 250% of the Federal SSI standard will be applied.

For out of state rehabilitation the income limit is 250% of the Federal SSI standard.

Refer to DSSM sections 20200, 20210, and 20240 for additional guidelines regarding income.

Resource Guidelines

The resource limit is $2,000.00. Refer to DSSM sections 20300 – 20360, and 20400 for additional information on determining countable resources.

Spousal

If applicable, Spousal Impoverishment rules should be followed. (DSSM 20900)

Financial Redetermination

A redetermination of the individual's financial eligibility should be completed at six month intervals.

Post Eligibility Budgeting

There is a patient pay requirement for these individuals. The patient pay amount is determined in accordance with DSSM section 20600 - (Post-Eligibility Definitions/Procedures). Notification of patient pay amount and approval must be sent to the appropriate hospital/rehabilitation social worker.

Medicaid Eligibility Effective Date

In no case shall the effective date of eligibility be earlier than the first day of hospitalization.