

The Arc Of The District of Columbia, Inc.

817 Varnum Street NE, Suite 229 • Washington, D.C. 20017
202-636-2950 • fax 202-636-2996
website: www.arcdc.net • email: ArcDC@arcdc.net

State ICF-MR Leave Policies: A Review

T.J. Sutcliffe, Director of Advocacy and Public Policy
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Summary: *Over 100,000 people with developmental disabilities live in Medicaid funded institutions and group homes across the United States. State Medicaid policies determine group home residents' ability to take leave for overnight family visits and other purposes. Overnight home and community visits improve quality of life, strengthen family ties, and are consistent with provisions of the federal Americans with Disabilities Act of 1990 that uphold individuals' rights to receive services in the most inclusive setting.*

The Arc of the District of Columbia undertook a review of state leave policies for Medicaid funded group homes in response to requests for help by parents of adult DC residents with developmental disabilities. These parents were finding the District's current policy, which only permits up to 18 leave days per year, to be woefully inadequate. The Arc of DC found that the District has one of the most restrictive, least family-friendly leave policies in the nation, ranking 46th among states. Unlike the District, most states either place no limits on home visits or cap home visits at a much higher level, permitting an average of up to 44 days of leave per resident per year. States typically reimburse for up to 14 days in a row when a resident is hospitalized (with no annual limit on hospital stays).

District of Columbia officials can support residents with disabilities and their families in a cost-neutral manner by expanding DC's leave policies to conform with state standards. Although the District plans to offer Medicaid group homes residents more individualized, community living, the Medicaid waiver that will fund this new model is currently being rewritten. It will be several years before the waiver has the capacity to assist all of the 838 District residents currently living in Medicaid group homes. Providing more leave days now will improve the quality of life of group home residents immediately and will also support transition to community living by giving residents opportunities to spend time with their families in the community.

Introduction

Intermediate Care Facilities for persons with Mental Retardation (ICFs-MR) are Medicaid-funded residences where four or more individuals with developmental disabilities (DD) receive active, 24-hour services.¹ ICFs-MR are federally authorized to provide health and supportive services to individuals who require ongoing support due to complex health and behavioral needs but who do not require ongoing nursing care. ICFs-MR range in size from large, state-operated institutions serving hundreds of individuals to group homes with 6 or fewer residents.²

Currently, an estimated 104,526 individuals live in 6,535 ICFs-MR across the United States.³ This represents approximately 25% of people with DD who receive residential supports from

state DD agencies; the remaining 75% typically live in community homes for 6 or fewer individuals.⁴ Another 650,655 individuals with DD are estimated to live with their family, with a host family, or on their own.⁵

ICF-MR residents can benefit significantly from spending time with family and friends in the community. Recognizing this, federal Medicaid regulations allow states to reimburse ICFs-MR to hold beds when residents are absent.⁶ States can limit the number and frequency of days that their Medicaid programs pay to hold ICF-MR beds, and can also establish other payment conditions. Without Medicaid reimbursement to reserve their bed, ICF-MR residents risk losing their bed during an absence.^a

In the District of Columbia, approximately 838 individuals live in 122 ICFs-MR which are mainly group homes with 6 or fewer residents.⁷ While most states use federal Medicaid waiver funds to help people with DD live in the community as an alternative to ICFs-MR, the District has been slow to transition to this model.⁸ As a result, approximately 54% of individuals receiving residential services from the District's Mental Retardation and Developmental Disabilities Administration (MRDDA) live in ICFs-MR.⁹

Currently, the District's Medicaid program, operated by the DC Medical Assistance Administration, pays for up to 18 ICF-MR leave days per year.¹⁰ Although most states have separate policies for "therapeutic leave" and "hospital leave," the District's 18-day limit is for any type of leave. As a result, not only do ICF-MR residents in the District have a limited number of annual leave days, but also they risk losing the opportunity for home visits if poor health requires them to use leave for hospital stays.

The Arc of DC's review of ICF-MR leave policies in the 50 states and the District of Columbia as of December, 2005 found that most states allow significantly more leave days than the District. This report presents The Arc of DC's findings by describing state leave policies by type and by limits on leave, by comparing the degree to which state policies are family-friendly, and by analyzing the relationship between state leave policies and other factors.

