

**STATE OF VERMONT  
AGENCY OF HUMAN SERVICES  
Office of Vermont Health Access (OVHA)**

**AHS Bulletin No: 09-07**

Secretary of State's ID Number: 09P-041

**FROM:** Susan Besio, Ph.D., Director  
Office of Vermont Health Access

**DATE:** 01/14/10

**SUBJECT:** Changes to Long-Term Care and Hospital Rules

**CHANGES ADOPTED EFFECTIVE** 02/06/10

**TYPE OF RULE CHANGE**

**Adopted Rule Changes**

**Final Proposed Rule Change**

**Proposed Rule Change**

**RULE REFERENCE(S):**

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| <b>7601</b>                   | <b>7603.1</b> | <b>7604.2</b> | <b>7605.4</b> | <b>7606.3</b> |               |

This bulletin proposes updated definitions and coverage rules for long-term care and hospital services. It reflects current practices for both, and reflects the changes in the service delivery system created by the Choices for Care waiver. It incorporates changes to the names of State agencies. These changes are the result of extensive collaboration between the Office of Vermont Health Access and the Department of Disabilities, Aging, and Independent Living; Department for Children and Families - Economic Services Division; Department of Mental Health; the Agency of Human Services - Rate Setting Division, and EDS, the fiscal agent for Vermont Medicaid.

***Specific Changes to Rule Sections Since the Last Filing***

- 7601 “Choices for Care: Long-Term Care Medicaid Waiver” was replaced with “Choices for Care 1115 Long-Term Care Medicaid Waiver”.
- 7605 A A sentence was added that states that DAIL will consider information from outside sources in determining clinical eligibility. A sentence was added in parentheses where clinical eligibility information can be found in the Choices for Care Long-Term Waiver regulations (It was also added in subsection #3 as well). The telephone number for the specific DAIL division was deleted and replaced with “DAIL”. In subsection #4, one “only” was moved and another was added.
- 7605 B The words “Need for” were replaced with “Decisions regarding”.
- 7606 The telephone number for the specific DAIL division was deleted and replaced with “DAIL”.

## ***Responses to Public Comments***

A public hearing was held on Monday, October 26, 2009 at 10:00 am in the Office of Vermont Health Access (OVHA) Large Conference Room, 312 Hurricane Lane, Suite 201, Williston, Vermont. Comments were received at the hearing from Laura Pelosi, the Executive Director of the Vermont Health Care Association.

OVHA received written comments from Laura Pelosi, the Executive Director of the Vermont Health Care Association.

Their comments, with OVHA's responses, are summarized below.

**Comment:** The Vermont Health Care Association expressed concern on the part of their members that DAIL is essentially the sole determinant of eligibility under Choices for Care regardless of any opinions or the exercise of judgment on the part of other health care professionals that might be treating the individuals enrolled in Choices For Care or seeking enrollment and the need to simply provide greater deference to physicians, the nurse practioners, the social workers, the psychologists, psychiatrists, that are treating these individuals.

**Response:** Choices for Care is a demonstration project (waiver) under Section 1115 of the Social Security Act. It provides an entitlement to home and community-based services for persons with the highest needs, within the long-term care infrastructure. It institutes a person-centered planning process by matching services to participants' needs and choices according to a person-centered assessment and options counseling process, within the limited funds available.

When Choices for Care began in 2005, the state and the Centers for Medicare and Medicaid (CMS) agreed that the prioritization of participants would be as follows:

1. Participants that were already receiving services at that time would continue to receive services before new participants and applicants in the Highest Need group; then
2. Participants and applicants in the Highest Need group would receive services before participants and applicants in the High Need group; then
3. Participants and applicants in the High Need group would receive services before participants and applicants in the Moderate Need group.

In addition, Choices for Care was "level-funded" which means funding for services is limited.

Choices for Care is a state-run program where eligibility determination combines both clinical and financial components. The Choices for Care waiver does not allow individual health care professionals to determine clinical eligibility and enrollment. The clinical determination is made based upon a face-to-face assessment, interview of the applicant, additional information from family and medical professionals, as needed and options counseling. In addition, there would be no way for individual providers to determine the financial eligibility. That said, DAIL does not make clinical eligibility and enrollment decisions in a vacuum, it relies on information from social workers and medical professionals.

