Legislative Regulation Review Committee

2009-014b

Department of Social Services

PAYMENT TO CHRONIC DISEASE HOSPITALS

R-39 REV. 04/04
IMPORTANT: Read instructions on bottom of Certification Page before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations.

STATE OF CONNECTICUT
REGULATION
OF

Name of Agency
Department of Social Services

Subject Matter of Regulation
Payment to Chronic Disease Hospitals

The Regulations of Connecticut State Agencies are amended by adding sections 17b-262-779 to 17b-262-791, inclusive, as follows:

(NEW) Section 17b-262-779. Scope

Sections 17b-262-779 to 17b-262-791, inclusive, of the Regulations of Connecticut State Agencies, set forth the Department of Social Services' requirements for payment to chronic disease hospitals for services to clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(NEW) Sec. 17b-262-780. Definitions

As used in sections 17b-262- 779 to 17b-262- 791, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Applied income" means the amount of income that each client receiving chronic disease hospital services is expected to pay each month toward the cost of his or her care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(2) "Assessment" means a comprehensive written evaluation of an individual's functional performance in relation to a set of measurable medical or physical criteria;

(3) "Client" means a person eligible for goods or services under the department's Medicaid program;

(4) "Chronic disease" means a disease having one or more of the following characteristics:

(a) is permanent;

(b) leaves residual disability;

(c) is caused by non-reversible pathological alteration;

(d) requires special training of the client for rehabilitation; or

(e) is expected to require a long period of supervision, observation or care;

(5) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(6) "Commissioner" means the Commissioner of Social Services or his or her designee;

(7) "Department" means the Department of Social Services or its agent;

(8) "Durable medical equipment" means equipment that meets all of the following requirements:

(a) can withstand repeated use;

(b) is primarily and customarily used to serve a medical purpose;

(c) is generally not useful to a person in the absence of an illness or injury; and

(d) is non-disposable;

(9) "Institution for mental diseases" means "institution for mental diseases" as defined in 42 CFR 435.1009, as amended from time to time;

(10) "Licensed practitioner" means any person licensed by the state of Connecticut, any other state, the District of Columbia or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(11) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(12) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(14) "Preadmission assessment" means a clinical assessment of ongoing needs and prognosis as necessary to determine the chronic disease hospital's ability to provide for a client's expected needs;

(15) "Provider" means a chronic disease hospital that is enrolled in Medicaid;

(16) "Provider agreement" means the signed, written, contractual agreement between the department and the provider;

(17) "Physician" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes;

(18) "Rehabilitation" means any medical or remedial services recommended by a physician or other licensed practitioner for maximum reduction of physical or mental disability and restoration of an individual to his or her best possible functional level;

(19) "Resident" means a client living in a chronic disease hospital;

(20) "Team" means a group of individuals employed by or under contract to the chronic disease hospital and may include physiatrists, specialized skilled nurses, physical therapists, occupational therapists or other rehabilitation specialists, such as speech therapists, respiratory specialists, prosthetists, orthotists, physiatrists or respiratory specialists. Other practitioners, including but not limited to, mental health practitioners, may be part of the team as appropriate;

(21) "Team conference" means a meeting of the team to develop a treatment plan of care;

(22) "Treatment plan of care" means the written description of services designed to meet a resident's medical, nursing and rehabilitation needs that are identified in the resident's assessment. The treatment plan of care shall include measurable objectives and a specific timetable; and

(23) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(NEW) Sec. 17b-262-781. Provider participation

(a) To enroll in Medicaid and receive payment from the department, a chronic disease hospital shall comply with the provider participation requirements of sections 17b-262-522 through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(b) In order to enroll in Medicaid and to receive payment from the department, a chronic disease hospital shall meet the requirements for state licensure described in section 19-13-D5 of the Regulations of Connecticut State Agencies, the requirements for federal certification to participate in the Medicaid program that are described in 42 CFR Part 482, as amended from time to time, and the requirements stated in sections 17b-262-779 to 17b-262-791, inclusive, of these regulations

(c) In addition to the requirements in subsections (a) and (b) of this section, in order to participate in the Medicaid program, a chronic disease hospital shall be federally certified as either:

(1) a long term care hospital that meets the criteria of 42 CFR 412.23(e);

(2) a rehabilitation hospital that meets the criteria of 42 CFR 412.23(b); or

(3) an acute care hospital with a PPS exempt psychiatric unit that meets the criteria of 42 CFR 412.25.

