

## SENIOR BULLETIN: MEDICAID

### **Medicaid supplementation – supplemental payments in long-term care settings**

This bulletin addresses Medicaid supplementation as it applies to Medicaid recipients who are residents of long-term care facilities such as: adult family homes (AFH), assisted living (AL) and boarding homes, adult residential care (ARC), enhanced adult residential care (EARC), and nursing homes.

#### **What is Medicaid supplementation?**

Long term care facilities are paid a daily Medicaid rate to provide certain items and services to Medicaid recipients residing there. When items or services are covered under the Medicaid program, the Department of Social and Health Services (DSHS) pays a pre-established rate to the provider of the service or item. DSHS also determines the amount that a Medicaid recipient will pay as part of the Medicaid rate, known as “participation” and what amount the Medicaid recipient may keep as a “personal needs allowance”.<sup>2</sup> The provider is not permitted to charge or accept any additional amount from the Medicaid recipient.<sup>3</sup>

On the other hand, if an item or service is not covered by the Medicaid program, then a provider of the service or item is permitted to charge the Medicaid recipient for it, provided that the Medicaid recipient (or someone on the recipient’s behalf) wants to make the purchase.<sup>4</sup> This additional payment is known as a “supplementation” of the Medicaid payment rate.

Facility providers must follow procedures outlined by law before receiving supplementation payments from or on behalf of Medicaid residents. AFH, ARC, EARC, or AL contractors must have a Medicaid supplementation policy in place before they may request or charge for a supplemental payment.

To understand Medicaid supplementation one must be able to distinguish between items and services that are covered by a facility’s daily Medicaid rate and services and items that are not covered by the

rate. If an item or service is covered by a facility's daily Medicaid rate, then no charge may be made to the resident.<sup>5</sup>

### **What is covered by Medicaid in AFH, ARC, EARC and AL facilities?**

Long-term care facilities contract with the Department of Social and Health Services (DSHS) to accept payment of a daily Medicaid rate in exchange for specified services, items, activities, room and board (including utilities for gas or electric) provided to Medicaid residents. The following sections discuss what is covered in different settings.

#### **ADULT FAMILY HOMES**

A person residing in an adult family home receives services as outlined in the resident's negotiated care plan. Negotiated care plans are required under DSHS regulations.<sup>6</sup> At a minimum, the AFH must ensure each resident's negotiated care plan includes:<sup>7</sup>

- A list of the care and services to be provided
- Identification of who will provide the care and services
- When and how the care and services will be provided
- How medications will be managed, including how the resident will get their medications when the resident is not in the home<sup>8</sup>
- The resident's activities preferences and how the preferences will be met
- Other preferences and choices about issues important to the resident, including, but not limited to:
  - (a) Food
  - (b) Daily routine
  - (c) Grooming, and
  - (d) How the home will accommodate the preferences and choices
- Nursing services as needed<sup>9</sup>
- Meals and nutritious snacks,<sup>10</sup> and
- Laundry services<sup>11</sup>

#### **AFH RESIDENTS WITH SPECIAL NEEDS**

For residents with special needs (such as dementia, mental health issues, seizures triggered by some event, etc.) AFH's must create a plan to follow: in case of a foreseeable crisis; to reduce tension, agitation and problem behaviors; to respond to resident's special needs, including, but not limited to medical devices and related safety plans; to respond to a

resident's refusal of care or treatment, including when the resident's physician or practitioner should be notified of the refusal. The AFH must identify any communication barriers the resident may have and how the home will use behaviors and nonverbal gestures to communicate with the resident. The AFH must develop a statement of the ability for resident to be left unattended for a specific length of time. The AFH must develop a hospice care plan if the resident is receiving services for hospice care delivered by a licensed hospice agency.<sup>12</sup>

#### WHAT AFH SERVICES ARE NOT COVERED – special rooms

The AFH must provide the services and items described above without any supplemental payment. The facility's contract with DSHS must be reviewed to determine what other items and services are or are not covered. For example, a room with special amenities may not be covered and may be a basis for supplementation.

