

- **STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
APPEALS OFFICE - LP Bldg.  
57 Howard Avenue  
Cranston, RI 02920  
(401) 462-2132 / Fax # (401) 462-0458  
TDD # (401) 462-3363**

Date: October 14, 2014

Docket # 14-1102  
Hearing Date: September 2, 2014

**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: 0396.05 Overview of Waiver Programs  
SECTION: 0396.10.10.05 Institutional Level of Care  
SECTION: 0398.30.05 Assisted Living Waiver Program  
SECTION: 0398.30.35 Eligibility Determinations**

The facts of your case, the Agency policy, 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: Your daughter and appointee for Power of attorney, Your legal representative Attorney John C. Revens, Jr., and Agency representatives: Joy Thibodeau-Moore, Bonita D'Abreu, and Deborah Castellano.

Present at the hearing were: your daughter, your legal representative John C. Revens, Agency representative Joy Thibodeau-Moore, and North Bay Manor representatives: Pamela Baldwin, and Brittany Tremblay.

**ISSUE: Was the appellant correctly assessed for level of care in January 2014?**

**DHS POLICIES:** Please see the attached APPENDIX for pertinent excerpts from the Rhode Island 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 representative testified:**

- The policy indicates that each person needs to have a level of care for eligibility.
- Regarding the January application, the medical eligibility portion of the Assisted Living Waiver program is forwarded over to DHS from Tri Town Community Action Agency (Tri Town). That did not happen.
- Subsequently, the application was denied.
- Without the assessment of medical eligibility, the system reads income and considers the applicant as someone who does not have institutionalization, resulting in the person falling into the community medical assistance rules.
- The system then defaults to those rules of anyone looking for additional health insurance, but not necessarily the rules for someone in a setting where they are receiving care.
- DHS was unaware that the application had been submitted to Tri Town.
- The bottom line is-the Agency did not receive it (the application).
- The Agency had told the DEA representative at one point that she already had the Medicaid application, and she was working with the attorney on the financial piece, so that was not needed.

- The only issue is the medical eligibility; as the finances are not the issue at this time.
- The question is not even whether she needs the eligibility or not, but simply that the piece of paper which confirms she needs that high level of care-in order to receive the assistance, has to be received.
- If the facility had completed the social security forms there is the possibility that they could have also assisted with payment.
- The notice indicating that the appellant had not met the level of care is incorrect.
- The issue, as identified on the notice in the free form section, is that the denial is specifically related to the fact that DHS never received the level of care.
- The August 2013 RI Continuity of care form used by the facility is not the same document which the Agency uses to determine Medicaid assisted living level of care.

**The appellant's legal representative and her daughter (power of attorney), and North Bay Manor representatives testified:**

- The North Bay Manor representatives sent in the application to Tri Town.
- They do a referral, and that's all they are actually supposed to do.
- However, the Tri Town representative told them they were to do more than just the referrals. They were told to complete the medicals, and the social security application.
- He (the representative from Tri-Town) would not accept the referral without everything being complete-and that was the reason for the delay. They were unable to get the doctor to sign everything he needed to sign. They had to repeatedly return the application to the doctor for one area or another to be completed.
- In a recent meeting with Mary Ladd of Elderly Affairs, the facility was informed that going forward, they were to send only the referrals to Tri Town-they were not responsible to complete additional forms.
- The North Bay representative did not have knowledge of her (the applicants) income.

