STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE
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July 11, 2014

Docket # 13-1860
Date of Hearing: 02-04-14

[redacted]

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided in your favor. During the course of the proceeding, the following issue(s) and Agency policy reference(s) were the matters before the hearing:

THE DHS POLICY MANUAL: **Medical Assistance**
Section: 0399.05.01.02 Needs-based LTC Determinations
Section: 0399.06 Assessment and Coordination Organization

The facts in your case, the Agency policy, and the complete administrative decision 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 (the appellant) and Agency representatives Michelle Szylin, Tom Conlon and The Policy Unit.

Present at the hearing were: You, your son, and the interpreter and Agency representative: Michelle Szylin.

ISSUE: Was the appellant's monthly budget for the Personal Choice Program reduced per Agency Policy?

DHS POLICIES: Please see the attached **Appendix** for pertinent excerpts from the Department of Human Services Policy Manual.

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

DISCUSSION OF THE EVIDENCE:

The Agency representatives testified that:

- The appellant was active on a Personal Choice Waiver since 2013.
- A letter was sent out from the Agency that due to new time units, and payment decreases, all recipients would be affected by these changes.
- A new assessment of the appellant's needs was completed and a new budget sent to her in March 2013.
- His previous budget was $1780.72 and his new budget $1278.50.
- The frequency and amount of need for assistance changed on some tasks.
- The amount paid was changed for some tasks as well as the unit times.
- The budget does not allow for companionship and supervision.
- Tri-Town did an evaluation in August 2013.
- The original assessment was done in 2011.
- The monthly budget for the appellant was lowered by $497.78 a month.
- Changes in the time certain activities take had been adjusted.
- Changes in the amount the Agency pays for certain tasks had been adjusted.
- The appellant was to use his budget to hire someone to give the needed care and for his needs.
- The appellant filed for a fair hearing regarding the new budget amount.

The Appellant with the aid of the Nepali interpreter testified:

- He had been active on the Personal Choice Waiver program.
- His monthly budget was $1780.72 a month.
- He needs help to go to bathroom.

- It is harder for him to walk now.
- He knows his caseworker from Tri-Town who did his assessment.
- He feels he needs more help now. Maybe more than one person to help.

Findings of Fact:

- The appellant was active in the Personal Choice Waiver program.
- The Agency did send a notice in March 2013 that his monthly budget was re-evaluated.
- The appellant's monthly budget was reduced by $ 498.78 a month.
- He did file for a timely hearing.
- The hearing took place on February 4, 2014.
- The record of hearing was left open for four weeks to allow the appellant to provide new evidence.
- New evidence was received while the record of hearing was open.

CONCLUSION:

The issue to be decided is whether the appellant's is budget for the Personal Choice Waiver program was decreased per Agency Policy.

A review of Agency Policy regarding the Personal Choice program reveals that the Personal Choice program provides the individual with the opportunity to receive self-directed home and community based services using a "cash and counseling" model. The recipient has the ability to hire and manage their own Personal Care Assistants and the options to purchase goods and services that are not otherwise covered by Medicaid.

An applicant must meet a clinical level of care for this program. The level of care level for this program is high or highest. The processes for determining clinical eligibility are based on a comprehensive assessment that includes an evaluation of the medical, social, physical and behavioral health needs of each beneficiary. An individual care plan is then developed that identifies the LTC core and preventive services and settings appropriate to meet the beneficiary's needs within the specified service classification.

The entities that conduct the assessments work in coordination with staff of the Medicaid agency, as appropriate, to ensure the eligibility determination process is coordinated and to preserve program integrity.

There is no argument that the appellant meets the level of care and the financial guidelines for the Personal Choice program. The appellant does argue the fact that the Agency adjusted and decreased his monthly budget amount. He feels that in order to continue to receive the care he needs due to his extensive health problems he will need to have his previous budget restored.
He needs a lot of care with hygiene and personal needs. He also needs care with meals.

The Agency argued that the Personal Choice Waiver has been reviewed under the Global Waiver to insure all Long-term Care consumers are receiving access to the same quality care.

The Agency uses an assessment of activities of daily living and the applicant's level of needed assistance with these activities to help determine a monthly budget. The comprehensive assessment used to determine clinical eligibility and additional information provided by the beneficiary and/or family members is used by the responsible agency to develop an individualized care plan, identifying the scope and amount of services required to meet the beneficiary's needs as well as the full array of service/care setting options. When the assessment is completed the number of activities a recipient needs assistance with and how often determines units of time needed for these activities. Each activity such as toileting, grooming, dressing and mobility among others is assessed for how much time is used to complete the activity, how many times a day or week it is needed and the cost of each activity. This is also based on how much assistance the individual needs with each activity. (Moderate, minimum or total)

The DHS is responsible for reviewing and approving the aggregate cost neutrality of the home and community based long-term care system on an annual basis. To meet cost neutrality, the average per capita expenditures for home and community-based services cannot exceed one hundred percent (100%) of the average per capita expenditures of the cost of institutional services if the individuals had been institutionalized.

The DHS uses these average monthly costs to Medicaid to assist in determining whether home and community-based services are cost effective as required under Title XIX of the Social Security Act.

In this case it was determined by the Agency, after completion of a new assessment, that the time it took a caretaker to complete the appellants Activities of Daily Living, as they would be completed by a majority of healthcare aides employed by Agencies, was less than the time that had been allocated in the appellants previous budget plan. The Agency also adjusted the amount they pay for each Activity of Daily Living completed by her caretaker and lowered the budget accordingly.

The appellant has the right to work with his case manager to determine what changes he can make to have the needed care provided within the budget. The appellant determines who cares for him, how much they are paid and how many hours they are paid for. The Agency allocates enough funds per month to insure the appellant can pay for the help he needs to complete her Activities of Daily Living needed to remain in the community, not solely for the supervision of the appellant. It is up to the appellant and his case manager to determine how his budget can be used most effectively.

In this case the appellant's budget was based on his need for assistance in almost all activities of daily living; however the Agency did revise the cost of certain activities and the amount of time it should take to complete these tasks.
A new Pm1 was received while the record of hearing remained open, which show higher need for care than the one the Agency's decision was based upon. This was signed by the appellant's doctor.
In summary when the Agency reduced the budget they were using old health information and the new information now needs to be taken into consideration.

After careful review of Agency Policy and the evidence and testimony presented this Appeals Officer finds that the appellant's budget was reduced inappropriately and is not consistent with Agency Policy; therefore his request for relief is granted.

Michael Gorman
Appeals Officer