State ICF-MR Leave Policies

Under federal Medicaid law, states establish their own policies governing Medicaid payment to ICFs-MR to reserve a bed when an ICF-MR resident is absent.¹¹ States typically define a "leave day" or "bed hold day" as an absence for most or all of a 24-hour calendar day. As a result, leave policies generally apply to overnight absences as opposed to times during the day when an ICF-MR resident is outside the facility for work or other purposes.

In general, states have implemented three types of leave policies for ICFs-MR:

Therapeutic leave policies typically include leave for overnight home visits with family and friends, for vacations, and for participation in therapeutic programs;

^a Many states offer families the option of paying to hold an ICF-MR bed if the state's Medicaid program will not. However, the high cost of ICF-MR care makes this option unrealistic for most families.

Hospital leave policies cover leave due to hospitalization; and

Combined leave policies cover leave for any purpose, including therapeutic leave as well as hospital stays.

With one exception, states either have combined leave policies or have separate policies for therapeutic and hospital leave.^b Leave policies for the 50 states and the District of Columbia are summarized in Table 1. Detailed information on each state is provided in Table 2 (page 13).

Table 1. Summary of ICF-MR Leave Policies in the 50 States and the District of Columbia

	Therapeutic Leave	Hospital Leave	Combined Leave (Therapeutic and Hospital)
States Providing Leave	43 states	29 states	5 states and DC
Annual Leave Limits			
States with no annual limits	8 states	24 states	0 states
States with annual or periodic limits	35 states	5 states	5 states and DC
Average days per year	44 days	49 days	79 days
States allowing days over the annual limits	11 states	1 state	3 states
States with additional special-purpose leave days	9 states	n/a	0 states
Consecutive Day Limits			
States with consecutive day limits	11 states	24 states	2 states
Average consecutive days	13 days	14 days	20 days

Therapeutic leave policies

ICF-MR residents generally use therapeutic leave to spend time with family and friends, to go on family trips, and to participate in therapeutic programs outside the ICF-MR. Families and ICF-MR residents value overnight home visits because the quality of time spent together is usually higher than during brief visits at an ICF-MR. States generally support therapeutic leave for this reason and because therapeutic leave is either cost-neutral or provides modest cost savings in states that reimburse leave days at reduced rates (see “Other limits on leave,” page 6).

On average, states either place no formal limits on therapeutic leave or provide enough annual leave days for residents to spend up to two to three weekends per month at home.^c Federal Medicaid law requires that absences for purposes other than hospitalization must be included in an ICF-MR resident’s plan of care (a written plan for supports developed by an interdisciplinary team).¹² As a result, states that place no specific limits on therapeutic leave days nevertheless can prevent excessive absences and ensure that leave days conform with a plan of care.

Forty-three states reimburse ICFs-MR for days when a resident is absent for home visits or other therapeutic leave. State therapeutic leave policies have the following characteristics:

^b Kentucky has an annual limit for leave of any type, but also has different consecutive day limits and per-month limits for therapeutic and hospital leave. For analysis, Kentucky was considered to have a combined leave policy.

^c With an average of up to 44 therapeutic days per year, states allow an average of up to 4 leave days per month.

- **Annual limits.** Eight states place no limits on the maximum number of therapeutic leave days per year that each resident can take. Another 35 states have annual limits, and on average these states allow up to 44 days of therapeutic leave per resident, per year. Eleven of these states also permit the state DD agency to authorize additional days, beyond the annual limit.
- **Additional leave.** Nine states with therapeutic leave policies also provide special-purpose leave days, outside of any annual limit.^d For example, Mississippi provides special leave days for holidays. Louisiana exempts days that residents attend conferences and Special Olympics from its annual therapeutic leave limit. Georgia, Louisiana and South Carolina pay to hold an ICF-MR bed during trial visits to determine the feasibility of alternative community living arrangements.
- **Consecutive day limits.** Eleven states with therapeutic leave policies limit the number of days in a row that residents can be absent from an ICF-MR for therapeutic leave. On average, these states allow absences of up to 13 consecutive days.
- **Periodic limits.** Five states with therapeutic leave policies limit the number of days ICF-MR residents can be absent for periods of less than a year's duration (e.g., 25 days per quarter, 15 days per month).^e

Hospital leave policies

Hospital leave ensures that ICF-MR residents who require hospitalization have a place to return to when they recover. While most states provide hospital leave, a significant number do not. In states without hospital leave, ICF-MR residents are at immediate risk of losing their ICF-MR bed if they become sick and require hospitalization. States that fail to provide hospital leave appear to do so at least in part because state Medicaid programs also typically pay for ICF-MR residents' hospital stays.

