Ohio | Department of Developmental Disabilities

John Kasich, Governor
John L. Martin, Director

To: **Superintendents, SSA Directors, COG Directors**

From: **Lori Horvath**

Date: **August 3, 2016**

Subject: **Short-term Institutional Stays for Waiver Enrollees**

The purpose of this communication is to share information regarding processes to follow when a person enrolled in a waiver requires a short-term stay in an intermediate care facility for individuals with intellectual disabilities (ICF) or a nursing facility (NF).

In accordance with 42 CFR 441.302 states must assure that people determined likely to require the level of care provided in an ICF, NF or hospital be given the choice of either institutional or home and community-based services (HCBS). Some people who are enrolled in waivers may occasionally require a short-term stay of 90 days or less in a facility that provides inpatient care.

The Ohio Department of Developmental Disabilities (DODD) used to have the ability to temporarily close a waiver span, known as suspension, through the Ohio Department of Medicaid's (ODM's) CRISE system. Doing so enabled facilities providing short-term services to people enrolled in waivers to be paid. On 8/1/16, the ODM began using its new eligibility system, Ohio Benefits, for people enrolled in waivers or receiving care in an ICF or NF. It is no longer possible to suspend waivers through this new system.

In order to accommodate the need for people enrolled in waivers to continue to access short-term institutional care, a new revenue code was made available to ICFs that is similar to a revenue code that has existed for NFs. Without this new revenue code, individuals enrolled in waivers would be limited to only accessing short-term care through the Residential Respite service that is only available from ICFs that are certified to deliver this waiver service. Revenue codes allow payment to facilities for up to 90 calendar days per year for individuals who remain enrolled in waivers. Failure to use the appropriate code will result in a denial of Medicaid payment. Furthermore, Medicaid payment will cease for individuals who remain in the facility for longer than 90 days while continuing to be enrolled in a waiver.

When an individual enrolled in a waiver requires short-term institutional care that will not be provided through the Residential Respite service, the following steps are required:

- The county board must submit a Notification of Individual Change in Status (NICS) to request suspension of waiver payment. This triggers DODD to temporarily to suspend PAWS to prevent a waiver provider from submitting a waiver claim in advance of the facility submitting the revenue code. If a waiver provider were to inadvertently submit a claim for a date on which a facility delivered care, the facility's claim would be denied.
- ICFs must submit a short-term admission NICS and attest to level of care.

- Staff from DODD's waiver eligibility unit (OA3s) will monitor the duration of suspended waiver payments and will notify county board waiver contacts when waiver payments have been suspended for 80 days. The county board will be reminded that Medicaid payment to the facility will end after 90 days.
- If the person is able to be discharged from the facility and resume waiver services within 90 days, the ICF must submit a discharge NICS and the county board must submit a NICS to restart the waiver.
- As soon as the team identifies the need for inpatient treatment to extend beyond 90 days for which no other funding source is available, the county board must submit a disenrollment NICS to DODD. Failure to do so will result in the loss of Medicaid payment to the facility.
- Upon receiving the disenrollment NICS from the county board, DODD will take action to disenroll the waiver. The actual disenrollment date or waiver end date will be retroactive to the date on which the person was admitted to the facility for the short-term stay.

  Example:

  Bob is enrolled in the IO Waiver with a span of 11/1/16 – 10/31/17. He is admitted to an ICF for a short-term stay on 6/1/17. The county board submits a disenrollment NICS on 8/25/17 due to the need to extend his ICF stay beyond 90 days. His actual disenrollment or waiver end date will be 6/1/17.
- The individual will receive hearing rights through the Ohio Benefits system. If a hearing is requested that results in a stay or continued waiver enrollment, no Medicaid payment will be available to the facility pending the outcome of the hearing.
- If the team determines the individual will require waiver services after being disenrolled as a result of requiring more than 90 days of care in a facility, the following actions must be completed. The same steps apply whether the person is "reslotting" or enrolling in a new waiver in a new program year.

  A "program year" is defined as July 1 – June 30. A person has the ability to return to the same waiver from which he was disenrolled if the waiver end date and new waiver start date occur within the same program year. This includes returning to a waiver with state funding or a locally-funded waiver. This is sometimes referred to as "reslotting."

  Example:

  Bob has an IO Waiver span of 11/1/16 – 10/31/17. He requires admission to a developmental center in 12/1/16 and is not ready to return home until 6/1/17. Bob was disenrolled from his waiver since his stay lasted longer than 90 days. His disenrollment or waiver end date was 12/1/16. His waiver span crosses two program years (7/1/16 – 6/30/17 and 7/1/17 – 6/30/18). Since he is returning home within the same program year, he is able to return to his previous waiver.

  1. The county board must add the person to PICT with the proposed enrollment date, as with any other waiver request.

2. If the person is re-enrolling in a waiver upon discharge from an ICF for a stay that was longer than 90 days, the ICF must submit a discharge NICS and the county board must submit an ICF-to-waiver NICS.
3. If the person is re-enrolling in a waiver upon discharge from a NF after a 90-day stay, the county board must submit a new initial level of care assessment. This is necessary regardless of the date of the last DD LOC determination. A new LOC assessment and a new clinician's verification form are required as a result of the person being determined to meet a nursing facility level of care for greater than 90 days.
4. Upon either reslotting or enrolling in a new waiver, the person will have a new level of care span based upon the new enrollment date.

Please feel free to contact Amy Coey at Amy.Coey@dodd.ohio.gov with any questions.