**Comment:** In many cases, a patient is not clinically assessed for eligibility until four or more weeks after a patient has been admitted to a facility. This occurs not only in those cases where a patient is admitted with Medicare as the initial payment source. By that point in time, a patient's condition has often improved substantially and eligibility is denied. In these situations, the provider is not reimbursed by Medicaid for the cost of providing care. Often this means a total financial loss of tens of thousands of dollars for the provider, who bears all of the risk.

**Response:**

There are separate situations here.

- For persons admitted to a facility with Medicare coverage primary and Medicaid secondary, Medicaid covers the co-payments and co-insurance coverage without a DAIL clinical eligibility assessment. This continues only as long as Medicare is primary.
- If a person was admitted to the facility under Medicare guidelines, having both Medicare and Medicaid, and the Medicare coverage is expiring, then Choices for Care (CFC)/DAIL will have to be notified so that a clinical assessment can be completed, and services approved or denied based on CFC participation guidelines. DAIL will complete the clinical assessments/eligibility within 10 days of notification. If the nursing facility waits until the person's Medicare coverage has ended, or waits too long before requesting a Choices for Care clinical eligibility determination, then yes, the provider will not be reimbursed by Medicaid for the cost of providing care, until such time as DAIL approves clinical eligibility.
- If a person is admitted to a nursing facility with Medicaid only, Choices for Care (CFC)/DAIL should be notified immediately, so that a clinical assessment can be completed, and services approved or denied based on CFC participation guidelines. DAIL will complete the clinical assessments/eligibility within 10 days of notification. If the nursing facility waits, then yes, the provider will not be reimbursed by Medicaid for the cost of providing care.
- If a person is admitted to a nursing facility without Medicare or Medicaid, Choices for Care (CFC)/DAIL should be notified immediately, so that a clinical assessment can be completed, and services approved or denied based on CFC participation guidelines. DAIL will complete the clinical assessments/eligibility within 10 days of notification. In addition, financial eligibility also has to be completed, and that sometimes takes time because people need to collect the required documentation. If the nursing facility waits, then yes, the provider will not be reimbursed by Medicaid for the cost of providing care.

Clinical eligibility for nursing facility care is different between Medicare and Medicaid. Medicaid funding is limited and has more stringent criteria than Medicare.

**Comment:**

Clinical assessments must be based on the patient's condition at the time of admission to a long term care facility and must rely on the professional judgment of the health care professionals rendering care to the patient. The potential for re-hospitalization or re-admission to the long term care facility is increased. The clinical assessment process does not adequately consider the stability of the patient and the potential for decline in a patient's condition if a patient is deemed to be no longer eligible for placement in that setting. As a patient's condition improves due to the care provided in a long term care facility, the patient is discharged and no longer has the care and support provided by that facility. The potential for re-hospitalization or re-admission to the long term care facility is increased. Consideration of the potential for post-discharge decline is integral to a holistic and appropriate assessment of the patient's needs. Consultation with a patient's health care team prior to a determination to terminate eligibility is critical in improving patient outcomes.

**Response:** The clinical determination is made based upon a face-to-face assessment, interview with the applicant, additional information from family and medical professionals, and options counseling. In addition, DAIL considers:

- The need for a beneficiary's admission to the facility.
- The need for continued stay.
- The level of care required.
- The appropriateness and quality of care received.
- Admission-Discharge status.

**Comment:** Once a patient is deemed to be no longer eligible for placement in a particular setting, it is often a challenge for VHCA members to identify appropriate home and community based supports necessary to maintain the continuity of care required to ensure the patient's stability upon discharge. It is the experience of VHCA members that the need for support in the community does not necessarily equal the availability of services.

**Response:** This is correct. Community-based supports for individuals are often a challenge, particularly as resources are limited and already stretched.

**Comment:** The Medicaid reimbursement system provides no incentive for nursing facilities to admit patients who do not need the highest level of care.

**Response:** Based on the terms and conditions of the Choices for Care waiver, that is correct.

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To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Office of the Vermont Secretary of State at: <http://vermont-archives.org/aparules/index.htm> or call Louise Corliss at 828-2863. [General information, not specific rule content information]

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For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedules/schedule2.cfm> or call 828-5760.

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Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing content.