However, most states have waiting lists for residential services for people with DD,¹³ and ICF-MR beds on average have one-fourth the cost of hospital beds.¹⁴ Furthermore, by ensuring that ICF-MR residents can return to the same bed after a hospital stay, states promote continuity of care which helps maintain health and well-being.¹⁵ For these reasons, many states find it cost-effective to pay to hold an ICF-MR bed during a resident's hospitalization, rather than to pay for additional hospital days while a new residence is located if an ICF-MR bed is lost.

^d Florida provides up to 30 infirmary days per year; Georgia provides up to two 7-day trial visits per year to aid transition to community living; Kansas provides up to 21 hospital reserve days to residents who are transferred to a state mental retardation facility; Louisiana excludes days at Special Olympics, Roadrunner events, conferences and trial discharge leaves of 14 days per visit; Mississippi provides leave for Christmas eve and day as well as the days before, of and after Thanksgiving; South Carolina provides a one-time 30-day period of consecutive leave per admission for discharge planning; Texas provides leave for participation in special activities away from the facility; Wisconsin provides unlimited days for therapeutic/rehabilitative programs, with prior approval; Wyoming does not count ICF-MR residents receiving infirmary services as absent.

^e Alabama allows up to 14 days per month; Missouri allows up to 12 days per half-calendar year; Utah allows up to 25 days per calendar quarter; Vermont allows up to 15 days per quarter; and Wyoming allows up to one absence of up to 15 consecutive days per month.

Twenty-nine states reimburse ICFs-MR for days when a resident is absent due to hospitalization. State hospital leave policies have the following characteristics:

- **Consecutive day limits:** Rather than instituting annual limits, most states that provide hospital leave limit the number of consecutive days eligible for reimbursement. Twenty-four states have taken this route, and on average reimburse for up to 14 days in a row when an ICF-MR resident is hospitalized, with no limit on the total number of hospital days per resident, per year.
- **Annual limits:** Five states authorize ICF-MR hospital leave under an annual-limit system. On average, these states reimburse for up to 49 hospital leave days per year. One state permits the authorization of additional days, past its annual limit.^f
- **Periodic and other limits:** Seven states place other limits on reimbursement for hospital days, including limits on days-per-month as well as a requirement that two days must elapse between hospital stays.^g

Combined leave policies

Combined leave policies generally provide a capped number of annual leave days that can be used for either therapeutic absences or hospitalization. In states with low annual caps, combined leave policies can pose significant difficulties for ICF-MR residents who wish to spend time with their families. Combined leave policies may force ICF-MR residents to choose between home visits and saving days for the contingency of hospitalization. Additionally, residents who are hospitalized early in a year may use all of their leave days and find they cannot take any home visits for the rest of the year.

Five states and the District of Columbia have combined leave policies that cover any type of leave from an ICF-MR. State combined leave policies have the following characteristics:

- **Annual limits:** All six jurisdictions with combined leave policies have annual limits. On average, these jurisdictions reimburse for up to 79 days of leave per resident, per year. Three states also permit state DD agencies to authorize additional days, beyond the annual limit.
- **Consecutive day limits:** Two states with combined leave policies limit the number of days in a row that a resident can be absent from an ICF-MR. On average, these states allow each resident to take up to 20 consecutive leave days per absence.

^f New York allows up to 5 additional days for hospital leave, if authorized by the state DD agency.

^g Delaware allows up to 7 consecutive hospital days in a 30-day period, and does not cover hospital leave if it immediately follows infirmary leave; Iowa allows up to 10 hospital days per month; Michigan only reimburses for emergency hospitalizations; Minnesota requires that 2 calendar days elapse between hospitalizations for the same condition; Missouri allows up to 6 days per half-calendar year, and deducts two therapeutic days for each hospital day taken; Montana only covers hospital days when all of an ICF-MR's beds are full or on hold, when the resident is expected to return to the ICF-MR, and when the cost of holding the bed is less than cost of finding new bed; Tennessee requires a physician's order, requires that residents intend to return to the ICF-MR, and requires hospitals to provide a discharge plan.