(NEW) Sec. 17b-262-782. Eligibility

Payment for chronic disease hospital services is available on behalf of all clients subject to the conditions and limitations that apply to these services.

(NEW) Sec. 17b-262-783. Need for service

In order for a client to be approved for admission to a chronic disease hospital, the client shall meet the criteria for admission as either a chronic disease client or a rehabilitation client. All care shall be medically necessary and medically appropriate.

(a) The criteria for admission as a chronic disease client are as follows:

(1) Each chronic disease client shall require services that can be provided safely and effectively at a chronic disease hospital level, shall be ordered by a physician and documented in the client's medical record, and shall include at least a daily physician visit and assessment or the 24-hour availability of medical services and equipment available only in a hospital setting; and

(2) The client's medical condition and treatment needs are such that no effective, safe, less costly alternative placement is available to the client.

(b) The criteria for admission as a rehabilitation client are as follows:

(1) Each rehabilitation client shall require an intensive rehabilitation program at the level of a chronic disease hospital level of care that includes a multi-disciplinary approach to improve the client's ability to function to his or her maximum potential. Factors shall be present in the client's condition that indicate the potential for functional improvement or freedom from pain. A client who requires therapy solely to maintain function shall not be considered an appropriate rehabilitation candidate;

(2) Each client's medical condition and treatment needs are such that no effective, safe, less costly alternative placement is available to the client;

(3) A preadmission assessment shall be developed, prior to admission by specialized skilled nurses, physical therapists, occupational therapists or other rehabilitation specialists, such as speech therapists, prosthetists or

orthotists;

(4) The treatment plan of care shall be directed by a physician who is board certified or eligible for board certification in an appropriate specialty; and

(5) The treatment plan of care shall be designed to achieve specific goals within a specified timeframe.

(c) Team conferences shall be conducted for each client. The first team conference shall occur not later than seven calendar days after the client's admission.

(d) For rehabilitation clients, subsequent conferences shall occur at least once every fourteen calendar days. All team members, or a designee within the same specialty, shall be in attendance. The purpose of the conference shall be to conduct an assessment of the client's progress, make adjustments to the established goals as indicated or terminate the program when the expected goal has been reached or determined to be no longer attainable.

(e) For chronic disease clients, subsequent conferences shall occur at least once every 90 days. The depth of the periodic review shall be appropriate to the client's clinical status and prognosis.

(f) The department may use nationally recognized guidelines applicable to chronic disease hospitals or inpatient rehabilitation hospitals in determining if the admission is medically necessary and medically appropriate.

(g) The department shall authorize payment for any individual who meets the criteria set forth in subsections (a) or (b) of this section when he or she:

(1) is a client seeking admission to a chronic disease hospital;

(2) is an individual who applies for Medicaid while in the chronic disease hospital; or

(3) is a client seeking an extension of treatment at a chronic disease hospital.

(h) The department shall pay a provider only when the department has authorized the client's admission to that chronic disease hospital and all other requirements for payment are met.