7201 Payment for Hospital Services - Medical and Psychiatric

7201.1 Reimbursement Standards

7201.2 Disproportionate Share

7202 Inpatient Services

7202.1 Excluded Services

7202.2 Dental Procedures

7202.3 Psychiatric Care

7202.4 Care of Newborn Child

7203 Outpatient Services

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7201 Payment for Hospital Services - Medical and Psychiatric

Medicaid payment for covered inpatient services is limited to the following hospitals:

A Vermont hospital approved for participation in Medicare; or

An out-of-state hospital, which is approved either for Medicare participation or for Medical Assistance (Title XIX) participation by the single state agency administering the Title XIX program within the state where it is located. Except for the out-of-state hospitals listed below, reimbursement will be made only if the admission receives a prior authorization. For elective inpatient care the prior authorization must be obtained prior to the provision of services. For emergent and urgent inpatient care, notification is required the next business day following admission. Emergent and urgent care is defined in Medicaid Rule 7101.3.

The following out-of-state hospitals will be considered to be Vermont hospitals due to their close proximity to Vermont and the fact that it is the general practice of residents of Vermont to secure care and services at these hospitals:

Alice Peck Day Hospital, Lebanon, NH  
Cottage Hospital, Woodsville, NH  
Dartmouth Hitchcock Medical Center, Lebanon, NH  
Glens Falls Hospital, Glens Falls, NY  
Littleton Hospital, Littleton, NH  
Mary Hitchcock Memorial Hospital, Hanover, NH  
North Adams Hospital, No. Adams, MA  
Upper Connecticut Valley Hospital, Colebrook, NH  
Valley Regional Hospital, Claremont, NH  
Weeks Memorial Hospital, Lancaster, NH

Payment for inpatient hospital services is limited to those instances in which the admission and continued stay of the beneficiary is determined medically necessary by the appropriate utilization review authority.

Payment may also be made to a Vermont hospital for inpatients who are determined no longer in need of hospital care but have been certified for care in a Nursing Facility. (Medicaid Rule 7606).

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**7202.2**      Dental Procedures

Payment of inpatient hospital services related to dental procedures is made only in the following situations:

For beneficiaries age 21 and over:

When a covered surgical procedure is performed (see Section 7312); or

When prior authorization has been granted by the Office of Vermont Health Access in a case where hospitalization was required to assure proper medical management or control of non-dental impairment during performance of a non-covered dental procedure (e.g., a beneficiary with a history of repeated heart attacks must have all their other teeth extracted) and need for such hospitalization is certified by the physician responsible for the treatment of the non-dental impairment. Should the beneficiary already be hospitalized for the treatment of a medical condition and a non-covered dental procedure is performed during the hospital stay, the prior authorization is not required. In these instances hospital and anesthesia charges are covered, but the services of the dentist performing the dental services are not.

For beneficiaries under the age of 21:

When prior authorization has been granted by the Office of Vermont Health Access before the provision of services in cases where dental treatment was performed and the dental consultant certified that the beneficiary required hospitalization either for management of other medical conditions or to undergo dental treatment.

**7202.3**      Psychiatric Care

Inpatient psychiatric services provided in a hospital are covered to the same extent as inpatient services related to any other type of care or treatment. Authorization requirements are defined in Rule 7201.

**7202.4**      Care of Newborn Child

For a period of seven days or until the mother is discharged, whichever is earlier, billing of post-delivery care for the newborn child of an eligible mother must be on separate claims using the mother's Medicaid identification number. Nursery days of care must be identified separately in the itemized listing of services rendered to both mother and child.

Payment for medically-necessary, continuing inpatient care of an infant, beginning with the eighth day of post-natal care or the day of mother's discharge if earlier, requires application for and determination of the infant's eligibility, a separate Medicaid identification number and separate billing.

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## 7601 Long-Term Care Services

These regulations apply to all long-term care services for Medicaid beneficiaries of any age. For beneficiaries age 18 or over, regulations promulgated by the Department of Disabilities, Aging, and Independent Living (DAIL) through the “Choices for Care 1115 Long-Term Care Medicaid Waiver” program (Social Security Act Section 1115 Demonstration Project Number 11-W-00191/1) shall be controlling if they conflict with the provisions in this chapter (7601 - 7606).

The Medicaid Program (Title XIX) includes long-term care services provided to eligible beneficiaries in the following settings.