- **Periodic limits:** Two states limit combined leave days for periods of less than a year's duration: one state (Kentucky) allows up to 45 days per fiscal quarter, while another (Oregon) allows up to 15 days in a 30 day period.

Other limits on leave

Most states that restrict ICF-MR leave do so using annual and/or consecutive-day limits. However, a few states have instituted other kinds of restrictions. These include prior authorization requirements, occupancy requirements, and reduced payments for leave days.

Four states require prior approval by the state DD agency for leave over a certain number of days.^h For example, states may require prior approval for more than a certain number of consecutive leave days (e.g., for more than 17 days in a row in Washington state), or for more than a certain number of days in a year (e.g., for more than 48 days in a year in Minnesota).

Eleven states only reimburse leave days when an ICF-MR meets a minimum occupancy rate, typically 95%.ⁱ Beds that are on hold due to a resident's temporary absence are usually considered to be occupied when calculating the occupancy rate. In five states, occupancy requirements apply to hospital leave but not to therapeutic leave.

Five states reimburse for leave days at a reduced rate, ranging from 50% to 95% of standard payment levels.^j States are more likely to reduce payments to large institutions and to provide 100% or 95% payments to smaller, community group homes.

State Comparisons

To further assess the impact of state ICF-MR leave policies on people with DD, The Arc of DC evaluated state leave policies for family friendliness, looked at differences between states which have unified versus separate leave policies for ICFs-MR and nursing facilities, and explored the relationship between state ICF-MR leave policies and the degree to which states provide residential supports in ICFs-MR as compared to in the community.

^h Idaho: prior approval for more than 14 consecutive therapeutic leave days; Minnesota: prior approval for more than 48 consecutive therapeutic leave days; Virginia: prior approval for more than 7 consecutive therapeutic leave days; Washington: prior approval for more than 17 consecutive therapeutic leave days or 17 days per year. As discussed on page 4 another 11 states permit their annual limits to be exceeded with prior approval.

ⁱ Arkansas: 85% occupancy for hospital leave; Idaho: 95% occupancy; Illinois: the number of vacant beds must be less than or equal to the number of residents on leave; Kansas: 90% occupancy for hospital leave; Michigan: 98% occupancy for hospital leave; Minnesota: 94% occupancy for facilities with 25 or more beds, and beds in facilities with 24 or fewer beds must not have been vacant for 60 consecutive days prior to the first day of leave; Missouri: 97% occupancy in the facility's Medicaid certified area during the prior quarter; Montana: all beds must be in use or on hold; New York: 94% occupancy for facilities with less than 30 beds; Tennessee: 95% occupancy for hospital leave; Wisconsin: 95% occupancy or fewer than 9 vacant beds.

^j Illinois pays for hospital leave at 100% for the first 10 days, at 75% for days 11 to 30 and at 50% for days 31 to 45, and pays for therapeutic leave at 100% for the first 10 days and 75% thereafter; Indiana pays at 50%; Iowa pays at 80% for facilities with more than 15 beds and at 95% for facilities with fewer than 15 beds; New Mexico pays providers the Level III rate; Oklahoma reimburses at 75% for therapeutic leave.

State Rankings: Family-Friendly, Community-Oriented Leave Policies

Family-friendly, community-oriented leave policies help ICF-MR residents spend time with their family at home in the community. Families provide ongoing support and advocacy for people with DD, and promoting family unification should be a high priority for states. States which provide ICF-MR therapeutic leave are also consistent with the federal Americans with Disabilities Act of 1990 and the Supreme Court's *Olmstead v. L.C.* decision which affirm the right of individuals with disabilities to live in the most inclusive setting.^k

To determine which states have the most family-friendly, community-oriented ICF-MR leave policies, The Arc of DC ranked all states and the District of Columbia on four criteria applied in the following order: number of annual therapeutic or combined leave days; number of consecutive therapeutic or combined leave days; number of annual hospital leave days; and number of consecutive hospital leave days. For jurisdictions which otherwise rank equally, those with therapeutic leave policies were ranked higher than those with combined leave policies (applied in two cases), and those which permit additional days beyond the annual limit were ranked higher than those which permit no additional days (applied in one case).