Medicaid covers a semi-private room. However, Medicaid will cover a single, private room when all rooms at the facility are single. When the AFH contractor only has one type of unit or all private bedrooms, the contractor may not request supplementation from or on behalf of the Medicaid resident to pay for a private bedroom. It may be permitted to seek supplementation if the bedroom has an amenity that some or all of the other units or private bedrooms lack (for example, a private bathroom, a view unit.)<sup>13</sup>

#### AL, ARC AND EARC FACILITIES

AL, ARC and EARC facilities must provide or arrange for, at no additional cost to the resident:<sup>14</sup>

- Intermittent nursing services
- Medication administration
- Personal care services
- Supportive services that promote independence and self-sufficiency
- Nutritious meals
- Make beverages and snacks available to residents, and
- Provide all residents with access to an on-site washing machine and dryer for resident use.

AL and EARC facilities must provide generic personal care items needed by the resident such as soap, shampoo, toilet paper, toothbrush, toothpaste, deodorant, sanitary napkins, and disposable razors. This does

not include items covered by medical coupons or preclude residents from choosing to purchase their own personal care items.<sup>15</sup>

Assisted living and ARC facilities must provide separate “apartment-like” units (for example, studio or one bedroom) each with a private bathroom.<sup>16</sup> EARC facilities may have no more than two residents in one room.<sup>17</sup>

#### MEDICAID SUPPLEMENTATION POLICY REQUIREMENTS FOR AFH, ARC, EARC, AND AL FACILITIES

Adult Family Homes (AFH), boarding homes, Adult Residential Care Facilities (ARC), Enhanced Adult Residential Care Facilities (EARC), and Assisted Living (AL) facilities must have a written Medicaid supplementation policy.<sup>18</sup> The policy must:

- Be provided to the resident before admission to the facility and at least once every twenty-four months thereafter
- Be in a language that the resident understands
- Advise the resident that (a) DSHS’s Medicaid payment plus any client participation assigned by DSHS is payment in full for the services, items, activities, room and board required by the resident's negotiated service plan per chapter 388-78A WAC or the negotiated care plan per chapter 388-76 WAC and its contract with DSHS; and (b) additional payments requested by the provider may only be for services, items, activities, room and board not covered by the Medicaid per diem rate
- List services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license
- List charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs
- State the charges for each item, service, and activity provided by the facility
- Detail the supplemental charges that the facility will impose upon residents
- State which units or bedrooms are subject to supplementation, and
- State what action the provider will take when a private pay resident converts to Medicaid and the resident or a third party is unwilling or unable to pay a supplemental payment in order for the resident to remain in his or her unit or bedroom. When the only units or bedrooms available are those for which a provider charges a supplemental payment, the provider is allowed to require the

Medicaid resident to move from the facility, unless the provider has agreed in advance to waive that right. However, the provider must give thirty days notice before requiring the Medicaid resident to move.

Generally, thirty days advance written notice must be given before any policy changes may take effect, except in emergencies. For facilities licensed for six or fewer residents (such as adult family homes), if there has been a substantial and continuing change in the resident's condition necessitating substantially greater services, items, or activities, then the charges for them may be changed after fourteen days advance written notice.

When a provider receives supplemental payment for a unit or bedroom, the provider must notify the Medicaid resident's case manager of the supplemental payment. The provider must also document in the Medicaid resident's record:

- The unit or bedroom for which the provider is receiving a supplemental payment
- The services, items, or activities for which the provider is receiving supplemental payments
- Who is making the supplemental payments
- The amount of the supplemental payments, and
- The private pay charge for the unit or bedroom for which the provider is receiving a supplemental payment.<sup>19</sup>

## BOARDING HOMES

Boarding homes must provide meals, nutritious snacks, housekeeping, activities program, and laundry services.<sup>20</sup> A boarding home is required to monitor residents for changes in physical, mental, or emotional functioning, and respond appropriately to changing needs.<sup>21</sup> Provision of health support services or medication assistance or supervision by the boarding home are optional.<sup>22</sup>

## NURSING HOMES

### WHAT IS COVERED BY MEDICAID AND/OR MEDICARE

A nursing home may not charge a resident for:

- Nursing services
- Dietary services

- Activities program
- Room/bed maintenance services
- Medically related social services.

