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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS)

SUBCHAPTER 05 - INSTITUTIONAL LONG-TERM CARE

Part 1 – Medicaid LTSS in Health Institutions

1.1 Overview and Purpose

A. Medicaid covers certain inpatient, comprehensive services, subacute and long-term services and supports as institutional benefits. The word "institutional" with respect to federal Medicaid requirements applies to benefits authorized under Title XIX of the federal Social Security Act. For the purposes of LTSS, Medicaid recognizes three distinct health institutions all of which must be licensed under State law – nursing facilities (NF), intermediate care facilities for persons with intellectual or developmental disabilities (ICF/I-DD), and long-term care hospitals (LTH), including psychiatric care facilities for children and youth under age twenty-one (21), and the Eleanor Slater Hospital. In Rhode Island, these institutions are licensed by the Department of Health as “health care facilities” under R.I. Gen. Laws Chapter 23-17.

B. The characteristics of health institutions for Medicaid LTSS coverage purposes are as follows:

1. They operate as residential facilities and assume total care of a person who is admitted.

2. The comprehensive care provided includes room and board. Medicaid LTSS provided in a home or community-based setting is specifically prohibited under Title XIX from covering room and board.

3. The comprehensive services health institutions provide are billed and reimbursed as a single bundled payment. The State may vary the services included as part of the bundled rate across institutions. Therefore, a covered service included as part of a bundled rate in one institutional setting may be billed as a separate service in another setting.

4. Medicaid payment is only available if the State licensed or certified health institution meets applicable federal standards to qualify for federal financial participation under the Medicaid State Plan.

5. Health institutions are subject to regulatory oversight, including surveys at regular intervals, to maintain their certification, license to operate, and status as Medicaid providers; and

6. The rights and safety of patients and residents are protected in accordance with Title XIX of the Social Security Act at 42 U.S.C. §§1902(i), 1902(y) and 1919(h) and R.I. Gen. Laws Chapter 23-17-19.1.

1.2 Legal Authority

A. This Part is promulgated pursuant to the following federal and state authorities:

1. Federal Law -- Title XIX of the U.S. Social Security Act 42 U.S.C. §§ 1396a, 1902(a), 1905, 1913, 1915(c)-(k), 1917(f),1919, 1922.

2. Federal Regulations -- 42 C.F.R. §§ 431.151,433.15, 433.36(h), 435.1110, 440.160, 441.154, 447.15 and 20-21,447.257, 447.204, 456.600-665, 483.440, and 488.430-442.

3. The RI Medicaid State Plan and the Title XIX, Section 1115 (a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.

B State Authority R.I. Gen. Laws Chapters 23-17; 40-8; and 42-35-3(c).

1.3 Definitions

A. For the purposes of this Part, the terms below are defined as follows:

1. "Institute for Mental Disease" or "IMD" means any hospital, nursing facility, or other licensed health facility or institution of more than sixteen (16) beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

2. "IMD exclusion" means the provision in Section 1905(a)(B) of Title XIX of the Social Security Act, the federal Medicaid law, that prohibits federal matching payments for psychiatric, behavioral health, or substance use treatment services provided for any person in an IMD who is under sixty-five (65) years of age except for inpatient psychiatric hospital services for children and youth under age twenty-one (21).

3. "Preadmission Screening and Resident Review" or "PASRR" means the evaluation for serious mental illness and/or intellectual disability that is conducted by a NF and reviewed by the State for all persons seeking admission to a NF as set forth in Subchapter 00 Part 5 of this Chapter.

4. "Primary care essential benefits" means and includes non-LTSS Medicaid health coverage, and includes an array of acute, subacute, and specialty essential benefits, as identified under the Medicaid State Plan, provided by licensed health professionals. These essential benefits include, but are not limited to: health promotion, disease prevention, health maintenance,

counseling, patient education, various specialty services and diagnosis and treatment of acute and chronic medical and behavioral health illnesses and conditions in a variety of health care settings (such as office visits, inpatient, home care, day care).

1.4 Accessing Medicaid in Health Institutions

A. Medicaid LTSS is available to applicants and beneficiaries who meet the non-financial, financial and functional/clinical eligibility criteria for eligibility set forth in Subchapter 00 Part 5 of this Chapter.