### A. Nursing Facilities (NF's)

A Nursing Facility provides, directly or by contract, room, board, skilled nursing and rehabilitation services on a 24-hour a day basis to assist beneficiaries to reach their optimal level of functioning.

All nursing facilities, pursuant to Section 1910(2) of the Social Security Act, have been certified for participation in Medicare or, if not participating in Medicare, have been continuously certified since July 1, 1980 for participation as a nursing facility as evidenced by a valid certification agreement on file with the Office of Vermont Health Access.

An out-of-state nursing facility must be participating in that state's Medicaid program as well as enrolled as a Vermont Medicaid provider. An in-state nursing facility (or distinct part of a facility) must be licensed by DAIL and enrolled as a Vermont Medicaid provider, in order to be reimbursed.

#### 1. Rehabilitation Center Services

Coverage of rehabilitation center services is limited to Medicare-certified nursing facilities, licensed and approved for Medicaid participation by the state where the facility is located, and enrolled as a Vermont Medicaid provider. These services include intensive sensory stimulation; intensive physical, speech and occupational therapy; adjustment counseling; training in the use of prosthetics, orthotics and durable medical equipment; and other medical services needed to improve the beneficiary's daily living skills and/or to facilitate recuperation from disease, injury, or medical event. Care must be supervised by physician specialists. The purpose of rehabilitation center services is to restore a beneficiary's functional abilities to the highest practical level of physical and/or mental self-sufficiency which will prepare the beneficiary for discharge. The discharge plan will provide for the active participation and training of family members, if appropriate.

Coverage is limited to one year unless an extension beyond one year is granted by DAIL when documented medical evidence shows that the beneficiary is continuing to demonstrate significant physical and/or mental progress and can reasonably be expected to be discharged to the setting for care established in the discharge plan. Under no condition will authorization extend beyond two years.

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### B. Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

A public or private institution (or distinct part thereof) certified for CMS participation by DAIL, Division of Licensing and Protection, for the provision of Intermediate Care Facility services for the Mentally Retarded (ICF/MR), as evidenced by a valid certification agreement on file with the Office of Vermont Health Access (OVHA) executed under 1902(a)(27) of the Social Security Act and 42 CFR 442, Subparts A, B, C, E and G. An ICF/MR provides, directly or by contract, health-related care and services to individuals with mental retardation.

### C. Home and Community-Based Services

Home and Community-Based Services include long-term care services provided in a home setting or an enhanced residential care setting. An individualized written service plan shall be developed for each participant. Services may include assistance with Activities of Daily Living, Instrumental Activities of Daily Living, Adult Day Service, Respite, Companion Service, Personal Emergency Response System, Home Modification/Assistive Devices, and other such services as DAIL may include (Choices for Care Regulations).

7602

### Supplementation Prohibition

Federal regulations require all Medicaid providers of long-term care services to accept the Medicaid payment as payment in full. For example, if a facility elects to serve Medicaid beneficiaries and the facility's customary charge for a semi-private room is \$250.00, but the Medicaid payment is \$200.00 per day, the Medicaid payment must be accepted as payment in full. The facility cannot collect any supplemental amount for the semi-private room from the beneficiary or anyone else acting on behalf of the beneficiary. If the beneficiary, or anyone acting on behalf of the beneficiary, requests to have a private room, the facility cannot charge more than the difference between the charges for a semi-private and a private room. In no case can the total payments for a private room exceed the charge for a private room.

Federal regulations also describe specific items and services for which a facility may charge residents extra. Beyond these items and services, supplementation by the beneficiary, family, friends or any other source is prohibited.

Federal regulations also require that Medicaid beneficiaries be informed, in writing, by the facility, at the time of admission to the nursing facility or when they become eligible for Medicaid, of the items and services that the facility offers and for which the beneficiary may be charged, as well as the amount of charges for those services. The Division of Licensing and Protection within DAIL is responsible for enforcing this regulation.

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7603      Services Covered in a Nursing Facility

The following covered services are included in the per diem rates for nursing facilities.