A nursing home may not charge for routine personal hygiene items and services as required to meet the needs of residents, including but not limited to:

- Hair hygiene supplies, comb and brush, bath soap, deodorant, Razor and shaving cream
- Toothbrush, toothpaste, and dental floss, denture adhesive and denture cleaner
- Moisturizing lotion
- Tissues, cotton balls and cotton swabs
- Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection
- Incontinence care and supplies
- Sanitary napkins and related supplies
- Towels and washcloths
- Hospital gowns
- Over the counter drugs
- Hair and nail hygiene services
- Bathing
- Basic personal laundry.<sup>23</sup>

Regarding items that Medicaid requires the nursing facility to provide, if a resident wants a different type or brand based solely on personal preference, the facility may charge the resident the difference (if any) between the cost of the facility's standard item and the resident's preferred alternative, without any mark up. The resident's informed consent to this charge must be documented. If a resident is unable to use a standard item for a medical reason, such as an allergy, the facility must provide another option at no additional charge. If a physician orders a particular brand or type of item for a medically necessary reason, there is no additional charge to the resident.<sup>24</sup>

#### FOR WHAT ITEMS AND SERVICES MAY A NURSING HOME CHARGE A RESIDENT ON MEDICAID?

Examples of items and services which Medicaid does not generally require a nursing home to provide, and for which a nursing home may charge a Medicaid resident include:

- Telephone

- Televisions for personal use acquired before July 1, 2001 (the nursing home may not charge residents for televisions it acquired on or after July 1, 2001)
- Radio for personal use
- Personal comfort items, including smoking materials, notions and novelties, and confections
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare
- Personal clothing
- Personal reading matter
- Gifts purchased on behalf of a resident
- Flowers and plants
- Social events and entertainment offered outside the scope of the activities program,
- Non-covered special care services such as privately hired nurses or aides
- Private room, except when therapeutically required (for example, isolation for infection control)
- Specially prepared or alternative food requested instead of the food generally prepared by the facility when such food is not medically necessary.<sup>25</sup>

Additionally, a nursing facility must not charge a resident (or his or her representative) for any item or service that was not requested by the resident. A nursing facility may not require a resident to request any item or service as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service in advance that there will be a charge for the item or service and what the charge will be.<sup>26</sup>

## TELEVISION AND CABLE

A nursing facility may choose — but is not required — to provide basic cable TV as a service covered within its daily rate. If a facility chooses to provide basic cable TV, the service must be provided to all its residents within its daily rate. If a resident wants enhanced cable service, that is not covered by Medicaid and the resident may be required to pay for it.<sup>27</sup>

## WHEN ONE-ON-ONE CARE IS NEEDED

As noted on the list above, a resident or a third party on the resident's behalf, would have to pay for "non-covered" special care

services. In some circumstances, this may mean paying for privately hired nurses or aides. If one-on-one care or supervision of a Medicaid resident is medically necessary, the service would be covered by Medicaid, and the nursing home must provide this care at no charge to the resident. If a resident wanted a private aide for companionship or convenience as opposed to a medical need, this would not be covered by Medicaid, and the resident or someone on the resident's behalf would have to pay for this non-covered service.

#### ARE THERE EVER EXCEPTIONS TO THE ITEMS MEDICAID COVERS?

The department may sometimes agree to cover an item or service not normally covered by a recipient's medical program by granting what is called an "exception to rule."<sup>28</sup>

#### **How do I make supplemental payments?**

Family members or friends may pay for non-covered items or services. Such payments are not counted as income to the Medicaid recipient, so long as payment is made directly to the provider, and money to pay the bill is not given to the Medicaid recipient. For example, family members or friends could pay for massages or acupuncture for a Medicaid recipient by making payment directly to the provider of the service. (Both services are non-covered.) If a private room in a nursing facility is not medically necessary for a Medicaid recipient, then it is a non-covered item under the Medicaid program. In that case, a family member or friend could pay an additional amount directly to the facility to cover the additional cost for a private room.

