Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd Floor, Cranston, RI 02920
Phone: 401-462-6827 / Fax: 401-462-0458

April 2, 2015

Docket # 15-303
Hearing Date 03/23/15

ADMINISTRATIVE HEARING DECISION
The Administrative Hearing that you requested has been decided against you. During the course of the proceeding, the following issue(s) and Agency Rules and Regulations reference(s) were the matters before the hearing:

Executive Office of Health and Human Services
Medicaid Code of Administrative Rules

SECTION: 0336.15 Deducting Recognized Medical Expenses
SECTION: 0396.15.05 Post-Eligibility Treatment of Income

The facts of your case, the Agency Regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You and Agency representatives Cynthia Lopes, Kimberley Andrews, Deborah Castellano and Tom Conlon.

Present at the hearing were: You, your mother and Agency representative Cynthia Lopes.

ISSUE: Did the Agency calculate the recipient's share of medical expenses correctly in December 2014?

EOHHS Rules and Regulations: Please see the attached **Appendix** for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules. (MCAR)

APPEAL RIGHTS:
Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision

DISCUSSION OF THE EVIDENCE:

The Agency representative testified:

- The appellant was active on a Long Term Care since June 2009.
- The case was transferred into the East Providence Long Term Care Office on April 30, 2014.
- When the file was received from the other unit the appellant was due for a re-certification.
- A recertification was completed by the supervisor.
- It was noted that there were some ambiguous bills that came in 2013 and in June of 2014 as Remedial Medical Expenses.
- There were slips from Walmart and CVS, most of which the supervisor was unable to read what they were for. One of the items was Depends and Medicaid will cover that if the appellant's doctor writes her a prescription.
- The appellant also wanted the cost of Tylenol to be deducted. Again with a prescription this is covered by Medicaid.
- The monthly cost towards Funeral expense is not allowable monthly expense.
- She has a share amount.
- The appellant receives $1591.90 in income.
- The appellant's share of the cost of her medical expenses was calculated to be $416.40 per month.
- The Agency calculated the share amount using the appellant's income.
- The Agency gave the correct deductions, medical insurance payments of $183.00 and the personal needs deduction of $992.50 per regulations.
- The Agency calculates each recipients share this way.
- The Agency had made in error in the past giving an incorrect amount for Remedial Medical Expenses.
- They can submit bills for services out of the scope of what the Agency considers normal expenses that Medicaid would pay she would check on the expense to see if she could accept it.

The Appellant's Son testified:

- The appellant is active on Medicaid Personal Choice Waiver.
- He is at a disadvantage because he just took over the responsibility for his mother's finances and he has not looked at the record.
- When he sees that his mother was being allowed remedial medical expenses before and not now that concerns him.
- He does not have a lot of background in this area and cannot argue with what the Agency representative says.
- His mother fell at Twin Rivers and there was an ambulance bill. He paid it.
- It's a financial struggle. His mother has dentist bills.
- Little things that are not kept track of add up.
- Life is not just cut and dry. He has retired to take care of his mother.
- He is trying to keep his mother in a comfortable position.
- If the Agency does not accept the bills he has provided he is ready to go. This is just too much.
- If he can submit individual bills going forward to see if they are acceptable that is fine with him.

FINDINGS OF FACT:

- The appellant was active on a Medicaid Personal Choice waiver.
- The Agency issued a written notice of Share of Medical Expenses on December 15, 2014.
- The appellant's share was higher than in 2013.
- The Agency had allowed some Remedial Medical Expenses in 2013.
- The appellant filed a request for hearing received by the Agency on January 21, 2015.
- The Hearing was held on March 23, 2015.

Conclusion: The issue to be decided is whether or not the appellant's Applied Income was calculated per EOHHS Regulations.

A review of EOHHS Regulations reveals that many individuals who require the level of care provided in an institutional setting may be able to receive such services at home.

Programs that provide home and community-based services to persons who would otherwise require institutional care require special waivers of the normal Medicaid rules. These Waivers must be approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

The state agency Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of the post-eligibility allocation of patient income to the cost of Waiver services for all Waiver services recipients who are subject to the post-eligibility process.
The calculation starts with the individual's full, gross income, including amounts which were dis-regarded in the determination of eligibility. For purposes of the post-eligibility process, income means all amounts that are available to the individual that would be defined to be part of the applicant's gross income in the determination of Medicaid financial eligibility. The deductions allowed by MCAR are the maintenance needs allowance and a deduction for medical insurance premium deduction.