1. Continuous need for LTSS – A person must have an established need for continuous LTSS as set forth in Subchapter 00 Part 1 of this Chapter to qualify for LTSS in a health institution.

2. Highest need for LTSS -- As indicated in the provisions on functional/clinical eligibility in Subchapter 00 Part 5 of this Chapter, access to LTSS in health institutions is tied to the level of need. Under the terms of the State's Section 1115 demonstration, an applicant or beneficiary must have the highest need for an institutional level of care to access care in a nursing facility, ICF/I-DD or long-term hospital.

B. Federal and state laws prohibit licensed health institutions from discriminating against a person solely because of health care payer. Accordingly, a health institution is not permitted to deny admission for LTSS on this basis to an otherwise qualified Medicaid beneficiary. Health institutions must adhere to the applicable notice and due process requirements specified herein prior to discharging a person based on the loss of Medicaid eligibility.

C. Medicaid LTSS in health institutions is a Medicaid State Plan covered benefit. Accordingly, Medicaid beneficiaries residing in health institutions have access to the full array of covered primary care essential benefits and long-term services and supports. The scope of Medicaid covered services each type of health institution provides differs, depending on licensure status and the needs of the populations they serve. The State must assure a beneficiary has access to a needed covered service in situations in which the health institution where he or she resides does not have the capacity or authority to provide that service.

1.5 Medicaid LTSS in Nursing Facilities

A. In general, licensed nursing facilities provide a mix of the following services:

1. Skilled nursing -- Intermittent or continuous skilled nursing or medical care and related services to address a clinical condition and/or functional limitation;

2. Subacute care -- Rehabilitative services needed due to injury, disability, or illness;

3. Long term services and supports -- Health-related services and supports (above the level of room and board) needed regularly due to a clinical or functional disability. Previously referred to as “custodial care”;

4. Hospice care – An array of services furnished to terminally ill beneficiaries including, nursing, medical social services, physician services, counseling services for the beneficiary, family members, and/or other care givers. When provided in a NF, hospice is an elective service in which the beneficiary waives access to treatments to cure the terminal illness in favor of palliative care. This election may be revoked at any time.

B. There is no exhaustive list of required Medicaid services in the NF benefit. A Medicaid participating NF is required to provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as established in a beneficiary’s individualized plan of care.

C. In accordance with the Rhode Island Medicaid State Plan and federal regulations:

1. Minimum services -- A NF must provide, and residents may not be charged for, at least:

a. Nursing and related services;

b. Specialized rehabilitative services including any required for residents who have a mental illness or intellectual disability, that are not provided or arranged for by the State, as specified in the PASSR evaluation set forth in Subchapter 00 Part 5 of this Chapter;

c. Medically related social services;

d. Pharmaceutical services including acquiring, receiving, dispensing, and administering of drugs and biologicals;

e. Dietary services individualized to the needs of each resident;

f. Professionally directed program of activities to meet the interests and needs for well-being of each resident;

g. Emergency dental services and routine dental services covered under the State Plan;

h. Room and bed maintenance services; and

i. Routine personal hygiene items and services.

2. The NF is not required to but may provide and charge residents for:

   a. Private rooms, unless medically needed;

   b. Specially prepared food, beyond that generally prepared by the facility;

   c. Access to and use of social and electronic media, including the internet, and/or a telephone, television, or radio;

   d. Personal comfort items including tobacco products and confections;

   e. Cosmetic and grooming items and services in excess of those included in the basic service;

   f. Personal clothing, reading materials, gifts, and/or room accoutrement including flowers, plants, hanging pictures or decorations;

   g. Social events and activities beyond the facility's established program; and/or

   i. Special care services not included in the facility's Medicaid payment rate.