- A. Room and board;
- B. Required nursing services (except private duty nurses);
- C. Therapy services (physical, occupational, speech; inhalation, recreational) furnished on the premises by staff employed by the facility;
- D. Modification of diet (i.e., salt free, low-fat, diabetic and other special diets and including sugar substitutes and food supplements);
- E. Other special care services, including, but not limited to: hand-feeding, incontinence care, total care, full-time care, etc.;
- F. Washing personal clothing and provision of clean bedding;
- G. Bathroom supplies including toothbrush, comb, soap, shampoo, tissue, rubbing alcohol, toothpaste, lotions, talcums and similar preparations used in daily care;
- H. Bedding, sheets, disposable pads, etc.;
- I. All prescribed over-the-counter drugs;
- J. Sterile water, saline solution, etc.;
- K. All medical supply items ordered by the physician; and
- L. Use of durable medical equipment with whatever frequency is medically indicated.

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7603.1

### 7603.1 Drugs in Long-Term Care Facilities

For those Medicaid beneficiaries entitled to Medicare Part A or enrolled in Medicare Part B and enrolled in a Medicare prescription drug plan, this section applies only to drugs not included in a Medicare-covered prescription drug class.

Drugs prescribed by the attending physician for a beneficiary in a nursing facility or in an ICF/MR are covered in the same manner as for a beneficiary living in the community. Covered drugs are those available only with a prescription, obtained from a participating pharmacy, and billed directly by that pharmacy to the Medicaid fiscal agent; the pharmacy cannot bill the nursing facility and the facility then re-bill Medicaid. An exception is made for a Medicare-participating nursing facility which must collect first from Part A for covered drugs supplied as an ancillary service during the period a beneficiary is receiving nursing facility benefits under Medicare Part A.

All prescribed over-the-counter drugs for their residents are to be furnished and paid for by each nursing facility or ICF/MR. The facility will obtain these drugs from a pharmacy or drug wholesaler and enter the charges incurred in the cost report submitted for purposes of calculating the per diem rate. The facility shall not make a charge either to the Medicaid program or to the beneficiary for prescribed over-the-counter drugs.

A pharmacy may, however, receive payment directly from a nursing facility or an ICF/MR for reasonable costs incurred for unit dose or other systems, consulting services, or other costs incurred by the pharmacy in complying with Medicaid Rule 7501.7 and the facility shall include this cost in its cost report.

### 7603.2 Personal Comfort Items

Radio, television, telephone, air conditioners, beauty and barber services, and similar personal comfort items are excluded from coverage under Medicaid. The beneficiary may be charged for any personal comfort item when the beneficiary has requested it and has been advised that he or she will be charged. The facility may also charge the beneficiary for store items secured on the beneficiary's behalf such as magazines, newspapers, candy, tobacco, dry cleaning, denture cream, hairbrush, and deodorant.

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7603.3 Ancillary Services in a Nursing Facility

A nursing facility participating in Medicare must bill under Medicare Part B for the following services provided to beneficiaries when that beneficiary has exhausted his or her extended care coverage under Medicare Part A. For beneficiaries not covered by Medicare, billing Medicaid for these ancillary services is allowed.

- A. diagnostic X-ray, diagnostic laboratory and other diagnostic tests;
- B. X-ray, radium and radioactive isotope therapy;
- C. surgical dressings, splints, cast and other devices used to reduce fractures;
- D. prosthetic devices;
- E. leg, arm, back and neck braces;
- F. "outpatient" physical therapy and speech therapy services. Payment for outpatient physical therapy and speech therapy services requires certification by a physician that:
  - 1) therapy services are or were required on an outpatient basis; and
  - 2) a plan for furnishing the therapy services is or was established and reviewed periodically by the physician; and
  - 3) the services are or were furnished while the patient was under care of a physician.

Therapy services furnished by a provider's employees to its residents may not be billed as outpatient services.

A nursing facility participating in Medicare may provide, under arrangements with another provider, certain covered outpatient services to its residents. Under the arrangements the nursing facility must exercise professional responsibility over the arranged-for services. The services would be treated just as though they were furnished directly by the nursing facility.

7604 Duration of Coverage

Payment on behalf of an eligible beneficiary, for the period(s) the beneficiary is determined to be in need of institutional care, will begin on admission to the facility or the first day of Medicaid eligibility, whichever is later. Payment will end on the day before the day of discharge or death, the last day the beneficiary is determined to need institutional care, or the last day of eligibility, whichever is earliest.

Payment will end for any absence from a facility for an inpatient stay in another medical facility (i.e., hospital, psychiatric hospital, another nursing facility) except as provided below (7604.1 B).