- The Tri Town representative was a Case Manager.
- The Tri Town case manager is not available and is no longer with the Agency.
- Tri Town is a subcontractor for DHS to determine partially the degree of eligibility of an applicant for medical assistance in an assisted living facility.
- We began taking steps on Feb.13, 2014 to begin the referral, which identifies: who the potential resident will be, what their diagnosis is, who their contact person is, who their doctor is, and, what assistance they need.
- Our health and wellness director filled out her part, and faxed it to the doctor around February 13, 2014, and the doctor signed the form on February 14<sup>th</sup>.
- The Facility thought the referral was complete at that time, and faxed it to Tri Town, who then returned it for lack of completion. They cannot currently locate all the initial fax cover sheets to identify the dates of correspondences.
- The Tri Town representative sent an email in April to the North Bay Manor boss, saying this was his second request for medicals-but they had been already sent.
- On April 16, he wrote that paperwork had not been completed. He circled what needed completion, and added that the he needed bank account balances.
- On April 25, 2014, the Nursing Home provided by fax, the completed packet to Tri Town. This included the living waiver form, assessments, SSI application, and the medicals.
- The appellant's daughter testified that the appellant initially moved to the first facility, Atria, in 2010 because she (the daughter) had been providing care, but her mother needed increased 24 hour round the clock care, which she could no longer provide.
- The appellant could bathe with assistance, and dress with assistance, and somewhat maintain her home. She could not shop, prepare meals, and take medications. She could not use the stove, or navigate the neighborhood, or walk outside the home.
- She had this diminution in functioning capacity prior to that first admission in 2010.
- Following ten months there, she was moved to New England Bay where she lived for two years.

- At New England Bay, she was originally on the assisted living side, and then she was moved to the memory care unit side around May 2013 because her ability to perform tasks of daily living diminished.
- She was moved from New England Bay to North Bay on September 6, 2013 partially because she was running out of money and New England Bay only accepted private pay; and, because she would need long term care.
- Also, the daughter was working as a CNA in the North Bay long term care facility at that time, and it was easier for her to have her mother in the same facility.
- Based on her two year experience, and training and education, it was clear that her mother (the appellant) was in need of long term care and that medically she should have qualified for medical assistance in an assisted living bed.
- The daughter feels she needs a high level of care.
- In January 2014, she was still on the assisted living side when the daughter filed the application for Medicaid in the attorney's office. She also notified the facility her mother would be applying for a of a Medicaid bed.
- Her mother was then moved from a private bed to a Medicaid bed within the first or second week of February, sharing a room with another resident, but still on assisted care.
- At that time, she could not bathe; could not dress herself, did not know when to take meals, nor could she prepare meals, could not take her medications, and could only sometimes complete toileting.
- There is no dispute about the financial piece.
- The Tri Town representative is not available for hearing as he is no longer with Tri Town.
- The Nursing facility filled out a Continuity of Care Form in house, signed by their Health and Wellness Director which determined on August 13, 2013 that she (the appellant) did meet the Level of Care.
- That assessment showed that she had dementia, IBS, HTN, UTI, MS, Gird, Osteopenia, and Depression.

**FINDINGS OF FACT:**

- A denial notice dated May 29, 2014 informed the appellant his January 2014 application had been denied. The free form text indicated "you do not meet the criteria for institutionalization, no level of care received."
- The appellant filed a timely request for a hearing date stamped July 2, 2014.
- A hearing was held on September 2, 2014.
- The record of hearing was held open for additional evidence, until September 12, 2014, per the appellant's request.
- An email was received from the appellant's representative indicating that no additional evidence would be forthcoming.
- An initial Medicaid referral packet was signed on February 13, 2014 by North Bay Manor, and signed by the primary physician on February 14, 2014.
- The initial packet was assumed to have first been sent to Tri-Town Community Action as evidenced by the transmission of 18 pages of application, on February 17, 2014.
- A fax cover sheet dated April 1, 2014 from Tri-Town Community Action representative notified the facility that the application was incomplete.
- A fax cover sheet dated April 16, 2014 from Tri-Town Community Action representative indicated that this was a second request as the application was incomplete.
- A fax cover sheet, and fax transmission date of April 25, 2014 identifies a completed 18 page referral sent from North Bay Manor to the Tri-Town representative.
- There were no further submissions from the Tri-Town representative to the facility or the appellant.
- The DHS Long Term Care worker never received a Level of Care application from the Tri-Town representative.
- The Tri-Town representative was unavailable for testimony, and no longer works for the Agency.

- Tri-Town Community Action is a Division of Elderly Affairs (DEA) Case Management Agency.
- DEA is under the authority of the Department of Human Services.

### **CONCLUSION:**

The issue to be decided is whether the appellant was correctly assessed for level of care in January 2014?

The Agency contends that the appellant was correctly denied eligibility because DHS never received a level of care request, thus rendering it impossible to make a determination.