In this case the appellant has been active on a Personal Choice Waiver.

The Agency representative testified that she calculated the appellant's cost of care amount by starting with her gross SSDI income of $1591.90, and then subtracted the maintenance needs allowance of $992.50 and her insurance premium of $183.00 determining that $416.40 would be her patient's share.
The appellant's son argued that the little expenses add up and he is just trying to keep his mother comfortable. He did not understand why she had been allowed other deductions in the past for medical expenses.

Further review of Rules and Regulation reveals that in establishing financial eligibility, excess income is applied toward reasonable incurred medical expenses that are not subject to payment by a third party (other than those medical expenses which are the liability of or paid for by 100% State funded medical care programs). In this case the Agency representative testified that the appellant had been given incorrect deductions in the past and indicated that if the appellant can produce bills for services that are recognized medical/remedial care expenses that are not provided within MA scope of services and which may be used to offset excess income she would certainly take them under consideration.
The appellant's son agreed that if he could submit bills when such expenses occurred that this is acceptable to him.

After careful review of Agency Policy and the evidence and testimony presented this Appeals Officer finds that the appellant's share of cost of medical expenses was calculated per Agency Regulations; therefore her request for relief is denied.

G Stanford

Geralyn B. Stanford
Appeals Officer

APPENDIX

0396.15 Average Cost of Care

The state agency Long Term Care/Adult Service (LTC/AS) units are responsible for determinations
and redeterminations of the post-eligibility allocation of patient income to the cost of Waiver services for all Waiver services recipients who are subject to the post-eligibility process. The calculation starts with the individual's full, gross income, including amounts which were disregarded in the determination of eligibility. For purposes of the post-eligibility process, income means all amounts that are available to the individual that would be defined to be part of the applicant's gross income in the determination of Medicaid financial eligibility.

0396.15.05 Post-Eligibility Treatment of Income

REV: April 2015

The following is a list of allowable deductions in the order they are to be deducted:

Maintenance Needs Allowance

The Maintenance Needs Allowance is one thousand dollars and eighty-three cents ($1,000.83) per month. This amount is in lieu of the Personal Needs Deduction and the Home Maintenance Deduction available to other institutionalized (non-Waiver) individuals.

For employed individuals eligible under the Waiver for the Developmentally Disabled (Section 0398.10), the Maintenance Needs Allowance is equal to one thousand dollars and eighty-three cents ($1,000.83) plus all gross earned income per month, an amount not to exceed the federal cap. To qualify for this expanded Maintenance Needs Allowance, the individual's employment must be in accordance with the plan of care.

- **Spouse/Dependent Allowance**

This deduction is an allowance for the support of a spouse and any dependents. The basic allowance for a spouse is equal to the monthly medically needy income limit for an individual, less any income of the spouse.

If there are also dependent children to be supported, the Medically Needy Income Limit for the number of children is used.

Medical Insurance Premiums

This deduction is insurance premiums paid by the individual, such as Medicare and Medigap policies such as Blue Cross and Plan 65.

Allowable Costs Incurred for Medical or Remedial Care

This deduction is reasonable costs for medical services recognized under state law but not covered in the scope of the Medicaid Program.

toward cost of home-based services according to the plan worked out with the Case Manager.

Allowable Income Deductions

REV: April 2014

Beginning with the second (2nd) month in which the individual receives services, income is allocated toward the cost of home-based services in the manner indicated below. The LTC/AS staff will calculate costs for individuals receiving services under the Aged and Disabled Waiver.

Calculation of Income Allocation

REV: 01/2012

From the full gross income of a single individual the following amounts are deducted in order:

- Maintenance Needs Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care.

Any balance of income remaining after these expenses are deducted is allocated toward the cost of home-based services according to the plan developed with the Case Manager.

*NOTE: To qualify as Medically Needy, an individual must have income within the Medically Needy income limit or incur allowable medical expenses (including the anticipated cost of Waiver services) which exceed the amount of the individual's monthly income which is over the Medically Needy Income Limit. The spouse's (or parent's) income is not considered in determining the amount the individual must pay for the cost of services.

Deduct from the applicant's full, gross income the following amounts, in the order presented:

Maintenance Needs Allowance
Spousal and Dependent Allowance
Medical Insurance Premiums
Allowable Costs Incurred for Medical or Remedial Care.

0336.15 DEDUCTING RECOGNIZED MEDICAL EXPENSES

In establishing financial eligibility, excess income is applied toward reasonable incurred medical expenses that are not subject to payment by a third party (other than those medical expenses which are the liability of or paid for by 100% State funded medical care programs).