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7604.1

7604.1 Leave of Absence from a Nursing FacilityA. Home Visit

Payment to a nursing facility on behalf of an eligible Medicaid beneficiary is continued during an absence for the purpose of a "home visit" (not including hospital stays) for up to 24 home visit days in a calendar year. A home visit is defined as a visit that includes an overnight stay. Such absences must be included in the beneficiary's plan of care.

B. Hospitalization

Pursuant to the Nursing Home Residents' Bill of Rights (33 V.S.A. §§7301 - 7306), a Medicaid beneficiary has the right to retain his or her bed in a nursing facility while absent from the facility due to hospitalization provided such absence does not exceed ten (10) successive days.

Medicaid payment will be made to a nursing facility that is not a swing bed facility for up to a maximum of six (6) successive days when the bed of a beneficiary is retained because the beneficiary is admitted as an inpatient to a hospital subject to the following conditions:

1. the nursing facility would otherwise be at its maximum licensed occupancy if the operator were not obligated to hold the bed open;
2. the beneficiary continues to meet Medicaid eligibility criteria;
3. the beneficiary has been an inpatient resident of the nursing facility and was admitted directly to the hospital;
4. the nursing facility has a valid provider agreement in effect on the dates of service for which payment is made;
5. the beneficiary's attending physician attests that the beneficiary is expected to be readmitted to the nursing facility from the hospital in ten (10) days or less, or, upon notice supplied by the hospital discharge planning unit to the nursing facility that the beneficiary will be discharged with an absence which shall not exceed ten successive days; and
6. documentation as required above (#3) is provided to the OVHA, and is on file at the nursing facility.

Payment for the days the bed is retained for the beneficiary will be made at the certified Medicaid per diem rates established for the nursing facility reduced by the amount, if any, of the beneficiary's share.

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7604.1 Leave of Absence from a Nursing Facility (Continued)

No payment will be made when a physician or hospital discharge planning unit makes a determination that the beneficiary will be hospitalized for more than ten (10) successive days, will never return to the nursing facility, or the beneficiary or legal representative waives the right to have his or her bed retained.

When a redetermination about the length of stay is made because of a change in the beneficiary's medical condition, payment will be made in accordance with the redetermination.

Each day reimbursed under this regulation is counted as a patient day for cost reporting purposes and must be reported separately from home visit days.

7604.2 Leave of Absence from an ICF/MR

Payments to an ICF/MR on behalf of an eligible beneficiary is continued for an absence of up to fifteen (15) days per quarter or sixty (60) days per year for the purpose of "home visit" providing it is consistent with and part of the beneficiary's current service agreement. Approval for an absence for the purpose of a "home visit" in excess of fifteen (15) days per quarter or sixty (60) days per year shall be obtained in advance from DAIL.

Medicaid payment shall be made to an ICF/MR for an eligible beneficiary during a leave of absence, subject to the following conditions:

- A. Any day for which the facility is paid to hold a bed open must be counted as a patient day and the revenue must be accounted for as patient revenue.
- B. The day of departure shall be counted as one day of leave and the day of return shall be counted as one day of inpatient care.
- C. The facility shall hold the bed vacant during leave.
- D. The beneficiary's return from leave shall not be followed by discharge within 24 hours.
- E. The facility shall identify the inclusive dates of leave in the manner designated by the DAIL.
- F. Leave shall be terminated on the day of death.

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7605 Authorization for Long-Term CareA. Nursing Facilities

After DAIL has determined clinical eligibility for long-term care, the Department for Children and Families - Economic Services Division (ESD) determines financial eligibility for long-term care. ESD then furnishes written authorization to long-term care service providers of financial eligibility for long-term care. Eligibility for long-term care services is based on financial eligibility, admission-discharge status, and clinical eligibility as determined by DAIL. Updated or revised authorizations are issued whenever one of these factors changes. The determination by DAIL shall control notwithstanding any statement by a physician or other health care professional to the contrary. Where applicable, such statements shall be reviewed by DAIL in making its determination.

Authorization for payment will be made on behalf of an eligible beneficiary based on a determination of financial eligibility (Medicaid Rules 4100 - 4400) and clinical eligibility made by DAIL (Choices for Care 1115 Long-Term Care Medicaid Waiver Regulations, Section IV.B).