#### **What can I do if a facility violates Medicaid supplementation rules?**

A resident or someone else who believes a provider has violated the Medicaid supplementation rules has the following options:

- Contact the State Long Term Care Ombudsman at 1-800-562-6028
- Contact the resident's DSHS case manager
- Make a complaint to the DSHS Complaint Resolution Unit (CRU) at 1-800-562-6078

If the violation is substantial, contact an attorney for a consultation. Violation of Medicaid supplementation rules may be a violation of the state

consumer protection act.<sup>29</sup> An intentional violation by a provider is a Class C felony.<sup>30</sup>

**Endnotes:**

<sup>1</sup> Joy Ann von Wahlde is an attorney with the Northwest Justice Project.

<sup>2</sup> A chart showing the various “personal needs allowance” amounts may be found in the DSHS EAZ Manual, Long Term Care Personal Needs Allowance (PNA) Chart, revised January 26, 2009, at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAsubfile.shtml>

<sup>3</sup> WAC 388-502-0160 and WAC 388-105-0050.

<sup>4</sup> WAC 388-105-0050.

<sup>5</sup> 20 *Id.*; 42 CFR 483.10(c) (8); 06 NH "Dear Administrator" Letters November 3, 2006, ADSA: NH #2006-027:

<http://www.aasa.dshs.wa.gov/professional/letters/nh/2006/06-027.htm>; *see also* WAC 388-106-0360.

<sup>6</sup> WAC 388-76-10355 to -10385 et seq.; WAC 388-76-10400.

<sup>7</sup> WAC 388-76-10355.

<sup>8</sup> WAC 388-76-10460.

<sup>9</sup> WAC 388-76-10405.

<sup>10</sup> WAC 388-76-10415; WAC 388-76-10420.

<sup>11</sup> WAC 388-76-10410.

<sup>12</sup> WAC 388-76-10355.

<sup>13</sup> WAC 388-105-0055.

<sup>14</sup> WAC 388-110-150.

<sup>15</sup> WAC 388-110-220(3)(o); WAC 388-110-150(3).

<sup>16</sup> WAC 388-110-140.

<sup>17</sup> WAC 388-110-220(1)(c).

<sup>18</sup> WAC 388-105-0050; *see* WAC 388-105-0055.

<sup>19</sup> WAC 388-105-0050(6).

<sup>20</sup> WAC 388-78A-2170.

<sup>21</sup> WAC 388-78A-2120.

<sup>22</sup> WAC 388-78A-2200; WAC 388-78A-2210.

<sup>23</sup> 42 CFR 483.10(c)(8).

<sup>24</sup> 2008 NH "Dear Administrator" Letters December 5, 2008, ADSA: NH #2008-006, <http://www.aasa.dshs.wa.gov/Professional/letters/rates/2008/08-006.htm>.

<sup>25</sup> 42 CFR 483.10(c)(8)(ii).

<sup>26</sup> 42 CFR 483.10(c)(8)(iii).

<sup>27</sup> 2006 NH "Dear Administrator" Letters August 16, 2006, ADSA: NH #2006-019, <http://www.aasa.dshs.wa.gov/professional/letters/nh/2006/06-019.htm>.

<sup>28</sup> An exception to rule (sometimes referred to as an “exception to policy”) is a waiver by DSHS of a department rule or policy for a specific DSHS recipient. The department may grant an exception if it does not conflict with other state or federal law, the recipient’s situation differs

from the majority, it is in the interest of overall economy and the client's welfare, and it increases the recipient's ability to function effectively. An exception may also be made because of an impairment or a limitation that significantly interferes with the usual procedures required to determine eligibility and payment. A recipient must ask a department employee to file the request. A recipient may ask to provide input or evidence to supplement the request. After the employee files the request, the department has 15 days to notify the client in writing as to whether the exception was approved or denied. Denials of requests for exceptions for non-covered items are not appealable. Recipients who do not agree with a decision may file a complaint with the department. WAC 388-501-0160.

<sup>29</sup> See Sorrel v. Eagle Healthcare, Inc., 110 Wn.App. 290 (2002).

<sup>30</sup> RCW 74.09.260.