These criteria focus on opportunities for home and community visits. As a result, in several cases states which provide no hospital leave are ranked higher than states which provide slightly fewer therapeutic leave but also provide generous hospital leave. However, the rankings are intended to focus on opportunities for ICF-MR residents to spend time in the community, and as a result, The Arc of DC chose to focus on therapeutic leave over hospital leave.

Table 2, page 13 shows the results of the state rankings. Illinois has the most family-friendly leave policy in the nation, with no formal limits on annual leave and a hospital leave policy which permits up to forty-five days per hospitalization. Massachusetts and Rhode Island, which reimburse for no leave of any type, rank last. The District of Columbia has one of the least family-friendly ICF-MR leave policies in the nation, ranking 46th among jurisdictions.

Leave Policies for ICFs-MR versus Nursing Facilities

Under federal Medicaid law, states can have a single leave policy for ICFs-MR, nursing facilities (NFs), and other Medicaid-funded long term facilities, or can establish different leave policies for each type of facility. Most states establish separate leave policies for ICFs-MR and nursing facilities to allow more leave for ICF-MR residents.

Thirty-three states have separate leave policies for ICFs-MR and nursing facilities.^l In all of these states, the ICF-MR policies allow more leave days than the nursing facility policies. Sixteen states and the District apply the same leave policy to both ICFs-MR and nursing facilities.

^k The Americans with Disabilities Act of 1990, approved July 26, 1990 (104 Stat. 327; 42 U.S.C. § 12101 et seq.) and *Olmstead v. L.C.* (119 S.Ct. 2176; 1999).

^l Alabama, California, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, and Wyoming.

States which have separate policies for ICFs-MR and nursing facilities on average rank as more family-friendly (as defined in this report) than states that have a single policy covering both ICFs-MR and nursing facilities. States with unified policies had an average rank of 34, while states with separate policies had an average rank of 20 and allow more leave days per year as well as greater flexibility in use of leave days.^m

Leave Policies and Community Residential Services

States vary widely in the way they use federal ICF-MR funding to provide residential supports. Most states operate at least one large state facility housing 15 or more individuals with DD. Four states and the District of Columbia have closed their large ICFs-MR and instead use ICF-MR funding to support community residences which house 15 or fewer individuals.¹⁶

Many states are moving beyond the ICF-MR model entirely. These states are funding residential services primarily through federal Medicaid waivers which fund home and community services as an alternative for individuals who otherwise qualify for an ICF-MR. For example, Alaska has no ICFs-MR, and seven states have only one ICF-MR.¹⁷ States using the Medicaid waiver are part of a national trend toward providing consumer-controlled services in the community. This trend is informed by the Americans with Disabilities Act of 1990, the Supreme Court's *Olmstead v. L.C.* decision, and President Bush's New Freedom Initiativeⁿ which all uphold the right of individuals with disabilities to receive services in the most inclusive setting.

Statistical analysis found no relationship between state leave policies and state ICF-MR size or state reliance on ICFs-MR versus Medicaid waivers. States with high or low annual numbers of leave days are no more likely to have large or small ICFs-MR, or to rely more or less on ICFs-MR versus Medicaid waivers.

Policy Context and Considerations

The Arc of DC's review of state ICF-MR leave policies found that states overwhelmingly use their leave policies to improve the quality of life and health of ICF-MR residents, promote family unity, and foster community inclusion.

By establishing separate leave policies for therapeutic leave and hospital leave, most states recognize the different purposes of these types of leave and avoid penalizing ICF-MR residents who require hospitalization. Most states provide enough leave to permit home visits for an average of two to three weekends per month. States typically structure their hospital leave policies to support ICF-MR residents during hospitalizations, but states also make beds available when it appears that an individual is unlikely to return from the hospital.

Most state ICF-MR leave policies have been in place for over a decade, and most states that have recently changed their policies have preserved ICF-MR leave days. The District of Columbia is one of the few jurisdictions that have instead decreased leave days for ICF-MR residents.