(NEW) Sec. 17b-262-784. Services covered

The department shall pay an all-inclusive per diem rate to the provider for each resident for whom payment has been authorized pursuant to section 17b-262-783 of the Regulations of Connecticut State Agencies. This per diem rate represents payment for the following goods and services:

(a) all services as required by section 19-13-D5 of the Regulations of Connecticut State Agencies and 42 CFR Part 482, as amended from time to time, including, but not limited to:

(1) medical direction in accordance with section 19-13- D5(c) of the Regulations of Connecticut State Agencies and 42 CFR 482.22;

(2) nursing services in accordance with section 19-13- D5(e) of the Regulations of Connecticut State Agencies and 42 CFR 482.23, as amended from time to time;

(3) therapeutic recreation in accordance with section 19-13- D5(k) of the Regulations of Connecticut State Agencies;

(4) rehabilitation services in accordance with section 19-13-D5(k) of the Regulations of Connecticut State Agencies and 42 CFR 482.56, as amended from time to time;

(5) room and board in accordance with sections 19-13-D5(h) and (i) of the Regulations of Connecticut State Agencies and 42 CFR 482.28 and 482.41 as amended from time to time,;

(6) diagnostic and therapeutic services in accordance with section 19-13-D5(f) of the Regulations of Connecticut State Agencies and 42 CFR 482.26, as amended from time to time;

(7) pharmacy services in accordance with section 19-13-D5(g) and 42 CFR 482.25, as amended from time to time;

(8) laboratory services in accordance with 42 CFR 482.27, as amended from time to time;

(9) respiratory services in accordance with 42 CFR 482.57, as amended from time to time; and

(10) consultation and assistance to residents in obtaining other needed services including, but not limited to, dental services, vision services, hearing services and services to address mental and psychosocial functioning;

(b) all services required as conditions of participation for certification under 42 CFR 412, Subpart B, Subpart O or Subpart P as applicable;

(c) all physical therapy, occupational therapy, speech therapy and respiratory therapy included in the treatment plan of care;

(d) routine personal hygiene items required to meet the needs of the resident including, but not limited to, hair hygiene supplies, soaps and other cleansing agents to treat skin problems, shaving supplies, dental and denture supplies, lotions, incontinence supplies, bathroom supplies and over the counter drugs;

(e) prescription drugs;

(f) durable medical equipment including customized equipment;

(g) supplies used in the care of the resident including, but not limited to:

(1) antiseptics and solutions;

(2) bandages and dressing supplies;

(3) catheters and urinary incontinent supplies;

(4) diabetic supplies;

(5) diapers and underpads;

(6) compression, burn and specialized medical garments;

(7) ostomy supplies;

(8) respiratory and tracheotomy supplies;

(9) enteral and parenteral supplies; and

(10) miscellaneous supplies;

(h) all oxygen supplies including oxygen concentrators; and

(i) transportation services necessary to transport a resident to and from any service included in the per diem rate as described in this section.

(NEW) Sec. 17b-262-785. Service limitations

Payment shall be made for the date of admission but not for the date of discharge. Exceptions to this are:

(a) Payment shall be made for the date of death when the resident dies in the chronic disease hospital.

(b) In the case of a resident admitted and discharged on the same day, payment shall be made for one day of care.

(NEW) Sec. 17b-262-786. Services not covered

(a) The department shall not pay a chronic disease hospital that is characterized as an institution for mental diseases except for services to clients aged 65 and older or under age 22 in accordance with section 17-134d-68 of the Regulations of Connecticut State Agencies and 42 CFR 435.1009.

(b) The department shall not reimburse any provider for any costs incurred before the authorized length-of-stay period or after the expiration of the specified length-of-stay period.

(NEW) Sec. 17b-262-787. Authorization process

(a) The department shall pay a provider only when the department has authorized payment for the client's admission to that chronic disease hospital.

(b) The provider shall comply with the authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies and sections 17b-262-779 to 17b-262-791, inclusive, of the Regulations of Connecticut State Agencies. The department, in its sole discretion, shall determine what information is necessary to approve an authorization request. Authorization does not, however, guarantee payment unless all other requirements for payment are met.

(c) An authorization request, on forms and in a manner as specified by the department, shall include documentation of medical need and shall be signed by the licensed practitioner. For individuals who become clients while in the chronic disease hospital, this authorization request shall include, but not be limited to, a treatment plan of care under the direction of a physician that is designed to achieve specified goals within a specified timeframe and developed by a team.