3. Payer of last resort -- Medicaid is the payer of last resort for all NF services.

   a. Full dual eligible Medicare and Medicaid eligible beneficiaries. Medicaid payment for NF services provided to Medicaid-Medicare dually eligible beneficiaries is only available if Medicare payment is not available. The State pays the Medicare premiums and co-insurance and deductibles for dual eligible beneficiaries with income up to 100 percent of the federal poverty level (FPL) or who are medically needy eligible for LTSS and do not include such Medicare costs toward their monthly spenddown.

   b. Partial dual eligible beneficiaries. Medicare beneficiaries who do not qualify for Medicaid LTSS due to excess resources, may apply for Medicaid coverage to cover Medicare co-insurance for skilled services through the State's Medicare Premium Payment Program.

4. Payment authorization – Payment for NF services is based on a per diem rate. Accordingly:

a. First day. Payment for NF services by the State begins on the first day of eligibility or the date in which the beneficiary is admitted and receiving services, whichever comes later and without regard to the hour of admission.

b. Last day. Payment does not cover NF services on the last day beneficiaries are in a NF, regardless of the hour of discharge from the facility.

c. Bed-hold days. The State does not pay for NF services to retain a bed or placement. When a beneficiary leaves a NF for a hospital stay or any other temporary absence, the State ceases making payment to the facility beginning the day after the beneficiary leaves the NF. NF personnel must notify the State of the beneficiary's departure as soon as possible, but no later than ten (10) business days.

d. PASSR. No authorization for NF payment is made until the PASSR evaluation has been completed.

1.5.1 Accessing NF Coverage

A. The State maintains a "No Wrong Door" policy for anyone seeking LTSS. Therefore, an applicant seeking initial Medicaid LTSS eligibility is treated the same irrespective of whether he or she is living at home or in a community-based supportive living arrangement, residing in a NF, or a patient in a hospital or other health institution. Once a determination of LTSS eligibility is completed, services in a NF are authorized providing all other factors affecting access have been met.

B. Certain factors affect access to Medicaid LTSS in a NF, including:

1. Age -- LTSS in a NF is available to eligible beneficiaries who are age twenty-one (21) and older. Medicaid treats LTSS for children and youth under age twenty-one (21) as a separate benefit. There is no difference in the range of NF services Medicaid covers for children and youth who have the applicable level of need.

2. Continuous need for LTSS – To qualify for Medicaid LTSS, an applicant must have an established need continuous long-term care as defined in Subchapter 00 Part 1 of this Chapter;

3. Highest level of need – Medicaid coverage of LTSS in a NF is available only to applicants and beneficiaries who have been determined in the functional/clinical eligibility process to have the highest need for the NF level of care. There are exceptions. Both the functional/clinical eligibility criteria and the exceptions are set forth in Subchapter 00 Part 5 of this Chapter.

4. PASSR – All persons seeking admission to a NF are subject to a PASSR evaluation and, as appropriate, the development of a treatment plan in accordance with Subchapter 00 Part 5 of this Chapter.

C. There are no waiting lists for Medicaid NF services. In accordance with R.I. Gen. Laws Chapter 40-8.10, a beneficiary determined to have the highest NF level of need who is receiving LTSS in a home or community-based (HCBS) setting may request a transfer to a NF if a waiting list for services develops, placement in the HCBS setting fails, or a hospital stay occurs without a re-evaluation of functional/clinical level of need if otherwise still eligible.

1.6 Medicaid in an ICF/I-DD

A. Intermediate care facility services for people with intellectual/developmental disabilities (ICF/I-DD) is an optional Medicaid benefit that provides comprehensive and individualized health care and rehabilitation services to optimize the functional status and independence of beneficiaries. In Rhode Island, ICF/I-DDs are licensed health care facilities that serve a limited number of beneficiaries in need of, and receiving, active treatment (AT) services.

B. The ICF/I-DD service is the most comprehensive benefit in Medicaid LTSS. In general, ICF/I-DD Medicaid covered services include, but are not limited to:

1. Active treatment – In an ICF/I-DD, AT is a continuous, aggressive, and consistent implementation of a program of specialized and generic training, treatment, and health or related services, directed toward helping a beneficiary function with as much self-determination and independence as possible. All services including health care services and nutrition are part of the AT, which is based on an evaluation and individualized program plan (IPP) by an interdisciplinary team. AT provides a continuous program of habilitation that excludes services to maintain generally independent beneficiaries who are able to function with little supervision.

