

Waiver Wise

Technical Assistance for the Medicaid Waiver Programs

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Institutional Stay Days

Under Wisconsin Medicaid eligibility, a person, residing in a nursing home and receiving Wisconsin Medicaid, may be required to pay a monthly patient liability amount to the nursing home. This patient liability offsets a portion of the cost that the nursing home bills to Medicaid. The amount of this patient liability is determined by the county income maintenance worker. Each Medicaid nursing home resident is allowed a \$45.00 monthly personal needs allowance 49.45(7)(a), Wis. Stats. and other person specific deductibles, before the final monthly patient liability amount is determined.

When an individual leaves a nursing home to return to community living, prior to the last day of the discharge month, there is no patient liability amount for the nursing home to collect from the individual, as directed in the Wisconsin Medicaid Eligibility Handbook (MEH 5.8.7.3.2).

Recently, the Department has issued a Patient Liability memorandum to all county Income Maintenance personnel to re-emphasize this procedure. Income Maintenance personnel are directed to decrease the patient liability for the calendar month of discharge to zero.

In order for this process to occur in a timely manner, it is imperative that the county care manager/support and service coordinator and the income maintenance worker keep each other fully informed of the month of the person's proposed discharge date from the nursing home.

This document specifically addresses institutional stay days as they relate to Human Services Reporting System (HSRS) reporting requirements.

HSRS Reporting and Reimbursement

The Human Services Reporting System (HSRS) is used to collect data on social/human service and mental health participants, the services they receive and the funds expended for those services. County procedures for entering information onto HSRS vary. In some counties, care managers/support and service coordinators are responsible for data entry; in others, data/fiscal personal enter the data.

If a waiver participant enters a hospital, nursing home, or like institution, waiver dollars cannot be used to fund waiver services during the time the person resides in the institution, except in three situations.

The three situations when the waiver may continue to pay for waiver services are (1) when a Personal Emergency Response System (PERS) is paid for on a monthly basis and it would be impractical and more costly to discontinue the service rather than to maintain it, (2) when discharge related care management is provided to a waiver participant within 30 calendar days of discharge from the institution, and (3) when admission to the institution is for the purpose of respite services that have been determined waiver allowable (SPC 103.24 – Institutional Respite).

In all situations, Medicaid pays for the day of admission to an institution and does not pay for the day of discharge. As a result, waiver dollars may not be used to pay for services on the day of admission to the facility, but may be used on the day of discharge.

Entering Information on HSRS and Institutional Stay Days

If a waiver participant is in a hospital or institution for **less than 30 consecutive calendar days**, the HSRS episode should remain open. The institutional days must be reported on HSRS. This can be done by opening a service strip on the HSRS Waiver Module under SPC 503-Inpatient. The service start date is the date of admission; the end date is the date of discharge. A new service strip with the appropriate admission and discharge dates must be opened each time the participant enters a hospital or nursing home, no matter how many times this occurs.

If a waiver participant is in a hospital or institution for **30 consecutive calendar days or more**, the waiver SPCs must be closed as of the date the person was admitted to the institution. Once the participant is discharged and begins to receive waiver services again, new waiver SPCs should be opened. The new SPCs starting dates would be the date of discharge. Important note: if an inpatient stay is reported some time after the actual admission date, the closing dates for the HSRS waiver SPCs must be the date of admission to the institution, not the date the inpatient stay is reported.

As mentioned earlier, the only waiver services that can be funded during an institutionalization are care management/support and service coordination (in limited circumstances related to discharge planning) and PERS. Costs for these services incurred while a participant is in a hospital or nursing home should be reported on HSRS as usual if the inpatient stay lasts less than 30 calendar days. If the inpatient stays last longer than 30 consecutive days, there is no open HSRS waiver SPC covering the period of the inpatient stay. As a result any cost incurred for these services during this period should be aggregated, incorporated into a revised rate and billed at that revised rate for the first month of the new HSRS episode after the participant is discharged. If the participant dies while in the institution, or a decision is made that the participant will remain in the institution resulting in no discharge date, the county may aggregate the cost of PERS only and add those costs to the month of the HSRS episode during which institutional admission occurred and then close the HSRS episode.

Example:

A participant enters a hospital on May 5th. She is then transferred to a nursing home on May 10th on what is hoped will be a short-term stay. The county continued to pay for PERS service. After several months, it is determined the participant will remain in the nursing home permanently and the county closes her case.

A HSRS closing date should be the day the participant entered an institution (in this example May 5th). The total cost of any PERS service paid during the months the participant was institutionalized should be added together and entered on HSRS in the last month the participant was open for the waiver program (in this example, May). In this example, because the participant was not discharged back into the community, no care management/support and service coordination that may have been provided while she was in an institution can be billed to the waiver. However, other funding options available to the county for billing any care management/support and service coordination time include COP, or the county may choose to not bill any funding source per se, and have the care manager/support and service coordinator's time be charged against administrative funds.

Reminder: When a case is going to be permanently closed, the participant needs to be given a written 10-day note of case closure, as well as appeal rights. If the written notice of the case closure is not sent, the case technically remains open. If later the individual chooses to leave the institution and appeals the decision of when he/she will be served by the waiver program, the county may be obligated to serve the individual since he/she never received proper notice and his/her case was never formally closed.

Does the billing need to be adjusted on HSRS if a participant was admitted into a hospital for only one day?

Yes. Because Medicaid dollars are used to pay for the day of admission to an institution, waiver dollars cannot be used to pay for waiver services even if the participant was only admitted for one day. Any waiver service that may have been provided on the day the person was admitted to an institution has to be billed to a non-waiver funding source. The only exception to this is PERS.

A participant went to the emergency room on May 20th. She was held for observation in the ER for several hours but not formally admitted to the hospital until May 21st. What is the first day of the institutional stay?

Because the participant was actually admitted to the hospital on May 21st, that date would be considered the first day of the institutional stay and the waiver cannot be billed effective May 21st.

A participant went to the emergency room on May 20th. After 6 hours he was sent home. He was never formally admitted to the hospital. Does any billing have to be adjusted on HSRS, or any institutional stay days entered on HSRS?

No. Because the participant was never formally admitted to the hospital, no dollar amount for services need to be adjusted; nor do any institutional stay days need to be entered on HSRS.