A review of Medical Assistance (MA) policy indicates that in order to be eligible for home-based services under a Waiver, an applicant must require the level of care provided in an institutional setting. The DHS Long Term Care Unit (LTC) receives, reviews and approves the Waivers (when appropriate), which are submitted by the Case Managers.

There is no dispute that the LTC worker never received the application from the case manager. There is no dispute between the Agency and the appellant regarding financial considerations or medical eligibility. The Agency identified they could not find for the appellant because they did not receive, nor were they aware that a referral had been made to the Tri Town case manager.

The North Bay representatives testified that they had made a good faith effort to apply for a Waiver through a Tri Town representative. They further testified that they completed and faxed their submission on April 25, 2014, but that they had submitted their first referral, dated February 13, 2014, somewhere in mid-February. They enumerated numerous difficulties completing the forms to the satisfaction of the representative. They cited in particular, that they were unable to obtain the completed medical forms from the primary physician which in turn delayed the process. A review of the evidence supports this argument in that the initial portion of the application signed by the doctor was done so on February 14, 2014. Fax face sheets indicated that per request of the Tri Town case manager, the medical portion was resubmitted on April 9, and April 10<sup>th</sup>, and a second identical document was then also completed by an RN who requested the doctor complete the form by signing it again. His signature on the identical second medical form was dated April 9, 2014. Review of the evidence indicated that the initial application was most likely submitted to Tri Town on February

17, 2014. A fax transmittal sheet dated April 1, 2014 from the Tri Town representative notes that the nursing facility had not completed page 2 of the referral. He also requested that the facility or the family was to submit proof of bank account balances, and he instructed the facility to "give family my phone and fax #". The representative had circled the section of the medical form which requested the doctor's name be printed legibly. However, the doctor had print stamped his name and address prominently on the bottom of the form. Additionally, the North Bay representative identified that she had not thought it was the responsibility of the nursing facility to complete the medicals, and they were unaware of the financial situation of the resident. They completed the forms but noted that a Department of Elderly Affairs representative has since informed them that they need not complete anything but the initial application "moving forward". The Tri Town representative was not present to dispute the testimony of the facility.

A second request for information, dated April 16, 2014, was requested by the Tri Town representative indicating that the paperwork was still incomplete. An 18 page application in which all the previously circled areas of omission were completed was sent to the representative on April 25, 2014. There were no other correspondences or requests noted between the facility and Tri Town. The appellant's daughter and her representative both noted dual requests from the Tri Town representative, indicating that on two occasions they had both been asked to resubmit information they had already submitted. Tri Town was not available to dispute any testimony.

The appellant's representative identified that Tri Town was a subcontractor for DHS. Paperwork submitted by Tri Town likewise identifies Tri-Town Community Action as a DEA Case Management Agency. Further exploration of policy notes that "case management function rests with DEA and may be performed by DEA or agency staff under contract to DEA." In this case it would appear that the Tri-Town representative was working on behalf of the Division of Elderly Affairs, whose agency in turn, is regulated by the Department of Human Services. The DHS worker present at hearing testified she had never received any correspondence, or referral from the case manager, who as noted above, was also working on behalf of the DHS agency.

In summary, the appellant's credible and undisputed testimony as presented by her daughter, by her legal representative, and through the North Bay Manor representatives, suggested that she had made a good faith effort to apply for medical assistance in February 2014. The initial application was sent on February 17, 2014, but no response was forthcoming until approximately 6 weeks later, when the Tri-Town representative requested on at least two occasions, a completed application. The North Bay Manor representatives testified that much of what was requested was outside their responsibilities. The appellant's daughter and legal representative indicated the requests were sometimes redundant. All three parties noted inconsistencies and negligence on the part of the Tri-Town representative. On April 25<sup>th</sup>, the application appeared to be complete, and no further evidence indicated that the Tri-Town representative ever requested more information. One month later, on May 29, 2014, the appellant was denied medical assistance as a direct result of the paperwork having

never been received by the Long Term Care worker. No evidence was available which might have shed light on the fate of the referral, as it never reached the Long Term care worker, nor was it returned to the appellant for completion. Clarity could not be obtained from the Tri-Town representative as he was not available at hearing, and testimony given identified that he is no longer an employee of Tri-Town. In short, undisputed testimony indicates that the appellant, through no fault of her own, was not given an opportunity to complete or submit her application in a timely manner. The appellant's request for relief is granted.