No Medicaid payment will be made for services provided by any out-of-state nursing facilities, other than those mentioned below, unless the facility has been enrolled by the OVHA, and the admission authorized by DAIL.

Some out-of-state nursing facilities are regarded the same as any participating Vermont facility. No prior authorization is needed. The current list of approved facilities can be found on the DAIL web site (<http://dail.vermont.gov/dail-programs/dail-programs-providers/dial-providers-list-ooanf/dail-ooanf-providers-default-page>) or can be requested from the DAIL.

Information regarding nursing facility care in a hospital (swing beds), is located in Medicaid Rule 7606.

1. Level of Care

DAIL has approval authority for all admissions of individuals for all nursing facilities. The determination by DAIL shall control notwithstanding any statement by a physician or other health care professional to the contrary. DAIL shall consider:

- The need for a beneficiary's admission to the facility.
- The need for continued stay.
- The level of care required.
- The appropriateness and quality of care received.

2. Pre-Admission Screening and Resident Review (PASARR)

Pre-admission Screening and Resident Review shall be completed for certain individuals who have been or will be admitted to a nursing facility, as required by federal regulations at 42 CFR §483(c). PASARR shall determine if a person with a diagnosis of mental illness, mental retardation or a related condition requires the care provided in another type of facility, home and community-based care, or specialized services while residing in a nursing facility. The Department of Mental Health shall be responsible for PASARR for those individuals suspected of having a mental illness, or with a diagnosis of mental illness. DAIL shall be responsible for PASARR for those individuals suspected of having mental retardation or a related condition, or

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with a diagnosis of mental retardation or a related condition.

3. Post-Admission Review

Clinical eligibility for any Medicaid beneficiary or applicant residing in or admitted to a nursing facility shall be determined by DAIL within ten (10) days of notification of admission or notification of application. If the beneficiary is found clinically ineligible, he/she will be notified by DAIL. (Choices for Care 1115 Long-Term Care Medicaid Waiver Regulations, Section IX. A and IX.B)

4. Children in Long-Term Care Facilities

Least restrictive alternate living situations shall be utilized for children under age 18. When necessary, children may be served by nursing facilities in Vermont. All out-of-state nursing facilities are covered only after obtaining prior approval from DAIL. Payment for out-of-state nursing facilities for children will be covered only if there is no less restrictive placement in Vermont, only if deemed necessary by DAIL, and only if the facility is enrolled as a Vermont Medicaid provider.

B. ICF/MRs

Decisions regarding initial admission and continued stay in an ICF/MR shall be made by DAIL in accordance with state and federal regulations.

02/06/10

Bulletin No. 09-07

7606

7606      Nursing Facility Care in Hospitals - Swing Beds

Payment may be made on behalf of a Medicaid beneficiary who remains residing in a hospital upon determination by the Department of Disabilities, Aging, and Independent Living (DAIL) that he/she no longer needs hospital care but has been found to be in need of nursing facility level of care (swing bed). Such payment will be made only if the following conditions are met:

- A. The beneficiary is eligible for Medicaid during the period for which reimbursement is requested.
- B. The beneficiary is determined by the appropriate Utilization Review authority to be in need of nursing facility care for this period.
- C. The beneficiary has a qualifying inpatient hospital stay in the hospital seeking nursing facility payment under these provisions.
- D. The hospital's documentation shows a concerted and continuous effort to secure appropriate alternative placement for the beneficiary. No payment will be made in instances in which the Office of Vermont Health Access establishes that discharge planning efforts have been inadequate; when payment has already been made, recovery will be sought.
- E. The beneficiary or anyone acting on his or her behalf has not declined an available bed in an appropriate participating long-term care facility in the area.

The per diem rate is all inclusive and includes the covered services as specified in Medicaid Rule 7603. For beneficiaries covered by Medicare, billing for ancillary services covered by either Part A or B is allowed. For beneficiaries not covered by Medicare, billing to Medicaid for ancillary services listed in Medicaid Rule 7603.3 is allowed.

Out-of-state pre-approved hospitals with swing bed status are regarded the same as any participating Vermont facility. The current list of approved facilities can be found on the DAIL web site (<http://dail.vermont.gov/dail-programs/dail-programs-providers/dial-providers-list-oosnf/dail-oosnf-providers-default-page>) or can be requested from the DAIL.