2. Day programs -- ICF/I-DD residents work in the community, with supports, or participate in vocational or other activities outside of the residence and engage in community interests of their choice. These activities are collectively often referred to as “day programs” and are often included as AT, though they may be covered separately as an HCBS core service for a beneficiary transitioning from an ICF/I-DD to a community setting.

C. An applicant must meet the requirements for services set forth in R.I. Gen. Laws Chapter 40.1-21 including a continuous need for LTSS and need active treatment for an intellectual or developmental disability that was manifested prior to age twenty-two (22). The applicant must also meet the functional/clinical eligibility criteria for the highest need for the level of care typically provided in an ICF/I-DD as indicated in Subchapter 00 Part 5 of this Chapter.

D. Under the State's Section 1115 demonstration, the Medicaid ICF/I-DD level of care is generally provided in the least restrictive setting that is appropriate to meet a beneficiary's needs. Accordingly, Medicaid covers AT both at home and in an array of community-based settings that offer beneficiaries greater independence than services in an ICF/I-DD health institution typically allow. Medicaid LTSS in an ICF/I-DD is thus reserved for only those beneficiaries who are unable to safely obtain the full range of services they need in an HCBS setting or a health institution that provides the same or a more extensive set of AT as well as the Medicaid covered services necessary to address other chronic health conditions.

1.7 Medicaid LTSS in a Hospital

A. Medicaid LTSS in a hospital is a Medicaid State Plan covered service for certain applicants and beneficiaries who meet age and need requirements. Access is limited by the provision in federal law which defines any health institution which provides behavioral health, psychiatric, substance use or related services to more than sixteen (16) beds as an "Institute for Mental Disease." Federal Medicaid matching funds are not available for LTSS provided in an IMD for beneficiaries aged 21 through 64. In addition, the State does not currently license any health institutions as "long-term acute care treatment (LTAC) facilities." This is the category of licensure for hospitals that provide an array of LTSS for people with non-IMD chronic and disabling conditions. Within these limitations, Medicaid LTSS hospital services are available only as follows:

1. Habilitation – Persons who have highest level of need for habilitative services may access the care they need in a hospital setting if HCBS options are unavailable.

2. Psychiatric Services Under Age 21 -- Medicaid covered hospital services are covered for children and youth through age twenty-one (21) in psychiatric residential treatment facilities (PRTFs). A PRTF provides intensive, short term comprehensive mental and behavioral health services for a range of clinical conditions that can most effectively be addressed in a residential treatment facility in collaboration with family members, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate treatment for mental illness and emotional and behavioral issues.

3. Over age 65 – Medicaid LTSS covers IMD services in a hospital or NF for persons sixty-five (65) and older. To access these services, an applicant or beneficiary must be found in the PASSR evaluation process to require services for a mental illness or intellectual disability in accordance with Subchapter 00 Part 5 of this Chapter. Medicaid covered services are based on need and include the full range of State Plan and waiver services required by the PASSR care plan.

B. Medicaid covers the full period of LTSS in a hospital beginning on the date of eligibility. Payment is not made for the date of discharge, irrespective of the time at which it occurs.

1.8 Medicaid LTSS Beneficiaries Receiving SSI

A. SSI recipients who are receiving Medicaid LTSS in a health institution may continue to receive full SSI benefits for up to three (3) months if they have an intent to return to the community within ninety (90) days. A treating, licensed health care practitioner must certify to both the State and the federal Social Security Administration (SSA) that the period of LTSS in the health institution is not expected to exceed ninety (90) days and that continuation of the SSI benefit is necessary for the beneficiary with SSI to retain his or her home. If the beneficiary remains in the health institution for a longer period than expected, the SSA terminates or reduces the SSI payment as appropriate.

B. SSI payments for adults with disabilities who are working and qualify for Section 1619(b) of Title XX, may receive up to two (2) months of continuing SSI benefits when admitted to a health institution if there is an expectation that the beneficiary will continue to work or resume working within the sixty (60) day period.

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PART 1 - MEDICAID LONG-TERM SERVICES AND SUPPORTS: INSTITUTIONALLY BASED LTSS (210-RICR-50-05-1)

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