After a careful review of the Agency's policies as well as the testimony given, this Appeals Officer finds that the appellant was not correctly assessed for level of care for January 2014.

#### **ACTION FOR THE AGENCY**

The Agency is to rescind the May 2014 notice of denial; and to allow the appellant to submit a level of care application dated January 2014 in order to make a determination of eligibility. The Agency is to inform the appellant in writing: what is needed in order to complete her application; and the name and phone number of the current Tri-Town liaison. The Agency is to document the process in order to allow a paper trail. The appellant has until November 14, 2014 to submit a completed application to DHS.



**Karen E. Walsh**  
Appeals Officer

**APPENDIX**

## **MEDICAL ASSISTANCE**

### **0396.05 Overview of Waiver Programs**

REV: April 2014

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 Waiver Programs must be approved by the Health Care Financing Administration of the U.S. Department of and Human Services.

Home and community-based services are a humane, cost-effective, and generally preferable way of providing institutional levels of care to eligible individuals. The Medicaid agency provides Home and Community Based Services to eligible aged and disabled individuals under a Waiver Program operated by the Long Term Care/Adult Services unit (see Section 0398.05).

The Medicaid agency also operates Waiver Programs in conjunction with other agencies to serve the needs of certain target populations. These jointly operated programs are the following:

The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) program for developmentally disabled individuals ("MR Waiver" - see Section 0398.10);

The Division of Elderly Affairs (DEA) program for individuals in the community or seeking to return home from nursing facilities ("DEA Waiver" - see Section 0398.20);

The Division of Elderly Affairs (DEA) program for aged and disabled individuals in specified Residential Care/Assisted Living Residences ("Assisted Living Waiver" - see Section 0398.30).

State agency Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of financial eligibility for Medicaid for all waiver recipients. Since categorically needy individuals receive a greater scope of services, waiver recipients must be determined to be eligible as categorically needy whenever possible.

Case managers at BHDDH, DEA, and for the Personal Choice Program assist in the determination of eligibility for the Waiver Programs by forwarding information to the state agency LTC/AS unit, and by communicating directly with their applicants and recipients regarding eligibility and income allocation matters.

The Waiver Programs differ in:

Target populations;

2

Special home and community-based services provided to eligible recipients;

Eligibility level required for participation (Categorically Needy or Medically Needy);

and

Procedures.

This section contains the policies that generally pertain to all Waiver Programs, including determinations of eligibility, post-eligibility treatment of income, and determinations of cost effectiveness.

Exceptions are listed, where applicable, in the following sections specific to each Waiver Program.

#### **0396.10.10.05 Institutional Level of Care**

REV: April 2014

In order for an individual to be eligible for home-based services under a Waiver, s/he must require the level of care provided in an institutional setting. Case managers recommend the appropriate level of institutional care for each Waiver applicant, subject to the review and approval of the State's Office of Medical Review (OMR).

Policy and criteria for establishing levels of care are found in Section 0378, prior authorization.

Each Waiver Program's targeted population is a specific subset of the overall population requiring institutional services. The appropriate level of care for eligibility varies with each Waiver Program.

#### **0398.30.05 Assisted Living Waiver Program**

REV: 12/2000

Pursuant to R.I.G.L. 42-66.8, the Department of Human Services (DHS) received approval from the Health Care Financing Administration (HCFA) to administer a home and community-based waiver for up to two hundred (200) elderly and disabled individuals residing in Assisted Living Facilities. Initiated through the combined efforts of DHS, DEA, and the Rhode Island Housing and Mortgage Finance Corporation (RIHMFC), this innovative waiver not only utilizes existing facilities but, for the first time, develops and provides publicly financed housing units for assisted living purposes for frail elderly and disabled individuals.

The purpose of the Assisted Living Waiver program is to provide home and community-based services to eligible elderly and disabled individuals in qualified assisted living facilities as an alternative to nursing facility care at a cost which is less than or equal to the cost of institutional care.