Recognized medical expenses include medical insurance premiums, co-payments, deductibles and certain medical and remedial care expenses recognized under state law (See section 0336.15.05 for recognized medical/remedial care expenses that are not provided within MA scope of services and which may be used to offset excess income). Incurred medical expenses may also include current payments on the principal of loans used to pay off old medical bills.

A loan that is taken out in the current eligibility period to pay a health care provider for services rendered in the same period (or, in the case of a new application, for services rendered in the month of application or within the 3 preceding months) may be applied against the spenddown liability for the current period IN PLACE of the provider's bill. (The loan expense and the provider's bill may not BOTH be applied against the spenddown liability.)

Determine the available excess income for the six (6) month period beginning with the month of application. Excess income can then be applied to recognized medical expenses incurred PRIOR to application and unpaid. If a medical expense is more than one (1) year old, it is necessary to ensure that the applicant is still liable for the payment. This can be done by presentation of a current billing. Apply the excess income to the medical expenses in the appropriate order.

Excess income is applied to the medical expenses in the following order:

FIRST: Deduct incurred medical insurance premiums, including any enrollment fee, Medicare premiums, capitation fees for enrollment in prepaid health care programs, and premiums for any other health insurance program which is primarily established for payment of medical costs. With the exception of Medicare premiums, the cost of such medical insurance must be actually incurred and MAY NOT BE PROJECTED over the six (6) months of the application period; Deduct any co- payments, co-insurance or deductibles under any health insurance program as they are incurred

SECOND: Deduct necessary medical or remedial care recognized under state law but not provided within the Medical Assistance scope of services, such as chiropractic services, adult day care, respite care, or Home Healt Aide/Homemaker services.

THIRD: Deduct necessary medical or remedial care provided within the Medical Assistance scope of services.

FOURTH: Deduct current payments on the principal balances of loans used to pay off medical bills incurred prior to the current budget period.

Deducting Recognized Medical/Remedial Car
Care which is not being provided within the MA scope of service and which may be used to offset excess income includes

- Adult Day Care;
- Respite Care; and,
- Home Health Aide/Homemaker Services.

Adult Day Care

The cost of adult day care services may be used to offset a flexible-test spenddown liability. In order to be considered a cost of "medical or remedial care", these conditions must be met:

- The service must have been rendered by a provider agency approved by the Department of Elderly Affairs (DEA); and,
- The service was required to assist an individual, who because of severe disability related to age or chronic illness, encountered special problems resulting in physical and/or social isolation detrimental to his/her well-being, or required close monitoring and supervision for health reasons.

0336.15.05.10 Respite Care

The cost of respite care may be used to offset a flexible-test spenddown liability if the applicant receives overnight respite care at a licensed nursing/convalescent facility or in-home respite care as provided by the Department of Elderly Affairs (DEA).

0336.15.05.15 Home Health Aide/Homemaker Services

The cost of Home Health Aide services or Homemaker services may be used to offset a flexible-test spenddown liability under certain circumstances. In order to be considered a cost of "medical or remedial care", the following three conditions must be met:

The service must have been rendered by an agency licensed by the Rhode Island Department of Health, an recognized as a service provider by DHS under the Homemaker Program (see Section 0530.35 for list); and

At least a portion of the service provided each month MUST be for personal care services (assistance with bathing, dressing, grooming, etc.). If the client does not (or did not) receive assistance with personal

car during a month, no part of that month's cost of service may be used to offset the flexible-test spenddown liability; and,

A physician must certify the client's need for personal care services, in writing, at least once in each flexible-test period (six (6) months). The certification must indicate the patient's diagnosis(es), and the type of services required.

If the foregoing three criteria are met, eligibility staff may recognize, without further review, the cost of up to 65 hours per month in Home Health Aide/Homemaker services to offset a flexible- test spenddown liability. Deductions in excess of thi amount must be approved in writing by the Nurse/Consultant for Homemaker Services located at C.O. The referral to the Nurse/Consultant is comprised of a brief cover memo prepared by the eligibility technician, a copy of the individual's Plan of Service obtained from the provider agency, and a copy of the physician's certification of need for services. The Nurse/Consultant reviews the material to determine the extent t which the costs of service in excess of 65 hours per month may be recognized as a deduction from excess income. Only the cost of substantive services may be allowed as a deduction from excess income.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Executive Office of Health and Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.