^m A Mann-Whitney Two-Sample Test found this difference to be statistically significant, $p < .001$.

ⁿ Executive Order 13217, "Community-based Alternatives for Individuals with Disabilities," signed June 18, 2001, George W. Bush, President.

The District's Medical Assistance Administration instituted its current policy of up to 18 days of combined leave per resident, per year in 1995. Prior to that, the District placed no formal limits on annual leave and allowed up to 14 consecutive days per hospital stay.¹⁸ The District changed its leave policy at a time when the city was under the jurisdiction of a financial control board that mandated across-the-board cuts in services and budgets.

In contrast, within the last five years most other states have preserved or expanded opportunities for ICF-MR residents to take therapeutic leave:

- In 2005, Pennsylvania state officials proposed eliminating annual limits on therapeutic leave entirely (Pennsylvania currently allows up to 75 days per year). This proposal is currently on hold pending further discussion among state officials.¹⁹
- In 2005, Tennessee state legislators safeguarded ICF-MR leave in the midst of sweeping cuts to the state's formerly-comprehensive TennCare Medicaid program. The scope and breadth of cuts to TennCare were enormous. Although the state legislature initially eliminated all leave days for nursing facilities, legislators nevertheless preserved leave days for ICF-MR residents, making no reductions to ICF-MR therapeutic and hospital leave.
- In 2004, New Mexico state officials proposed reducing annual leave days from 65 to 18 days per year. However, residents, families and advocates defeated this proposal by pointing out that it went against President Bush's New Freedom Initiative, which seeks to place individuals with disabilities in community settings rather than institutions, and would have actually resulted in increased costs to the state.²⁰
- In 2004, Delaware reduced the maximum number of ICF-MR bed hold days per hospitalization from 14 to 7 consecutive days (with no annual limit), but made no reductions to therapeutic leave days.
- In 2003, Nevada established a leave policy permitting up to 24 therapeutic leave days per year; the previous policy allowed absences of up to 20 consecutive days.

Recommendations

The Arc of DC recommends that the District of Columbia amend its Medicaid state plan to implement a new, family-friendly, community-oriented ICF-MR leave policy that:

1. Establishes separate guidelines for therapeutic leave and hospital leave;
2. Imposes no annual limits on therapeutic leave (but requires that therapeutic leave be approved in a plan of care); and
3. Permits reimbursement for up to 14 days in a row for hospital leave, with no annual limit.

These changes will bring the District in line with the rest of the country and are consistent with the Americans with Disabilities Act of 1990 and the New Freedom Initiative which affirm the right of people with disabilities to live and receive services in the most inclusive setting.

As noted earlier, the District will incur no new costs by expanding opportunities for ICF-MR residents to take therapeutic leave. While there may be a modest cost associated with hospital leave, the costs of reserving an ICF-MR bed are likely to be far less than the costs of extended hospitalization when an ICF-MR bed is lost. The daily cost of an ICF-MR bed is typically one-fourth the cost of a hospital bed.²¹

Expanding opportunities for home and community visits will also lay the ground for future transitions of ICF-MR residents to community living funded by the District's new Medicaid waiver. The District currently lags behind nearly every state in the nation in the degree to which government programs help people with developmental disabilities to live in the community. The District is currently working to redesign its Medicaid home and community-based waiver, but it will unfortunately be several years before the waiver has the capacity to assist all of the 838 individuals who currently live in DC ICFs-MR. Providing more leave days now will give ICF-MR residents more opportunity to spend time in the community and will help prepare them to live in more independent settings under the waiver.

Most importantly, by expanding ICF-MR leave, the District will take a modest but significant step to improve the quality of life of residents with developmental disabilities and their families.

Methodology and Data Notes

The Arc of DC reviewed ICF-MR leave policies in the 50 states and the District of Columbia as of December, 2005. For each state, the Arc of DC gathered data with regard to:

1. Whether the state provides Medicaid reimbursement for any type of ICF-MR leave;
2. Which types of leave the state provides;
3. Whether the state imposes annual, consecutive-day, or other periodic limits on leave;
4. Whether the state allows any time-period limits to be exceeded under special circumstances;
5. Whether the state provides for additional, special kinds of leave; and
6. Whether the state imposes occupancy requirements, reduces payment during some or all leave days, and/or imposes other limits on reimbursement.