(d) Initial authorizations for treatment shall be authorized by the department for up to 30 days. Subsequent requests for the extension of authorization for the same client may be made for up to three months or longer, on a case-by-case basis.

(e) If a safe discharge is not possible from the chronic disease hospital, the Department shall authorize a continued stay and payment at the current Medicaid rate for up to three months or longer, on a case by case basis.

(f) The Department shall act on prior authorization requests for readmissions to a chronic disease hospital from an acute care hospital within one business day so that clients do not remain at the acute care hospital level longer than necessary.

(g) No chronic disease hospital shall be required to admit a client if such hospital has not received an authorization for treatment from the department.

(h) The department will process a request for authorization for treatment, and deliver a decision on such request within two full business days from the date a chronic disease hospital notifies the department that a client who is a patient of such hospital has exhausted his or her other third party insurance or whose coverage by

such insurance has been denied.

(NEW) Sec. 17b-262-788. Applied income

(a) A client who receives chronic disease hospital services is responsible for paying applied income to the chronic disease hospital.

(b) The department shall calculate the applied income. The department shall notify the chronic disease hospital of the amount of any applied income that the chronic disease hospital is responsible for collecting. Applied income shall be deducted from what otherwise would have been the department's monthly payment to the chronic disease hospital.

(c) The chronic disease hospital shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(d) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the chronic disease hospital multiplied by the per diem rate.

(e) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

(NEW) Sec. 17b-262-789. Billing and payment procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The chronic disease hospital is responsible for:

(1) completing the daily admission and discharge forms in accordance with the department's instructions;

(2) notifying the department's caseworker if the chronic disease hospital is aware that the resident's asset level exceeds the established resource limit. The report shall be made on the form specified by the department;

(3) notifying the department of any and all credits due the department on the form specified by the department; and

(4) exhausting other payment sources of which the chronic disease hospital is aware before billing the department.

(NEW) Sec. 17b-262-790. Rates

(a) The per diem rate for a chronic disease hospital is determined annually pursuant to section 17b-239 of the Connecticut General Statutes for freestanding chronic disease hospitals or section 17b-340 of the Connecticut General Statutes for chronic disease hospitals associated with chronic and convalescent nursing homes.

(b) The department shall reimburse the chronic disease hospital at the lower of:

(1) the per diem rate minus the applied income; or

(2) the usual and customary charge minus the applied income.

(NEW) Sec. 17b-262-791. Documentation

(a) The chronic disease hospital shall maintain all documentation required for rate setting purposes in accordance with section 17-311-56 of the Regulations of Connecticut State Agencies. This documentation is subject to review and audit by the department.

(b) The chronic disease hospital shall maintain all other documentation required by this section for at least five (5) years or longer as required by statute or regulation, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the chronic disease hospital shall maintain all documentation until the end of the dispute, for five (5) years, or for the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain all required documentation may result in the disallowance and recovery by the department of any amounts paid to the chronic disease hospital for which the required documentation is not maintained and provided to the department upon request. Documentation requirements are described in detail in the provider agreement and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) The department requires that each chronic disease hospital maintain fiscal and medical records to fully disclose services and goods rendered to residents. Records shall be maintained in accordance with the department's Provider Enrollment Agreement as signed by the chronic disease hospital.

(e) Required documentation includes:

(1) certification for chronic disease hospital admission as required by the department. The form shall be signed by a licensed practitioner;

(2) the department's written authorization of the client's need for chronic disease hospital care;

(3) all admission and discharge forms supporting the claim;

(4) medical records in accordance with section 19-13-D5(d) of the Regulations of Connecticut State Agencies and 42 CFR 482.24 that contains all pertinent diagnostic information and documentation of each service provided;

(5) the initial and all subsequent treatment plans of care signed and dated by a licensed practitioner; and

(6) For clients in the rehabilitation level of care, a record that includes:

(A) each team member's goals for the client and progress notes from each team conference;

(B) all decisions reached; and

(C) the reason for any lack of progress in reaching a specific goal.