##### **Target Population**

REV: 12/2000

The program is designed to assist individuals who:

- are over the age of sixty-five (65) or disabled;
- receive SSI or meet the categorically needy MA eligibility requirements for an institutionalized individual (income within the Federal Cap);
- require the level of care provided in a nursing facility; and
- reside or have the opportunity to reside in an Assisted Living Facility.

##### **Waiver Services**

REV: 12/2000

In addition to the normal scope of categorically needy services, the following special services are provided under the waiver:

- **Case Management Services**

Services which assist individuals in gaining access to needed waiver, MA, and any necessary medical, social, or educational services. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care. In addition, they are responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

- **Specialized Medical Equipment and Supplies**

Includes devices, controls, or appliances specified in the plan of care, which enable individuals to increase the ability to perform activities of daily living (ADLs), or to perceive, control or communicate in the environment in which they live.

Also includes items necessary for life support, ancillary supplies and equipment necessary to proper functioning of such items, and durable and non-durable medical equipment not available to MA eligible individuals except as provided under this waiver. Items which are not of direct medical or remedial benefit to the individual are excluded. All items must meet applicable standards of manufacture, design and installation.

- **Assisted Living Services:** Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to such arrangement) which must contain bedrooms and toilet facilities. The consumer has a right to privacy. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Also included are medication administration and transportation specified in the plan of care.

MA payments for assisted living services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement, twenty four (24) hour skilled care or supervision.

## **Facility Certification Standards**

REV: 12/2000

In addition to meeting all requirements of Rhode Island's assisted living licensing regulations, a facility must meet the following criteria in order to participate as a provider under this waiver:

### ○ **Affordability**

Providers must agree to make available up to 20% of their units to low-income and/or MA waiver individuals subject to demand and availability. Facilities with less than 20% low income/waiver occupancy are required to retain residents who exhaust their resources and convert from private pay to SSI/MA waiver status.

### ○ **Design Guidelines**

The architectural design of the facility should create a residential setting that emphasizes a "home-like" environment while providing for a supportive service infrastructure.

### ○ **Occupancy requirements**

Facilities must provide for single occupancy units with private bath and toilet. Double occupancy may be allowed in the case of consumer choice, i.e., spouses or siblings, upon approval of the Department of Elderly Affairs.

### ○ **Service Requirements**

Each facility must provide at a minimum a service package as follows:

- 1 . Direct assistance to residents with at least two (2) activities of daily living (ADLs) by a Certified Nursing Assistant (CNA) and including but not limited to assistance with bathing, continence, dressing, ambulation, toileting, eating and transfers.
- 2 . Assistance with housekeeping, medication management (with M-1 licensure), linen services, laundry services (including personal laundry, exclusive of dry cleaning), and such transportation services as may be specified in the plan of care.
- 3 . A program of social and recreational activities.
- 4 . Twenty-four (24) hour on-site staff adequate to meet scheduled or unpredictable needs in a way that promotes dignity and independence while maintaining provider supervision, safety, and security.

### ○ **Participation Requirements**

Owners of existing assisted living facilities who wish to participate in the Assisted Living Waiver Program must meet the standards stated above. The physical plant, financial capacity, adequacy of services, and commitment to servicing low-income individuals will be evaluated prior to approval of participation in the program.

### **DHS Responsibilities**

REV: 12/2000

The DHS Center for Adult Health has the responsibility to review and approve or deny the level of care assessments completed by DEA.

The Center for Adult Health has the responsibility for:

- initial determinations and annual redeterminations of MA eligibility;
- review and approval of DEA's calculation of the recipient's income to be allocated to the cost of waiver services (if any);
- related InRhodes approval/denial;
- notification of agency action in accordance with 0376.25; and
- maintenance of the DHS case file.

### **DEA Responsibilities**

REV: 12/2000

The case management function rests with DEA and may be performed by DEA or agency staff under contract to DEA. The case management function does not include determination of MA eligibility.

Specific DEA responsibilities are:

#### **1. POINT OF ENTRY IDENTIFICATION**

DEA staff or DEA contracted staff identifies potential candidates in the target population of aged and disabled individuals residing in or seeking to reside in Assisted Living Facilities. Individuals may be referred to the

waiver program by family, friends, facility staff, community based social service agencies, the LTC Ombudsman or through self-referral.