To gather these data, the Arc of DC examined each state's Medicaid State Plan, Attachment 4.19-C, "Payment for Reserve Beds," on the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Service web site. The Arc of DC next compared each state's Attachment 4.19-C with state regulations and policy manuals on the state's web site. If the Attachment 4.19-C and state web site information agreed and the policy was clear on all factors,

no further research was performed. If the Attachment 4.19-C and state web site information disagreed, or if any of the research factors were unclear, The Arc of DC contacted relevant state officials to obtain the correct policy. State officials were contacted in 12 states.

The Arc of DC included three states in the analysis under special circumstances:

- Alaska has no ICFs-MR, but maintains a policy in its Medicaid State Plan dealing with ICF-MR bed hold days.
- Massachusetts' Medicaid State Plan provides 30 therapeutic leave days for small, community ICFs-MR and no leave days for large ICFs-MR. Massachusetts has shut down all of its small, community and as a result state officials report that the state provides no ICF-MR leave. For the purposes of this analysis, Massachusetts was therefore counted as providing no leave days.
- New Hampshire has shut down all ICFs-MR for adults, and operates one ICF-MR for children. The Arc of DC verified the bed hold policy for that facility through emails with state officials and discussion with staff at the facility.

For states that have a monthly or periodic maximum on ICF-MR leave (e.g., up to 12 days per 6 month period), an annual maximum was calculated by multiplying out the number of days per time period (e.g., 12 days per 6 months times 2 equals 24 days per year).

To assess any potential relationship between state leave policies and state ICF-MR size or state reliance on ICFs-MR versus Medicaid waivers, The Arc of DC compared state rankings and therapeutic leave days with data from Lakin, Coucouvanis and Prouty (2005), Table 3.1 and Table 3.9.

Finally, in determining the number of states that have different policies for ICFs-MR and nursing facilities, Ohio was counted as having a separate policy. Ohio has the same annual limit for both kinds of facilities, but establishes different payment rates, reimbursing ICFs-MR at a higher rate than nursing facilities.

Endnotes:

¹ ICFs-MR are defined in Section 1905(d) of the Social Security Act (42 U.S.C. 1396d(d)); 42 CFR 435.1009. "Institution" is defined at 42 CFR 435.100.

² Lakin, K.C., Coucouvanis, K., and Prouty, R.W. (July, 2005). "Utilization of and Expenditures for Medicaid Institutional and Home and Community Based Services," Table 3.1. In *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2004*. Minneapolis, MN: Research and Training Center on Community Living, University of Minnesota.

³ Lakin, K.C., Coucouvanis, K., and Prouty, R.W. (July, 2005). "Utilization of and Expenditures for Medicaid Institutional and Home and Community Based Services," Table 3.1 and Table 3.2. In *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2004*. Minneapolis, MN: Research and Training Center on Community Living, University of Minnesota.

⁴ Coucouvanis, K., Prouty, R.W., and Lakin, C.K. (July, 2005). "Services Provided by State and Nonstate Agencies in 2004," Table 2.2. In *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2004*. Minneapolis, MN: Research and Training Center on Community Living, University of Minnesota.

⁵ Coucouvanis, K., Prouty, R.W., and Lakin, K.C. (July, 2005). “Number of Residential Settings and Residents by Type of Living Arrangement,” Table 2.7, Table 2.8 and Table 2.9. In *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2004*. Minneapolis, MN: Research and Training Center on Community Living, University of Minnesota.

⁶ 42 CFR §447.40. Payments for reserving beds in institutions.

⁷ DC Department of Human Services, Mental Retardation and Developmental Disabilities Administration, Management Care Information System data as of January 23, 2006.

⁸ Lakin, K.C., Coucouvanis, K., and Prouty, R.W. (July, 2005). “Utilization of and Expenditures for Medicaid Institutional and Home and Community Based Services,” Table 3.5b. In *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2004*. Minneapolis, MN: Research and Training Center on Community Living, University of Minnesota.

⁹ Ibid.

¹⁰ District of Columbia Medicaid State Plan, Attachment 4-19.C.

¹¹ *Supra* note 6. State leave policies are outlined in the Medicaid State Plan, Attachment 4-19.C.