Statement of Purpose: (A) The purpose of the proposed regulation is to adopt requirements for payment to chronic disease hospitals for services provided to Medicaid clients in accordance with Public Act 05-209. The problems, issues or circumstances that the regulation proposes to address: The proposed regulation provides requirements for Medicaid payment for chronic disease hospital services which are separate from the requirements for payment for services provided by acute care hospitals. Previously, the requirements for payment of these services were incorporated into the requirements for payment of general hospitals. The new regulations implement prior authorization for chronic disease hospitals which, at the moment, is not required.

(B) The main provisions of the regulation provide: (1) definitions of necessary terms; (2) the requirements for provider participation; (3) client eligibility; (4) criteria for admission to a

chronic disease hospital as either a "chronic disease client" or a "rehabilitation client"; (5) the services covered by Medicaid under the chronic disease hospital benefit; (6) service limitations; (7) services not covered by Medicaid; (8) the authorization requirements and process; (9) the calculation and collection of applied income; (10) billing and payment requirements and procedures; (11) payment rates; and (12) documentation requirements.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation provides the requirements for payment to chronic disease hospitals for services provided to Medicaid clients.

R-39 REV. 1/77

IMPORTANT: Read instructions on bottom of Certification Page before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations.

STATE OF CONNECTICUT

REGULATION

OF

NAME OF AGENCY

Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION

Payment to Chronic Disease Hospitals

SECTION_____

Statement of Purpose: (A) The purpose of the proposed regulation is to adopt requirements for payment to chronic disease hospitals for services provided to Medicaid clients in accordance with Public Act 05-209. The problems, issues or circumstances that the regulation proposes to address: The proposed regulation provides requirements for Medicaid payment for chronic disease hospital services which are separate from the requirements for payment for services provided by acute care hospitals. Previously, the requirements for payment of these services were incorporated into the requirements for payment of general hospitals. The new regulations implement prior authorization for chronic disease hospitals which, at the moment, is not required.

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(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation provides the requirements for payment to chronic disease hospitals for services provided to Medicaid clients.

CERTIFICATION
R-39 REV. 1/77

Be it known that the foregoing:

☒ Regulations ☐ Emergency Regulations

Are:

☒ Adopted ☐ Amended as hereinabove stated ☐ Repealed

By the aforesaid agency pursuant to:

☐ Sections _____ of the General Statutes.

☒ Section 17b-239 of the General Statutes, as amended by Public Act No. 05-209 of the _____ Public Acts.

☐ Public Act No. _____ of the Public Acts.

After publication in the Connecticut Law Journal on April 1, 2008, of the notice of the proposal to:

☒ Adopt ☐ Amend ☐ Repeal such regulations

(If applicable): ☒ And the holding of an advertised public hearing on 8th day of May, 2008

WHEREFORE, the foregoing regulations are hereby:

☒ Adopted ☐ Amended as hereinabove stated ☐ Repealed

Effective:

☒ When filed with the Secretary of the State.

(OR)

☐ The _____ day of _____ _____.

In Witness Whereof:	Date 8/26/09	SIGNED (Head of Board, Agency or Commission)	OFFICIAL TITLE, DULY AUTHORIZED Commissioner
Approved by the Attorney General as to legal sufficiency in accordance with sec. 4-169, as amended C.G.S.		SIGNED	OFFICIAL TITLE,DULY AUTHORIZED

☐ Approved
☐ Disapproved
☐ Disapproved in part, *(Indicate Section Numbers disapproved only)*
☐ Rejected without prejudice

By the Legislative Regulation Review Committee in accordance with Sec. 4-170, as amended, of the General Statutes.	Date	SIGNED (Clerk of the Legislative Regulation Review Committee)

Two certified copies received and filed, and one such copy forwarded to the Commission in Official Legal Publications in accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State.)	BY

INSTRUCTIONS

1. One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.

2. Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.

3. Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.

4. Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capital letters and deleted language in brackets. Section 4-170 of the General Statutes.