The case manager contacts the appropriate LTC office and, when necessary, assists the individual in completing an application for Medical Assistance/LTC. The application is then forwarded to the appropriate LTC office for determination of eligibility.

#### **2. CONFIRMING MA ELIGIBILITY STATUS**

Prior to providing services under the waiver program, and at each reassessment, the case manager contacts the LTC unit and confirms that the individual is eligible for Medical Assistance and has an active case number.

#### **3. PRELIMINARY CALCULATION OF COST-EFFECTIVENESS AND CALCULATION OF INCOME ALLOCATION TO COST OF CARE:**

The case manager completes a preliminary calculation of the cost effectiveness of program services, and the amount of income to be allocated to the cost of care. These determinations are subject to review and approval by the LTC unit. Once the individual plan of care is completed, forms CP-3 and CP-4 are completed by the case manager. The CP-3 worksheet is designed to assist the case manager in calculating the monthly cost of the individual's plan of care. The CP-4 worksheet is used by the case manager to calculate the cost effectiveness of waiver services compared to institutional services, the maximum amount that can be paid by Medical Assistance for waiver services, and the amount the individual must contribute towards the cost of care.

#### **4. NOTIFICATION TO INDIVIDUALS ACCEPTED INTO THE PROGRAM**

The CP-7A is used to notify individuals of acceptance into the program and to indicate the amount of any income which must be contributed to the cost of care. Enclosed with the CP-7A is form CP-5A, the Individual's plan of care. The forms are completed by the case manager. The original forms and one copy of each are forwarded to the appropriate LTC office along with the completed CP-3 and CP-4 for review and approval. If approved, the LTC worker countersigns the CP-7A and sends the CP-7A and CP-5A, along with forms used to request a hearing (AP-121 and 121A), to the individual.

#### **5. CASEMANAGEMENT**

The case manager evaluates and monitors the abilities and needs of the candidate and develops an individual written plan of care based upon the functional assessment used by DEA to measure the abilities, deficits and environmental modifications required. The informal supports that are available for each individual are incorporated into the plan. DEA's recommended plan of care is recorded on the CP-1 and forwarded to the DHS Office of Medical Review for approval. OMR's approval is recorded on the CP-1, and copies of the completed form are returned to DEA and the LTC office for incorporation into the case record.

The plan of care contains at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each services. A copy is retained in individual's record at both DEA and DHS for a minimum period of three (3) years.

Specifically, the casemanager:

- makes a preliminary evaluation, using the CP-4, of the cost-effectiveness of waiver services and income to be allocated to the cost of services;
- secures an information release form signed by the candidate allowing DEA and DHS to share information regarding the candidate;
- apprises each candidate in writing of the availability of services in either an institutional or in a community assisted living setting under the waiver. The candidate's choice is recorded on the CP-12A, forwarded to the LTC unit for filing in the case record with a copy retained by DEA for the individual's record;

- assesses, reassesses and updates the recipient's plan of care at least every twelve (12) months to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability;
- monitors the provision of services included in the individual's plan of care; and
- coordinates with the individual, the LTC unit, and the assisted living facility the allocation of the individual's income to be applied to the cost of care.

## **6. REASSESSMENT OF NEED FOR NURSING FACILITY CARE**

The case manager has the responsibility for re-evaluating the recipient's need for a nursing facility level of care at least every twelve (12) months. To remain eligible for the program, the individual must continue to require a nursing facility level of care. If reassessment indicates nursing facility care is required, the case manager completes and forwards form CP-1 to the Center for Adult Health, Long Term Care Unit at Central Office, where it is reviewed and approved.

### **0398.30.35 Eligibility Determinations**

REV: 12/2000

To receive services under this waiver program, the aged or disabled individual must receive SSI or be eligible as a categorically needy institutionalized individual (income must be within the Federal Cap), reside in or have the opportunity to reside in an Assisted Living Facility meeting the certification requirements in Section 0398.30.20, and require a Nursing Facility level of care. The DEA case manager assists the individual in completing the application and related forms needed to apply for Medical Assistance Waiver Services, and forwards the completed forms to the appropriate LTC office.