¹² 42 CFR §447.40. Payments for reserving beds in institutions.

¹³ Coucouvanis, K., Prouty, R.W., and Lakin, K.C. (July, 2005). “Number of Residential Settings and Residents by Type of Living Arrangement,” Table 2.5. In *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2004*. Minneapolis, MN: Research and Training Center on Community Living, University of Minnesota.

¹⁴ Whereas data provided by Lakin et al. (Table 3.4) estimate the U.S. average daily expenditure on ICFs-MR to range from \$309 to \$312 per resident (based on expenditures per end of year resident versus expenditures per daily resident), the Kaiser Family Foundation estimates daily U.S. hospital expenses per inpatient day at \$1,371. (<http://www.statehealthfacts.org>), “Hospital Adjusted Expenses Per Inpatient Day, 2003”).

¹⁵ U.S. Department of Health and Human Services (2002). Closing the Gap: A national blueprint to improve the health of persons with mental retardation. Report on the Surgeon General’s Conference on Health Disparities and Mental Retardation. Appendix A.

¹⁶ Lakin, K.C., Coucouvanis, K., and Prouty, R.W. (July, 2005). “Utilization of and Expenditures for Medicaid Institutional and Home and Community Based Services,” Table 3.1. In *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2004*. Minneapolis, MN: Research and Training Center on Community Living, University of Minnesota.

¹⁷ *Supra* note 16.

¹⁸ DC Coalition for Community Services.

¹⁹ Pennsylvania Office on Mental Retardation.

²⁰ The Arc of New Mexico.

²¹ *Supra* note 14.

Table 2. State Rankings: Family-Friendly, Community-Oriented Leave Policies
States are ranked by opportunities for home and community visits.

Rank	State	Annual Combined Leave Days	Annual Hospital Leave Days	Consecutive Hospital Days	Annual Therapeutic Leave Days	Consecutive Therapeutic Days	Additional Days Therapeutic (✓) or Special (*) Days*
1	Illinois		No Limit	45	No Limit		
2	New York		No Limit	15	No Limit		
3	Wisconsin		No Limit	15	No Limit		*
4	South Dakota		No Limit	5	No Limit	15	
5	Arkansas		No Limit	5	No Limit	14	
6	New Jersey		0		No Limit		
7	Texas		0		No Limit	3	*
8	Washington		0		No Limit		
9	Kentucky	180		15		30	
10	Alabama		0		168		
11	Oregon	168					
12	Utah		0		100		✓
13	Mississippi		No Limit	15	84	15	*
14	Pennsylvania		No Limit	15	75		
15	California		No Limit	7	73		
16	Minnesota		No Limit	18	72		✓
17	New Mexico	65					*
18	Indiana		No Limit	15	60		
19	Vermont		0		60		✓
20	North Carolina		0		60	15	✓
21	Oklahoma		0		60	14	
22	Maine		No Limit	25	52		
23	New Hampshire		0		52		
24	Florida		No Limit	15	45		*
25	Louisiana		No Limit	7	45	30	*
26	Colorado		0		42		
27	Nebraska		No Limit	15	36		✓
28	Connecticut		No Limit	15	36		
29	Tennessee		No Limit	15	36		
30	Idaho		0		36		
31	Georgia		No Limit	7	30		*
32	Iowa		120		30		✓
33	Wyoming		15		30	15	*
34	Ohio	30	0		0		
35	North Dakota		No Limit	15	24		
36	Montana		No Limit		24	3	
37	Missouri		12	3	24		
38	Nevada		0		24		
39	West Virginia		No Limit	14	21		
40	Kansas		No Limit	10	21		✓ *
41	Maryland		No Limit	15	18		✓
42	Michigan		No Limit	10	18		
43	South Carolina		No Limit	10	18	9	*
44	Delaware		84	7	18		✓
45	Virginia		0		18		
46	DC	18					
47	Alaska		0		12	12	✓
48	Hawaii	12					
49	Arizona		12		9		
50	Massachusetts		0		0		
50	Rhode Island		0		0		

* Does the state allow additional therapeutic days, past the annual limit, and/or does the state provide for special-purpose leave days such as infirmary days or Special Olympics days?