Individuals applying for this program may already be eligible for Medical Assistance as determined by the LTC Unit or a community MA unit, or automatically eligible as an SSI recipient. A new application is not required when a DHS-2 has been completed within the past twelve (12) months and the individual is still within a current certification period. In this case, the current case file may be used, together with any additional required documentation (e.g., information relating to trusts and transfers of resources), to determine eligibility for the program.

Eligibility determinations and redeterminations are conducted by appropriate Long Term Care (LTC) staff as if the individual were institutionalized. An applicant must meet the technical and characteristic requirements, have resources within the Categorically Needy limits and income under the Federal Cap in order to qualify.

When the individual has a community spouse, resources are evaluated in accordance with spousal impoverishment rules contained in Section 0380.40 - 0380.40.35. In the application of spousal impoverishment rules to waiver applicants or recipients, all Section 0380 references to institutionalized spouses and continuous periods of institutionalization include individuals receiving assisted living waiver services in lieu of institutional services.

Any transfer of assets must be evaluated in accordance with policy in Section 0384. The look-back period for evaluating transfers of assets is calculated from date the individual began receiving assisted living waiver services or the date of MA application, whichever is later.

Individuals are provided with written notice of eligibility or ineligibility in the usual manner. The LTC unit conducts redeterminations of eligibility each year, unless a change is anticipated sooner. Individuals are required to report changes in circumstances, such as changes in income or resources, which could affect eligibility.

#### **Maintenance of Case Files**

The LTC unit is responsible for maintenance of both the electronic (InRhodes) and paper case file, which contains all documents and information relating to the determination of financial eligibility and income allocated to the cost of care.

#### **Allocation of Income to the Cost of Care**

Once eligibility has been determined the DEA Case Manager calculates the individual's income to be applied to the cost of care, using forms CP-3 and CP-4. The completed forms are forwarded to the appropriate LTC unit for review and approval.

#### **Review of Cost-Effectiveness and Income Allocation**

The LTC worker receives the completed CP-3, CP-4, CP-5A, and CP-7A from DEA. The LTC worker is responsible for review and approval of the DEA case manager's preliminary calculations of the cost effectiveness of Waiver services and the income to be applied to the cost of care. If approved, the LTC worker countersigns the CP-7A and sends it and the CP-5A to the individual. If corrections are needed, the LTC worker consults with the DEA Case Manager to make the necessary changes prior to notifying the individual.

#### **Allocation of Income to Cost of Care**

REV: 12/2000

All individuals receiving services under this waiver program are subject to the post-eligibility treatment of income and allocation of income to cost of waiver services. This includes those individuals receiving the enhanced SSI payment for Residential Care/Assisted Living, providing however that no part of the SSI Federal Benefit Rate (FBR) is allocated to the cost of waiver services.

The individual's income is allocated toward the cost of waiver services as follows:

#### **FOR A SINGLE INDIVIDUAL**

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

- o **Personal/MaintenanceNeedsAllowance**

An amount equal to the facility's charge for room and board plus a \$100 personal needs allowance, the combined total not to exceed the SSI standard for an individual in residential care/assisted living (See Section 0402.05).

The individual is allowed to retain \$100 for personal needs, and is then responsible for paying the facility's charge for room and board.

- **Medical Insurance Premium**

- **Allowable Costs Incurred for Medical or Remedial Care FOR AN INDIVIDUAL WITH A COMMUNITY SPOUSE AND/OR DEPENDENTS**

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

- **Maintenance Needs Allowance** - as above

- **Spouse/Dependent Allowance**

An amount of income may be allocated for the support of the community spouse in accordance with policy contained in 0392.15.20 - 0392.15.20.10. The community spouse may reside either with the individual in the assisted living unit or in the community.

An additional amount of income may be allocated for support of other dependent family members who live with the community spouse following provisions contained in 0392.15.25.

When there is no community spouse, an amount of income may be allocated for the support of dependent family members in accordance with Section 0392.15.25.05.

- **Medical Insurance Premium**

- **Allowable Costs Incurred for Medical or Remedial Care**

Any balance of income remaining after these expenses are deducted is allocated toward the cost of the waiver services. Note that the individual is responsible for paying the facility's charge for room and board

### **NOTICE OF APPELLATE RIGHTS**

This Final Order constitutes a final order of the Department of 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.